

Tuberculosis Prevention and Control Guidelines For Homeless Service Agencies in Miami Dade County, Florida

March 12, 2013

For emergency shelters, day centers, safe havens, supportive housing programs, Single Room Occupancy (SROs), and other programs that work with people experiencing homelessness.



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Acknowledgements

The TB shelter guideline was adopted from:

- 1) Centers for Disease Control: Division of Tuberculosis Elimination
- 2) Florida Department of Health in Miami Dade County, Tuberculosis Control & Prevention Program
- 3) Public Health—Seattle & King County: Tuberculosis Prevention and Control Guidelines for Homeless Service Agencies in Seattle-King County, Washington June 2010
- 4) San Francisco Tuberculosis & Homelessness Task Force: Tuberculosis Control Guidelines for Homeless Shelters. 2005
- 5) Shelter and TB: What staff needs to know 2nd edition. Francis J Curry International Tuberculosis Center
- 6) Tuberculosis Infection Control: Francis J Curry National Tuberculosis Center. A Practical Manual for Preventing TB

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Section 1: Problem

Why TB is a problem in Homeless Shelters

Homeless shelters have been associated with Tuberculosis in the United States including Florida. Homeless persons are included in the high-risk classification for developing TB disease by CDC as they suffer disproportionately from a variety of health problems.

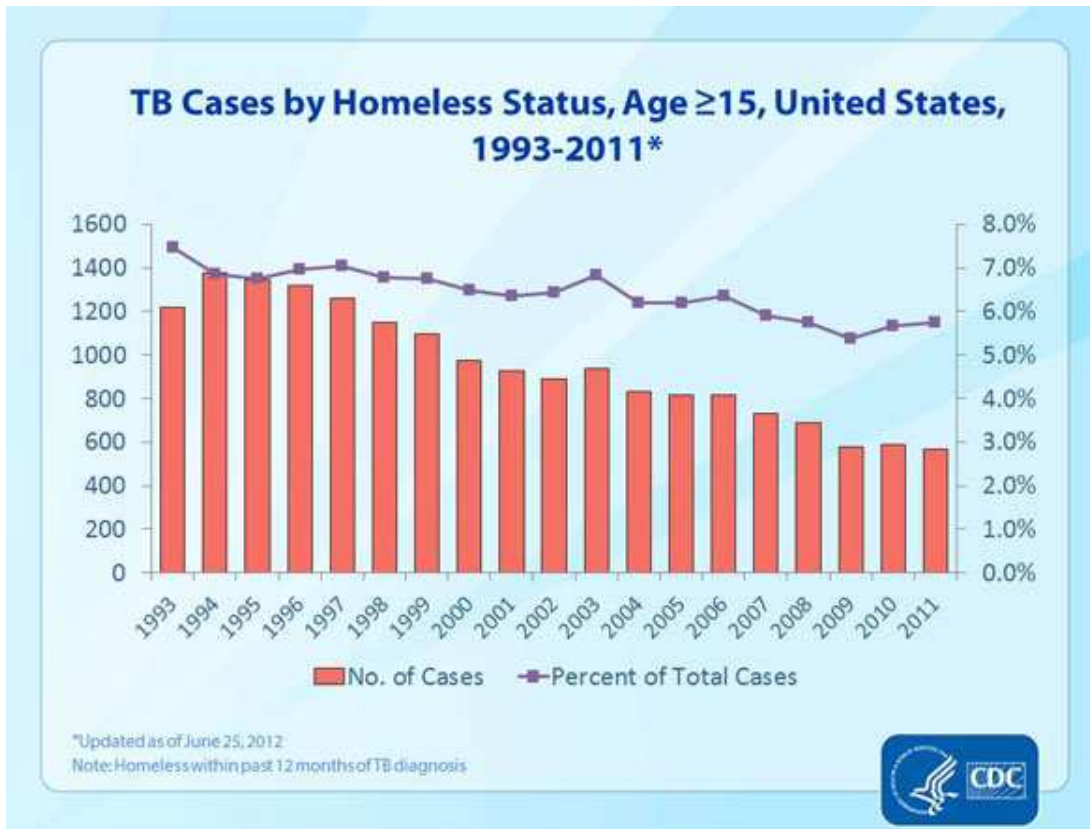
The homeless are more likely than the general population to acquire TB because risk factors for TB, including the following, are more common:

- Contact with other homeless people who have TB
- Poor Nutrition
- Poor access to health care
- Poor adherence to follow-up visits and prescribed treatment for TB.
- Substance abuse, especially injection drug use and alcohol.
- Limited access to TB and HIV education and prevention measures
- Shelter environment, overcrowding
- Lack of preventive measures.
- Loss to follow up.

Epidemiology

Specific to United States

In 2011, the reported number of tuberculosis (TB) cases decreased to 10,528 from 11,171 in 2010. Among those affected, disproportionately higher rates of TB occur among high-risk populations, especially homeless persons. In the United States, 1% of the population experiences homelessness in a given year, but 5.8% of persons with TB reported being homeless within the past year. These findings are not surprising, as persons who are homeless have a high prevalence of conditions that increase the risk of TB, including substance abuse, HIV infection, and residence in crowded shelters. This combination of conditions is conducive to transmission of TB. Persons who are homeless often lack ready access to the medical care required to make an early diagnosis of TB.



