IHSC Public Health Actions for Tuberculosis Care Guide

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ICE

ICE Health Service Corps

FOREWORD

This U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) 05-11 G-02 *Public Health Actions for Tuberculosis (TB) Care Guide: IHSC Headquarters* supplements IHSC Directive 05-11 (ERO 11786.1), *Public Health Actions for Tuberculosis Care*.

The IHSC Public Health, Safety, and Preparedness (PHSP) Unit developed and maintains the guide. This document provides guidance for IHSC Headquarters (HQ) staff on public health actions for TB case management and continuity of care.

This guide applies to IHSC headquarters staff who support ICE health care operations.

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TABLE OF CONTENTS

I. INTRODUCTION

A. Purpose

The *IHSC Public Health Actions for Tuberculosis Guide: IHSC Headquarters* provides official guidance for IHSC Headquarters staff who implement IHSC Directive 05-11, *Public Health Actions for Tuberculosis Care*. This guide supplements IHSC 05 G-01, *IHSC Public Health Actions for Tuberculosis Guide: IHSC-Staffed Medical Clinics*.

B. Background

Tuberculosis, commonly referred to as "TB," is a serious infectious disease caused by the Mycobacterium *tuberculosis* (M. *tuberculosis*) bacterium. It usually attacks the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. TB bacteria transmit through airborne particles (droplet nuclei) that result when persons with pulmonary or laryngeal TB cough, sneeze, shout, or sing. Effective treatment for TB disease requires uninterrupted, supervised treatment by directly observed therapy with multiple medications for 6-24 months. If a person with TB disease does not complete the entire course of treatment, interrupts treatment, or takes treatment irregularly, the person may become seriously ill, return to a contagious state, transmit TB to other people, acquire drug resistance or multi-drug resistance, and/or die from TB.

The protocols described in this guide give IHSC Headquarters staff the resources and tools for TB case management and continuity of care. The goal is to facilitate successful and uninterrupted completion of treatment during custody, transfer, release, or removal for ICE detainees with TB. IHSC conducts these activities in collaboration with other health care and public health professionals outside the detention health system.

C. Policy

IHSC staff implement public health actions for TB care which include a broad range of activities and interventions that promote and protect health and prevent or mitigate infectious disease transmission.

D. Roles and Responsibilities

- **Infection prevention officers (IPOs)** at field sites implement TB case management activities in accordance with IHSC 05-11 G-01, *Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinic*s. When present, IPOs lead TB contact investigations within IHSC-staffed facilities.

- **Facility healthcare program managers (FHPMs),** at field sites without IPOs, implement TB case management activities in accordance with IHSC 05-11 G-01, *Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics.* FHPMs lead TB contact investigations when the facility does not have an assigned IPO on-site.
- **Health services administrators (HSAs),** at field sites without IPOs or FHPMs, ensure appropriate implementation of TB case management activities in accordance with IHSC 05-11-G-01, *Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics*. HSAs lead TB contact investigations when the facility does not have an assigned IPO or FHPM on-site.
- **Regional infection prevention supervisory nurses** provide guidance to IHSC staff in all locations and oversee TB case management activities within their respective regions. The regional infection prevention supervisory nurses liaise with IHSC facility staff, field medical coordinators (FMCs), IHSC supervisors, and government and non-government public health and law enforcement partners.
- The **PHSP Unit chief** provides overall supervision to the PHSP Unit and advises on public health actions for TB care.
- The **PHSP Unit senior public health analyst** supports data collection, data management, data analysis, and communications with government and non-government public health and law enforcement partners.
- **IHSC FMCs** liaise with PHSP Unit staff and facilitate communications and information sharing about ICE detainees with confirmed or suspected TB disease in their areas of responsibility.
- The national infectious disease consultant, infectious disease advanced practice provider, and infectious disease public health analyst(s) liaise with PHSP Unit staff on public health actions for TB care.

II. PROCEDURES

A. Reporting to the PHSP Unit

- IHSC staff must initiate reporting of detainees with confirmed or suspected TB disease who meet any of the following criteria, including detainees diagnosed at previous facilities or prior to custody:
- nucleic acid amplification test result positive for mycobacterium TB,
- bacteriology result positive for acid fast bacilli,

- cavitation on chest radiography,
- symptoms consistent with TB disease lasting two weeks or longer,
- multi-drug TB therapy initiated or continued, and/or
- culture-confirmed TB.
- IPOs, FHPMs, and FMCs report detainees with confirmed or suspected TB disease to the PHSP Unit using the TB case management reporting tools on the PHSP Unit SharePoint page.
- IPOs, FHPMs, other designated staff (at facilities with no IPO or FHPM), and FMCs update records in the reporting tools promptly as new clinical, diagnostic, laboratory, and treatment information becomes available.
- For any detainee identified with multi-drug resistant TB or extensively drug resistant TB, IHSC staff notify the regional infection prevention supervisory nurse promptly by telephone.