This graph shows the number of TB cases reported to be homeless within 12 months prior to their TB diagnosis from 1993 through 2011. Cases must have been above 14 years of age. The number of homeless cases has decreased from a high of 1379 cases in 1994 to 565 in 2011 and parallels the overall decline in cases during this time. This category has seen a continuous decrease in cases since 1994; the years 2003, 2006, and 2010 have been exceptions with a small increase in cases. Of total cases, 6.8% were homeless in 1994 and percentages have ranged between 7.5% in 1993 and 5.4% in 2009. Since 2009 there has been a small increase in 2010 (5.7%) and in 2011 (5.8%). <http://www.cdc.gov/features/dsTB2011Data>

Specific to Florida

From year 2006-2010 335 cases of TB were identified with history of Homeless in past year

Specific to Miami Dade County

For the past 3 years based on the data reported by Miami-Dade County Homeless Trust, and the 2010 Report Homeless Conditions in Florida, Office of the Governor

- In 2009 there were 4333 people homeless. 8 cases of TB in homeless people have been reported to the state, representing an incidence rate of 0.18% in homeless population, and 5% of total TB cases reported for the year.
- In 2010 there were 3832 people homeless. 6 cases of TB in homeless community have been reported to the state, representing an incidence rate of 0.15% in Homeless population, and 4% of total cases reported for the year.
- In 2011 there were 3818 people homeless. 9 cases of TB in the homeless community have been reported to the state, representing an incidence rate of 0.23% in homeless population, and 5.6% of total cases reported for the year.

Outbreaks in Homeless Population

Despite overall declines in U.S. TB cases, outbreaks continue to pose serious challenges to our ability to control TB, and populations such as persons affected by homelessness are particularly vulnerable. Outbreaks among persons experiencing homelessness are difficult to control, in part because of the challenges in finding and locating contacts and providing treatment for LTBI. Excess alcohol use and congregation in crowded shelters, which frequently are associated with homeless persons, increase their risk for TB. Of patients in Kane County outbreak, 80% spent time at sites other than the shelter during their infectious periods, and attendance at certain bars had a non-statistically significant association with being a case-patient, suggesting transmission was not limited to the shelter. Therefore, outbreaks of TB among homeless populations can pose a risk to entire communities.

Following are examples of Tuberculosis Outbreaks in Homeless population.

Place	Time(Year)
New York City	2000-2003
Portland Maine	2002-2003
King County, Washington	2002-2003
Kane County, Illinois	2007-2011
Duval County, Florida	2007-2012
Grand Forks County, North Dakota	2009-2012
Los Angeles California	2013

Although TB cases among the homeless population are declining in number, the homeless population still represents an important risk group among U.S.-born TB patients.

Section 2: Purpose

A. Introduction

The purpose of the Tuberculosis (TB) Infection Control Guidelines for Homeless Shelters is to provide the management and staff who work at homeless shelters in the Miami Dade County with the tools for making appropriate decisions about persons seeking shelter at homeless facilities who may be suspected of having tuberculosis.

These guidelines will help to ensure that people seeking services from homeless shelters are not excluded from these services and are evaluated because of infectious disease concerns, but are directed into the appropriate health care delivery system with minimal risks to shelter staff.

B. Justification for Tuberculosis (TB) Guidelines

According to the 2011 Council on Homelessness report nearly 60,000 Floridians live on the street or stay in emergency shelters. These include elderly individuals, veterans, and clients with co-morbidities as well as children.

Despite the recent decline in total number of TB cases in Miami Dade County, TB continues to persist as a health hazard in the homeless community. Homeless shelters are among the most likely places where TB can be transmitted.

Standardizing TB guidelines at each Miami Dade County shelter, based on recommendations from the Centers for Disease Control and Prevention (CDC), will help to minimize or eliminate the possibility that homeless individuals seeking shelter for the evening will be turned away by shelter staff for unwarranted fears of contracting tuberculosis and will better facilitate TB control in Miami Dade homeless shelters

For more information about Florida Department of Health in Miami Dade County TB epidemiology, please refer to "Profile of TB in Miami Dade" on the TB Control Section webpage <http://www.dadehealth.org/tb/TBintro.asp>

C. Goal of TB Infection Control Guidelines

The goal of these guidelines is to eliminate the spread of TB in Miami Dade homeless shelters by providing uniform recommendations for TB screenings, TB training, and other preventive measures for both shelter staff and clients.

D. Objectives

1. To provide standardized guidelines to assist Homeless shelter staff in their efforts to house clients and control the spread of TB by:
 - a. Requiring TB screening for the clients and newly hired staff or biannual follow up
 - b. Early identification of suspected cases of active TB
 - c. Ensuring rapid evaluation of suspected cases by appropriate health care providers
 - d. Providing timely access to an appropriate health care facility if an evaluation cannot be done at the shelter.

2. To assist shelter staff with good decision-making tools when homeless persons arrive at shelters with signs and symptoms of illness, which could be perceived as active TB.

E. Who Should Use These Guidelines?

The guidelines are written for directors and staff of agencies that work with homeless people. TB guidelines are important for all homeless-serving agencies, including shelters, day centers, feeding programs, housing programs, and more. Information is provided to help you assess the level of TB risk for your staff and clients, and this in turn will help you establish reasonable TB policies for your programs.

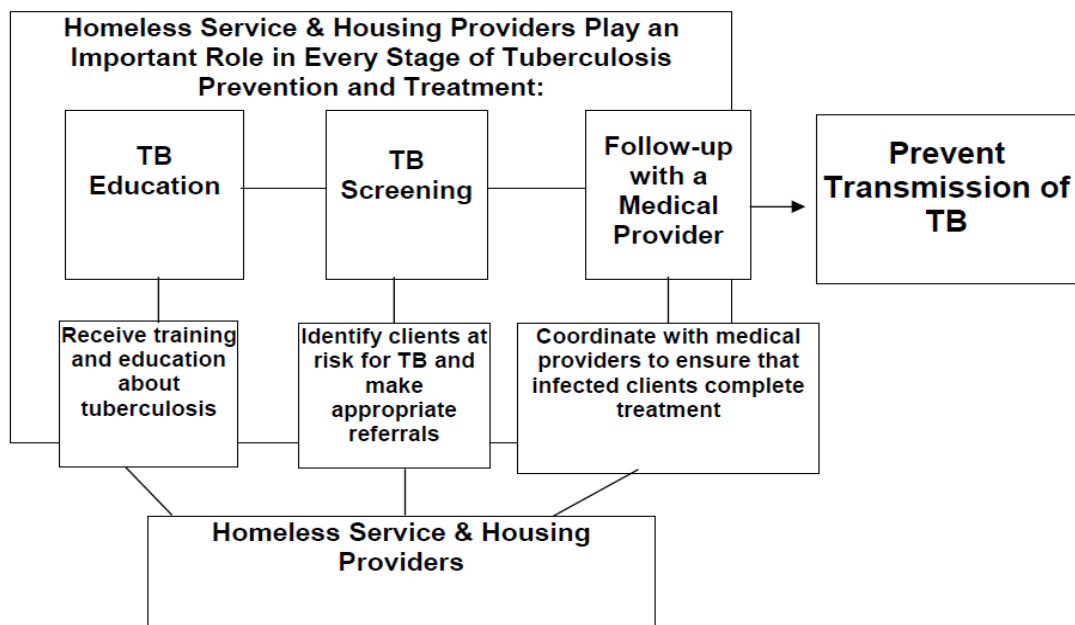


Chart from "Tuberculosis Prevention Guide for Homeless Service Providers, prepared by Homeless Health Care Los Angeles, 2002.

Section 3 Understanding TB

What is TB?

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.

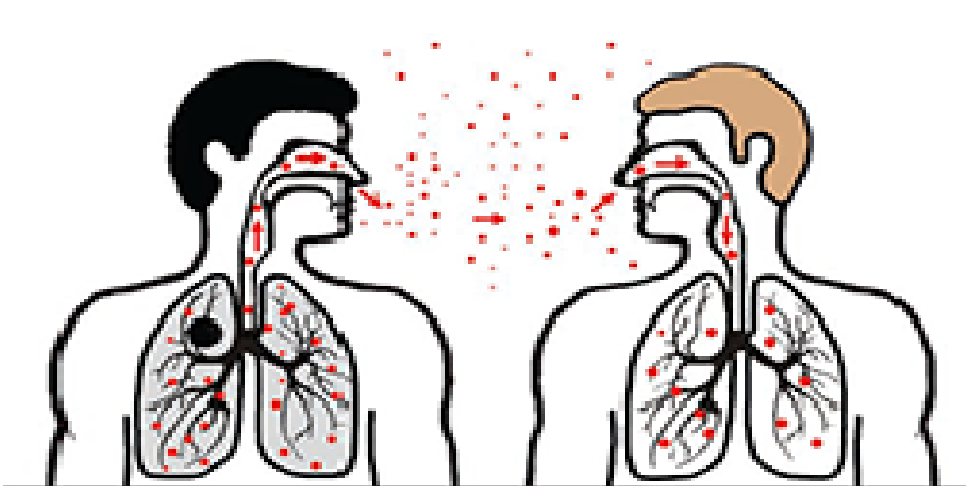
When TB germs are active (multiplying in your body), this is called TB disease. These germs usually attack the lungs. They can also attack other parts of the body, such as, the kidneys, brain, or spine. TB disease will make you sick. People with TB disease can spread the germs to people they spend time with every day.

How TB Spreads

TB is spread through the air from one person to another. The TB bacteria are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.

TB is NOT spread by

- shaking someone's hand
- sharing food or drink
- touching bed linens or toilet seats
- sharing toothbrushes



<http://www.cdc.gov/tb/topic/basics/default.htm>

Latent TB Infection and TB Disease

Latent TB Infection

TB bacteria can live in the body without making you sick. This is called latent TB infection. In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with latent TB infection do not feel sick and do not have any symptoms. People with latent TB infection are not infectious and cannot spread TB bacteria to others. However, if TB bacteria become active in the body and multiply, the person will go from having latent TB infection to being sick with TB disease.