B. Placement in general population

- For detainees initially evaluated for TB disease at IHSC-staffed facilities, medical providers follow the *IHSC Suspected and Confirmed Pulmonary Tuberculosis Medical Provider Guidance* available in the IHSC Clinical Guidelines library on SharePoint. This guidance provides clinical protocols for initial evaluation and management of suspected and confirmed TB; it includes clinical criteria for placement in, and release from, airborne infection isolation to general population housing.
- For detainees sent from an IHSC-staffed facility to a local hospital for initial evaluation and management of suspected TB disease, the IPO in collaboration with the medical providers (or the FHPM if the facility does not have an IPO position), must review clinical, diagnostic, laboratory, and treatment information from the hospital to ensure the detainee meets non-contagious criteria for placement in general population housing. The HSA should delegate these responsibilities if the facility does not have IPO for FHPM positions.
- For detainees sent from a non-IHSC-staffed facility to a local hospital for initial evaluation and management of suspected TB disease, the FMC in collaboration with the regional infection prevention supervisory nurse must review clinical, diagnostic, laboratory, and treatment information from the hospital to ensure that the detainee meets non-contagious criteria for placement in general population housing.

- FMCs must provide non-IHSC staff within their AORs with the Memo to Community Healthcare Providers on Identification and Treatment of Pulmonary Tuberculosis. This resource is available on the National TB Controllers Association website. It informs community health care personnel about the burden of pulmonary TB disease that exists among individuals held in ICE custody and ICE's approach to pulmonary TB disease management. The memo includes a checklist for return to referring detention facility for placement in general population following evaluation for suspected TB.

C. Medical holds and medical alerts

- IHSC staff utilize medical holds as a tool to communicate the need for a requested action for medical or public health reasons. Examples include recommended movement restrictions: while the detainee is contagious; until the transnational referral process is complete; or prior to transfer, release, or removal.
- IPOs, FHPMs, and FMCs, in collaboration with regional infection prevention supervisory nurses, must place medical holds and medical alerts for detainees with suspected or confirmed TB disease.
- For a full description and instruction medical holds and medical alerts, IHSC staff should refer to IHSC Directive 05-06, *Infectious Disease Public Health Actions* and 05-06 G-02, *Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms*.

D. Public health coordination

Guiding principles:

IHSC staff facilitate release planning, including domestic or transnational referrals for continuity of care for detainees with suspected or confirmed TB disease requiring anti-TB therapy. Effective release planning involves interviewing the patient to obtain intended addresses, telephone numbers, email addresses, and personal contacts in the U.S. and in the country of nationality. Health department staff and/or Centers for Disease Control and Prevention (CDC) CureTB staff may conduct these patient interviews in person or by telephone at pre-arranged time. The PHSP Unit recommends IHSC staff always prepare for any possible outcome to a detainee's immigration proceedings, including release or removal. IHSC should not delay release planning until the outcome to proceedings is known.

IHSC staff should always confirm with local or state health departments that health department staff are aware of detainees with suspected or verified TB disease in

their jurisdictions. Coordination with public health authorities ensures the health department TB Program is aware the detainee is in ICE custody and takes this into consideration when release planning.

IHSC staff must coordinate with local or state health departments to ensure TB public health continuity of care and conduct contact investigations. Coordination may also include expert consultation for detainees with significant medical complications, such as multi-drug resistant (MDR) TB, extensively drug resistant (XDR) TB, poor tolerance to therapy, or a history of non-compliance. ICE has an agreement with the CDC Division of Global Migration and Quarantine for transnational referral services through the CDC's CureTB Program; it is the only program ICE uses to link TB patients to care outside the United States.

IHSC must not disclose information regarding a detainee's immigration case, status, or proceedings and other law enforcement-sensitive information to non-DHS entities. IHSC staff must refer questions about the detainee's immigration case, status, or proceedings to the ICE Office of the Principal Legal Advisor (OPLA).

Public health coordination for detainees in facilities with IHSC medical staffing:

For IHSC-staffed facilities, the IPO or FHPM facilitates the transnational referral and communications with the local health department TB program before and after ICE releases the detainee from custody. If the facility does not have IPO or FHPM positions, the HSA delegates these responsibilities.