TB Disease

TB bacteria become active if the immune system can't stop them from growing. When TB bacteria are active (multiplying in your body), this is called TB disease. People with TB disease are sick. They may also be able to spread the bacteria to people they spend time with every day.

Many people who have latent TB infection never develop TB disease. Some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria. Other people may get sick years later when their immune system becomes weak for another reason.

<i>The Difference Between Latent TB Infection and TB Disease</i>	
Latent TB Infection	TB Disease
There are germs in the body, but in dormant state	There are TB germs in the body in active stage
Positive skin test	Positive skin test
Normal Chest X-ray	Abnormal Chest X-ray
No symptoms of TB	Symptoms of TB
Not contagious	Contagious if there is TB in lungs and it is not properly treated.
At risk of developing TB disease in the future	TB disease is already active in lungs or other part of the body and treatment is required.
A prophylactic treatment with one drug is recommended for at least period of 6-9month	A combination of antibiotics will be prescribed for at least 6-9 months

TB Symptoms

- a bad cough that lasts 3 weeks or longer
- pain in the chest
- coughing up blood or sputum
- weakness or fatigue
- weight loss
- no appetite
- chills
- fever
- sweating at nights

TB Risk factors

- Has HIV Infection
- Has been recently infected with TB bacteria (in the last 2 years)

- Has other health related problems, like diabetes, that make it hard for the body to fight bacteria
- Abuses alcohol or uses illegal drugs
- Was not treated correctly for TB infection in the past
- Babies and young children
- Elderly
- people who are enduring homelessness and other underserved populations
- people who come from or travel to countries with a high incidence of TB disease

Testing for TB Risk infection

There are two kinds of tests that are used to detect TB bacteria in the body: the TB skin test (TST) and TB blood tests.



The TB skin test, also known as a PPD or Tuberculin Skin Test (TST), is the most common way to find out if you have TB infection. You can get a skin test at Public Health Clinics or at your doctor's office. The TB skin test is performed by injecting a small amount of testing liquid (called Tuberculin) into the skin of the forearm. The test needs to be read 48 to 72 hours later by someone trained in reading skin tests. Persons with suppressed immune systems may not react to the TB test, so other tests are often needed.

If you have a positive reaction to the skin test, your doctor or nurse may do other tests to see if you have TB disease. These tests usually include a chest x-ray and occasionally a test of the phlegm you cough up. Because the TB bacteria may be found somewhere besides your lungs, your doctor or nurse may also check your blood or urine, or perform other tests. If you have TB disease, you will need to take medicine to cure the disease.

How do I know if I have been infected with TB germs?

If you have been around someone who has TB disease, you should go to your doctor or your local health department for tests.

There are two tests that can be used to help detect TB infection: a TB skin test or TB blood test. The skin test is used most often. A small needle is used to put some testing material, called tuberculin, under the skin. In 2-3 days, you return to the health care worker who will check to see if there is a reaction to the test. In some cases, a TB blood test is used to test for TB infection. This blood test measures how a person's immune system reacts to the germs that cause TB.

To tell if someone has TB disease, other tests such as chest x-ray and a sample of sputum (phlegm that is coughed up from deep in the lungs) may be needed.

Is TB treatable?

There is good news for people with TB disease: TB disease can almost always be cured with medicine. But the medicine must be taken exactly as instructed by a health care provider. To treat TB, several antibiotics need to be taken together over a period of 6 months to a year. For this treatment to work, it's vital that these medicines be taken regularly and that the full treatment cycle be completed. Lengthy treatment is necessary because the bacteria grow very slowly and hide very well.

People with TB disease of the lungs are usually infectious and should stay away from shelters, day centers, work, school, or other public places so that the TB bacteria are not spread to other people. After taking TB medicine for a few weeks, people feel better and a test by their medical provider will determine when they are no longer contagious. Even after starting to feel better, one must keep taking the medication until directed otherwise by a health care provider.

People who are diagnosed as cases are provided with Directly Observed Therapy (DOT). DOT consists of a health care worker meeting with a person and observing them swallowing their TB medication on a daily or twice weekly basis. DOT is an extremely effective treatment method that allows careful monitoring to ensure that treatment is completed and to observe any side effects of the medication.

TB treatment is available, regardless of insurance status, at the Florida Department of Health in Miami Dade County TB Clinic. The TB Control Program supports people who are homeless and undergoing TB treatment by providing them with directly observed therapy, food, and transitional housing while they are infectious.

Is there a vaccine for TB?

BCG is a vaccine for TB. This vaccine is not widely used in the United States, but it is often given to infants and small children in other countries where TB is common. BCG vaccine does not always protect people from getting TB.

If you were vaccinated with BCG, you may have a positive reaction to a TB skin test. This reaction may be due to infection with the TB bacteria. However, in some people, BCG may cause a positive skin test when they are not infected with TB bacteria. Unlike the TB skin test, TB blood tests are not affected by prior BCG vaccination. The TB blood tests (IGRAs) are less likely to give a false-positive result in people who have received BCG.

If I was exposed to someone with TB disease, can I give TB to others?

If you were exposed to someone with TB disease, you may become infected with TB bacteria, but you would not be able to spread the bacteria to others right away. Only persons with TB disease can spread TB to others. Before you would be able to spread TB bacteria to others, you would have to breathe in TB bacteria and become infected. Then the bacteria would have to multiply in your body and cause TB disease. At this point, you could possibly spread TB bacteria to others.

Some people develop TB disease soon (within weeks) after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick years later, when their immune system becomes weak for another reason. Many people with TB infection never develop TB disease.

Section 4: Shelter Management of TB Control

A. Engineering Controls

TB transmission is affected by building ventilation. Re-circulated air may contribute to transmission within a shelter. Because even optimal ventilation does not preclude TB transmission, supplemental upper room germicidal ultraviolet (UV) air disinfections may be useful to further reduce the chance of transmission. For safety and efficacy reasons, UV fixtures should be planned, installed, and monitored after installation by an experienced consultant.

B. Engineering Control Recommendations

1. A one-time engineering assessment of shelter ventilation is recommended in order to determine the most appropriate ventilation system. With proper filter maintenance in place, continued engineering assessment will be determined by engineering consulting group and shelter director.
2. Implementation of recommended engineering controls should be based on funding available and prioritized to areas where transmission is likely to occur.
3. Directors of shelter programs are responsible for ensuring that maintenance and monitoring are carried out in their facility according to a written schedule. Records should be kept confidential.
4. Filters used in ventilation systems should be the pleated type. They should be checked every month.
5. Filters should be replaced when fully loaded with dust, and at least every six months. Filter maintenance is recommended since it decreases the chances for spreading TB in shelter facility.
6. Janitorial staff shall be trained to change and maintain filters routinely.
7. Ventilation air outlets should be cleaned free of dust and lint every month.
8. Ventilation systems should be set to run continuously while the building is occupied.

9. Windows and doors should be kept open as often as possible to provide fresh air.

10. Small offices frequented by shelter clients should have working windows to provide fresh outside air, and/or a portable HEPA filter unit.

11. For crowded congregate rooms, such as TV lounges and lobbies, consider the use of upper room UV lamps and HEPA filter units to supplement the central ventilation system.

C. Respiratory Protection Recommendations

1) Mask (disposable paper or cloth surgical mask) should be readily available in the shelter.

2) All homeless shelter staff or clients who are coughing should be encouraged to wear a mask to help prevent infection. Staffs that are ill should be encouraged not to work until free of infection.

3) Clients in homeless shelters who are actively coughing should be asked to wear a mask until they can be medically evaluated and treated for their illness.

4) It is recommended that each shelter post the signs for client awareness and cough monitoring

NOTE: Asking someone to wear a mask can potentially make a client feel offended and singled out. A coughing client, as all clients, should be treated with dignity and respect

Listed below are key characteristics to help you assess your agency’s level of risk for TB Transmission.

Higher Risk	Lower Risk
Crowded conditions; clients sleep close together	Separate dwelling units
Clients spend a lot of time in close quarters (e.g., sleeping or visiting in common rooms)	Clients are in and out of program quickly
Poor ventilation / closed windows; or the incorrect use of a ventilation system	Good ventilation & environmental controls
Staff not well educated about TB	Management requires that all staff participate in regular TB trainings
Clients/tenants are not educated about TB	Clients are educated – pamphlets & signage
Clients not instructed to cover coughs	Clients use masks & tissues to cover coughs
Program serves high risk groups	Program serves low-risk homeless population
No TB Policy	Agency implements a TB Policy

For the complete PDF of the “Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care settings, 2005,” please visit the Centers for Disease Control and Prevention (CDC) website: <http://www.cdc.gov/mmwr/PDF/rr/rr5417.pdf>

Section 5: TB Screening of Homeless Shelter Staff

Early identification of clients who present with signs or symptoms which may indicate the presence of a communicable disease can help reduce the risk of disease outbreaks

TB counseling, screening, and prevention program for homeless agency staff—including volunteers who expect to work for cumulative hours of more than 10 hours—should be established to protect both staff and clients. Screening requirements should be included in the agency TB policy, in job descriptions, and in personnel policies. All homeless shelters should have a written and enforced policy that staff will be required to show proof of TB screening

A. Goals for screening/recommendations

1. All homeless shelter staff should be screened for TB on a biannual (every 6 months) to annual (every 12 months) basis. All homeless shelter staff will be required to show proof of TB screening.
2. If an employee has tested positive for TB in the past, she/he should not re-test. Instead, s/he should be screened with a chest x-ray (if no prior treatment) and a TB symptom assessment (questionnaire) to identify any symptoms of active TB.
3. Staff that has not had prior TB screening with a skin-test within the last 12 months will be required to undergo two step baselines TB skin testing. Having the TB blood test avoids this extra procedure.