Public health coordination for detainees in facilities without IHSC medical staffing:

For non-IHSC-staffed facilities, the FMC collaborates with the regional infection prevention supervisory nurse to communicate the importance of release planning with facility medical staff. Release planning includes transnational referrals through CDC CureTB and notifications to local health department TB programs. Facility staff must initiate planning and notification as soon as they identify a patient with suspected or confirmed TB disease who requires multi-drug therapy.

The regional infection prevention supervisory nurse communicates with local or state health department TB program staff to identify and report the patient with suspected or confirmed TB disease is in ICE custody and request the health department facilitate domestic or transnational referral.

E. TB clearance requirements for transportation

ICE Air Operations may reference the Tuberculosis Clearance for Air Transport for ICE Detainees: Reference Sheet to guide their decisions for TB clearance to board aircraft. IHSC does not have authority over ICE Air Operations policies or decisions. However if needed, IHSC staff may refer ICE Air Operations and ICE Enforcement and Removal Operations (ERO) leadership to the Tuberculosis Clearance for Air Transport for ICE Detainees: Reference Sheet to facilitate acceptance of the detainee for boarding.

F. TB contact investigations

- TB contact investigations are a tool to facilitate public health actions following significant exposures to a person identified as contagious with pulmonary or laryngeal TB.
- TB contact investigations may or may not involve testing of other individuals.
- The index patient's contagious status and exposure factors determine the need for testing of contacts. Factors include proximity to the index patient, duration of exposure, ventilation, and other environmental conditions during exposure.
- When testing is indicated, the IPO or FHPM collaborates with local health department TB programs to prioritize contacts and establish tiered groups for testing. Highest priority contacts are those with most significant exposures and/or highest risk of TB disease progression; they are in the first tier. IHSC and health department staff use their test results to guide the decision to expand testing to lesser priority tiers. IHSC and health department staff can expand testing to successive, lower priority tiers only if testing of higher priority contact tiers suggest transmission occurred.
- Detainee contacts may include, but are not limited to:
- Bunk mates and roommates in close proximity.
- Close contact dorm mates prioritized by proximity of head position during sleeping and high risk for TB disease progression.
- Detainees held in holding cells with the index patient for eight hours or longer.
- Detainees transported with the index patient in an enclosed vehicle for 8 hours or longer.
- Detainees transported on an airplane within 3 rows for 8 hours or longer.

- Detainees that routinely socialized in close proximity with the index patient.
- Detainees who lived or traveled with the index patient prior to custody.
- Detainees with high risk for progression to TB disease if exposed and infected, include individuals who:
- Have HIV.
- Have diabetes mellitus.
- Have silicosis.
- Have a history of injection or non-injecting illegal drug use.
- Abuse alcohol.
- Undergo cancer treatment.
- Have another condition that causes an immunosuppressed state (e.g., lymphoma, autoimmune disorders, on chronic steroid therapy)
- Is more than 10 percent underweight.
- IHSC staff conduct or facilitate contact investigations in consultation with the local health department, to determine the index patient's contagious period, significant exposures, scope of the contact investigation, and scope of follow up actions.
- IHSC staff must consult with the HSA and ERO leadership to identify detainees potentially exposed to the index patient, obtaining information about current custody status and location. IHSC staff may gather lists of contacts concurrently to efforts to determine the scope of the investigation.
- Staff preparing the lists of potentially exposed detainees should identify detainees with high risk for progression to TB disease.
- IHSC staff cannot provide medical services or public health interventions to ICE or facility staff.
- IHSC staff must cooperate with health departments to facilitate contact investigations involving detainees or ICE and facilities staff.

G. Terms and Definitions:

Acid fast bacilli (AFB) examination. A laboratory test that involves microscopic examination of a stained smear of a patient specimen (usually sputum) to determine if mycobacteria are present.

Airborne infection isolation room. A room designed to maintain airborne precautions with negative pressure ventilation. An airborne infection isolation room is a single-occupancy patient care room used to isolate persons with suspected or confirmed conditions transmitted through the airborne route, such as infectious TB disease.

Cavity (pulmonary). A hole in the lung parenchyma, usually not involving the pleural space. A TB cavity substantial enough to see with a normal chest radiograph predicts contagiousness.

Close contact to a TB patient. A person who shared the same air space in a cell or room, or other enclosed environment for a prolonged period (days or weeks, not minutes or a couple hours) with a person with suspected or confirmed TB disease. Close contacts considered high priority because they have the highest risk for infection with *M. tuberculosis*.

Directly observed therapy (DOT). Adherence-enhancing strategy in which a health care professional or other trained person watches a patient swallow each dose of medication. DOT is the standard care for all patients with TB disease.

Exposure. The condition of being subjected to something (e.g., an infectious agent) that could have an adverse health effect. A person exposed to *M. tuberculosis* does not necessarily become infected.