B. Two step TB skin testing

Two step TB skin testing means that a second TB skin test is placed one week after the first skin test on all staff whose first skin test was negative (no skin reaction). This second tests helps to ensure that the employee with an old TB infection is identified. This technique helps avoid false converters and the fear of recent infection.

C. Staff who are Skin Test Positive (+PPD) or Blood Test Positive (+QFT)

1. Should have an initial chest x-ray or provide documentation regarding a chest x-ray (written report of a chest x-ray within the past 6 months).

2. Receive a medical evaluation to determine need for further workup or treatment.

D. Staff who are suspected of having TB or are symptomatic

Staffs who are suspected and symptomatic (show signs of disease) of active TB disease shall be required to have

1. An immediate medical evaluation that include a doctor's interview, TB skin or blood test and chest x-ray within 48 hours.
2. Be immediately excluded from workplace until confirmed noninfectious.

E. Staff who are HIV positive/immunocompromised

Immunocompromised staff or residents will need TB screening by chest x-ray since TB skin testing may be falsely negative for these individuals

Section 6: Shelter Staff Orientation and Training Curriculum Outline

A. Required Training

All employed and volunteer staff working at homeless shelter in Miami-Dade County will

- 1) Review CDC TB Modules within specific amount of days set by shelters management.
- 2) Attend a TB training provided by trained shelter staff or TB Outreach & Prevention Services.

B. TB Training Outline

1. What is Tuberculosis?
 - TB prevalence in Miami Dade County
 - TB prevalence among the homeless population
2. Tuberculosis transmission: How it is given to others.
3. Interpretation of TB skin testing: What a positive skin test means.
4. The difference between TB infection and TB disease.
5. Who is at risk for TB infection and disease?
 - TB and HIV connection
 - Poor health
 - Drug use
6. The signs and symptoms of active TB disease.
7. The difference in TB skin test requirements for homeless shelter staff, case-managed clients, drop-in clients, and the reasons for these differences.
8. How to effectively ask a client about TB symptoms.
9. How to evaluate and handle clients who seek shelter and are suspected of having active TB disease.
10. Treatment and preventive therapy.
11. TB prevention measures: How can shelter staff protect themselves?
 - Where masks are stored
 - Importance of using tissues to cover coughs and other preventive measures
 - Ventilation
12. Identifying and referring persons for medical evaluation.
13. TB policies and procedures.
14. Maintaining confidentiality of client information and records.

Section 7: TB Screening of Shelter Clients/Residents

Shelters should maintain a daily census listing all staff, volunteers, and clients who are at the facility. This practice serves both security and infection control purposes. For example, if a person with a case of active TB is found to have stayed at the shelter, a daily census allows health department officials to know who was at the site when and to determine who may have been exposed. In the event of an evacuation or other emergency, roll call can be taken to avoid losing anyone.

Agencies should appoint one person responsible for documenting TB status and skin-test results of all staff and volunteers. The tuberculosis and immune status of staff members is confidential health information and individual privacy needs to be protected by law. If a client at the shelter is found to have active tuberculosis, the shelter manager and staff will cooperate with the Health Department's investigation of the case

A. Shelter Admission

1. Attendance Logs and Bedmaps. On a daily basis, all clients entering shelters or day centers must sign in or be signed in upon arrival at the facility. The client's first and last name should be clearly printed (legible) and it should be evident what date(s) the client stayed at the program. If the program rotates location, the sign-in log should also state the location of the program that night. If the program has a system for identifying bed numbers or locations (bedmap), that would ideally be recorded in the log as well. This serves as a record should TB contact investigation become necessary. All client logs should be kept for a minimum of three months. If possible, keep records for six months

All homeless shelter staff will be instructed that clients who have a cough and are seeking shelter will not be turned away. Shelter staffs have the option of offering a mask to a client who is coughing

2. Recommendations for admitting a client with a cough

a. When a client with a cough is identified, he or she should be taken aside by shelter staff and asked if he/she has had a *cough for more than three weeks*.

b. Shelter staff must ask if the client has had *one or more* of the following *clinical symptoms of TB Disease*.

- Unexplained weight loss

- Night Sweats
- Fever
- Chronic Fatigue/Malaise
- Bloody phlegm

c. Advise client to cover their nose and mouth with tissue when coughing. Anyone who has a chronic cough will be asked to wear a mask.

d. If deemed necessary, segregate client from the other residents until a medical evaluation can be performed.

e. All clients who have a chronic cough for three weeks or more plus more than one clinical symptom should be referred to a medical evaluation as soon as possible, and preferably early the next morning.

B. Clients receiving shelter services for more than 3 days

(cumulative within a 30-day period) at any shelter.

1. If symptomatic with a cough, client will need medical evaluation ASAP, preferably the next morning
2. If no symptoms are present, clients should complete screening for TB within 10 days of notification or risk losing their shelter bed

C. Cough Alert:

The “cough alert” policy has been developed to protect the safety of homeless agency clients and staff from tuberculosis. Homeless agency employees play a key role in detecting communicable diseases because of familiarity with the clientele and facilities. This policy is to be implemented by facility staff working closely with clients. The cough alert should be instituted as defined below:

Definition:

1. Individuals coughing throughout the night or
2. Patient coughing for more than 2-3 weeks without improvement (especially if [1] the cough is accompanied with weight loss, night sweats and fever or [2] patient coughing up blood)

Procedures:

1. Instruct the client to cover nose and mouth when coughing and offer a mask or tissue to use.
2. Record the date, client name, dates served and give the information to assigned supervisor
3. Assigned agency staff will notify the coughing client confidentially that a medical evaluation is needed within 48 hours, and will assist the client in arranging an evaluation with their primary

care provider or community clinic.