Extensively drug resistant (XDR) TB. Multi-drug resistant TB plus resistance to a fluoroquinolone and an injectable aminoglycoside.

Index patient. The first person with TB disease identified in a particular setting. This person might indicate a potential public health problem; this individual is not necessarily the source patient.

Infectious period. The period during which a person potentially transmitted a communicable micro-organism to others. For patients with positive AFB sputum smear results, the infectious period begins three months before the collection date of the first positive smear result or the symptom onset date (whichever is earlier). The infectious period ends when the patient is placed into airborne infection isolation, or the date of collection for the first of consistently negative smear results. For patients with negative AFB sputum smear results, the infectious period extends from one month before the symptom onset date and ends when the patient is placed into airborne infection isolation (whichever was earlier).

Mycobacterium (M.) tuberculosis. The namesake member organism of *M. tuberculosis* complex and the most common causative infectious agent of TB disease in humans. In certain instances, the species name refers to the entire *M. tuberculosis* complex, which includes *M. bovis, M. africanum, M. microti, M. canetii, M. caprae,* and *M. pinnipedii*.

***M. tuberculosis* culture.** A laboratory test that grows the organism from a submitted specimen (e.g., sputum) to confirm the presence of M. tuberculosis. This test usually takes 2–4 weeks for mycobacteria to grow.

Multi-drug resistant (MDR) TB. TB with resistance to at least isoniazid (INH) and rifampin.

Nucleic acid amplification test (NAAT). Laboratory method used to target and amplify a single DNA or RNA sequence usually for detecting and identifying a microorganism. The NAA tests for *M. tuberculosis* complex are sensitive and specific and can accelerate the confirmation of pulmonary TB disease. Some versions of NAAT also test for molecular mutations consistent with rifampin resistance.

Smear (AFB smear). A laboratory technique for preparing a specimen to view the bacteria under a microscope. Sputum smear results are usually reported as numbers of AFB per high-powered microscopy field or as a graded result, from +1 to +4. The quantity of stained organisms predicts infectiousness.

Sputum. Mucus containing secretions coughed up from inside the lungs. Tests of sputum (e.g., smear and culture) can confirm pulmonary TB disease. Sputum is different from saliva or nasal secretions, which are unsatisfactory specimens for detecting TB disease.

H. References

- Memo to Community Healthcare Providers on Identification and Treatment of Pulmonary Tuberculosis. This resource is available on the National TB Controllers Association website. It informs community health care providers about the burden of pulmonary TB disease that exists among individuals held in ICE custody and ICE's approach to pulmonary TB disease management. The memo includes a checklist for return to referring detention facility for placement in general population following evaluation for suspected TB.
- CDC TB Guidelines by Topic. CDC Tuberculosis guidelines should be referenced as the national standards on tuberculosis public health actions.

- CDC CureTB Referral Program. References and resources for the CDC CureTB Program.
- TB Centers of Excellence. Federally-funded TB Centers of Excellence provide useful resources, products, training, and clinical consultation for medically-complex TB patients.
- National Tuberculosis Controllers Association, State-City-Territory. Useful resource for key points of contact with state and big city health department TB programs.
- CDC TB website, State TB Control Offices. Useful resources for links to state health department TB programs.
- National Tuberculosis Controllers Association, Resources for TB Care in Corrections Settings. Resources for TB care in detention settings.
- Find TB Resources, TB Education & Training. Useful educational and training resources on TB care.
- IHSC staff may refer ICE Air Operations and ERO leadership to the Tuberculosis Clearance for Air Transport for ICE Detainees: Reference Sheet, if needed to facilitate acceptance of the detainee for boarding. This reference sheet is not an IHSC policy; IHSC does not have authority for ICE Air policies or boarding decisions.

III. IMPLEMENTING TOOLS AND RESOURCES

- Tuberculosis reporting and case management tools are available on the PHSP Unit SharePoint page. IHSC staff use TB reporting tools for overall TB case management, reporting to the PHSP Unit, reporting and notifications to local and state health departments, facilitating transnational referrals for linkage to care, and public health surveillance.
- The *IHSC Suspected and Confirmed Pulmonary Tuberculosis Medical Provider Guidance* available in the IHSC Clinical Guidelines library on SharePoint. Medical providers who care for patients with suspected and confirmed TB disease use this guide.
- References and resources for the CDC CureTB Program are accessible at CDC CureTB Referral Program. IHSC staff who facilitate transnational linkage to care use this guide.
- Educational and training resources for FMCs is available through the PHSP Unit SharePoint page, navigating to "Tuberculosis" and "FMC Resources." This page provides FMCs easy access to resources.