- Evaluation should occur as soon as possible through one of the following mechanisms:
 - Client's own primary care provider
 - Health Care for the Homeless Nurse (if program has one on-site)
 - Community clinic or public health clinic
- TB Control Program

D.TB Screening Policy

All shelter clients will be required to show evidence of TB clearance within 10 days after admission to the shelter.

E. Confirmation and screening tests for active TB

Symptomatic clients will be expected to complete a medical evaluation that includes a TB test, a chest x-ray, doctor's assessment and possibly other diagnostic tests at TB Clinic. The evaluation must be done as soon as possible and within 48 hours. Clients must be assured that if they do have active TB disease, they will be treated at TB Clinic and upon release will be assisted in finding stable housing until completion of their TB treatment.

F. Medical Treatment of Active TB Cases

Clients with medically confirmed active TB will not be admitted until clearance is provided in writing by Florida Department of Health in Miami Dade County Tuberculosis Control & Prevention Program.

Section 8: TB and Law

The 2012 Florida Statutes

Title XXIX
PUBLIC HEALTH

Chapter 392
TUBERCULOSIS CONTROL

CHAPTER 392
TUBERCULOSIS CONTROL

- 392.501 Short title.
- 392.51 Tuberculosis control.
- 392.52 Definitions.
- 392.53 Reporting required.
- 392.54 Contact investigation.
- 392.545 Naming of persons subject to proceedings.
- 392.55 Physical examination and treatment.
- 392.56 Hospitalization, placement, and residential isolation.
- 392.565 Execution of certificate for involuntary hold.
- 392.57 Emergency hold.
- 392.58 Service of notice and processes; duties of sheriff.
- 392.59 Forms to be developed.
- 392.60 Right of appeal; immediate release.
- 392.61 Community tuberculosis control programs.
- 392.62 Hospitalization and placement programs.
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392.501 Short title.—This chapter may be cited as the “Tuberculosis Control Act.” History.—s. 1, ch. 88-389; s. 1, ch. 88-398.

392.51 Tuberculosis control.—A statewide system is established to control tuberculosis infection and mitigate its effects. The system consists of mandatory contact identification, treatment to cure, hospitalization, isolation for contagious cases, and voluntary, community-oriented care and surveillance in all other cases. Tuberculosis control services shall be provided by the coordinated efforts of the respective county health departments and contracted or other private health care providers.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 2, ch. 94-320; s. 94, ch. 97-101; s. 81, ch. 2012-184.

392.52 Definitions.—As used in this chapter, the term:

(1)“Active tuberculosis” means tuberculosis disease that is demonstrated to be contagious by clinical or bacteriological evidence, or by other means as determined by rule of the department. Tuberculosis disease is considered active until cured.

(2)“County health department” means an agency or entity designated as such in chapter 154.

(3)“Cure” or “treatment to cure” means the completion of a course of antituberculosis treatment.

(4)“Department” means the Department of Health.

(5)“Directly observed therapy” means treatment in which a patient ingests medications under the observation of a health care provider or other responsible party.

(6)“Threat to the public health” means a rebuttable presumption that a person has active tuberculosis and:

(a)Is not taking medications as prescribed;

(b)Is not following the recommendations of the treating physician;

(c)Is not seeking treatment for signs and symptoms compatible with tuberculosis; or

(d)Evidences a disregard for the health of the public.

(7)“Tuberculosis” means a disease caused by *Mycobacterium tuberculosis*, *Mycobacterium bovis*, or *Mycobacterium africanum*.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 3, ch. 94-320; s. 95, ch. 97-101; s. 34, ch. 97-237.

392.53 Reporting required.—

(1) Each person who makes a diagnosis of tuberculosis or who treats a person with tuberculosis and each laboratory that performs a test on a specimen that reveals the presence of the tubercule bacilli shall report or cause to be reported such facts to the department in addition to other facts that the department requires by rule to be reported, within a time specified by rule of the department, which period must not exceed 72 hours after the presence of tuberculosis is discovered.

(2) The department shall adopt rules specifying the information that must be included in a report of tuberculosis, the time within which the report must be filed, and where the report must be filed. The department shall consider the need for information, protection of the privacy and confidentiality of the patient, and the practical ability of persons and laboratories to report in a reasonable fashion. Rules adopted by the department may provide for telephonic, electronic, and written reporting and may establish different time periods and content for each method of reporting.

(3) A person who reports to the department the name of a person who has tuberculosis is not liable for damages caused by such report, unless the report is made with knowledge that it is false or with reckless disregard of the truthfulness of the report.

(4) A person who violates this section or the rules adopted under this section may be fined by the department, in the manner prescribed in s. 392.67. The department shall report each violation of this section to the regulatory agency that is responsible for licensing the person or laboratory that commits the violation.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 2, ch. 93-264; s. 4, ch. 94-320.

392.54 Contact investigation.—

(1) The department and its authorized agents may counsel and interview, or cause to be counseled and interviewed, any person who has active tuberculosis, who is reasonably suspected of having active tuberculosis, or who is reasonably suspected of having been exposed to active tuberculosis, in order to investigate the source and spread of the disease and in order to require such person to submit to examination and treatment to cure as necessary.

(2) All information gathered in the course of contact investigation is confidential, subject to the provisions of s. 392.65. Such information is exempt from s. 119.07(1).

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 11, ch. 90-344; s. 5, ch. 94-320; s. 203, ch. 96-406.

392.545 Naming of persons subject to proceedings.—

(1)When requesting an order from a circuit court under the provisions of s. 392.55, s. 392.56, or s. 392.57, the department shall substitute a pseudonym for the true name of the person to whom the order pertains. The actual name of the person shall be revealed to the court only in camera, and the court shall seal such name from further revelation.

(2)All court decisions, orders, petitions, and other formal documents shall be styled in a manner to protect the name of the person from public disclosure.

(3)The department, its authorized representatives, the court, and other parties to the lawsuit shall not reveal the name of any person subject to these proceedings except as permitted in s. 392.65. Such information is exempt from s. 119.07(1).

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 12, ch. 90-344; s. 204, ch. 96-406.

392.55 Physical examination and treatment.—

(1)Subject to the provisions of subsections (3) and (4), the department and its authorized representatives may petition the circuit court to examine or cause to be examined, or treat to cure or cause to be treated to cure, any person who has, or is reasonably suspected of having or having been exposed to, active tuberculosis.

(2)Subject to the provisions of subsections (3) and (4), a person who has active tuberculosis or is reasonably suspected of having or having been exposed to active tuberculosis shall report for complete examination or treatment to cure, as appropriate, on an outpatient basis to a physician licensed under chapter 458 or chapter 459, or shall submit to examination or treatment to cure, as appropriate, at a county health department or other public facility. When a person has been diagnosed as having active tuberculosis, he or she shall continue with the prescribed treatment on an outpatient basis, which includes the use of directly observed therapy, until such time as the disease is determined to be cured.

(3)A person may not be apprehended or examined on an outpatient basis for active tuberculosis without consent, except upon the presentation of a warrant duly authorized by a circuit court. In requesting the issuance of such a warrant, the department must show by a preponderance of evidence that a threat to the public health would exist unless such a warrant is issued and must show that all other reasonable means of obtaining compliance have been exhausted and that no other less restrictive alternative is available.

(4)A warrant requiring a person to be apprehended or examined on an outpatient basis may not be issued unless:

(a) A hearing has been held with respect to which the person has received at least 72 hours' prior written notification and has received a list of the proposed actions to be taken and the reasons for each such action. However, with the consent of the person or the person's counsel, a hearing may be held within less than 72 hours.

(b) The person has the right to attend the hearing, to cross-examine witnesses, and to present evidence. After review and consultation by the court, counsel for the person may waive the client's presence or allow the client to appear by television monitor where available.

(c) The court advises the person of the right to have legal counsel present. If the person is insolvent and unable to employ counsel, the court shall appoint legal counsel for the person pursuant to the indigence criteria in s. 27.52.

(5) The circuit court, legal counsel, and local law enforcement officials, as appropriate, shall consult with the department concerning any necessary infection control procedures to be taken during any court hearing or detention.

History.—s. 1, ch. 88-389, s. 1, ch. 88-398; s. 6, ch. 94-320; s. 1041, ch. 95-148; s. 96, ch. 97-101; s. 105, ch. 2003-402.

392.56 Hospitalization, placement, and residential isolation.—

(1) Subject to the provisions of subsections (2) and (3), the department may petition the circuit court to order a person who has active tuberculosis to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home as a result of the probable spread of tuberculosis, until such time as the risk of infection to the general public can be eliminated or reduced in such a manner that a threat to the public health no longer exists.

(2) A person may not be ordered to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home, except upon the order of a circuit court and upon proof:

(a) By the department, by clear and convincing evidence, that a threat to the public health is posed by the person who has active tuberculosis;

(b) That the person who has active tuberculosis has been counseled about the disease, the threat to the public health posed by tuberculosis, and methods to minimize the risk to the public, and, despite such counseling, indicates an intent by words or action to expose the public to active tuberculosis; and

(c) That all other reasonable means of achieving compliance with treatment have

been exhausted and no less restrictive alternative exists.

(3) A person may not be ordered by a circuit court to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home, unless:

(a) A hearing has been held, with respect to which the person has received at least 72 hours' prior written notification and has received a list of the proposed actions to be taken and the reasons for each such action. However, with the consent of the person or the person's counsel, a hearing may be held within less than 72 hours;

(b) The person has the right to attend the hearing, to cross-examine witnesses, and present evidence. After review and consultation by the court, counsel for the person may waive the client's presence or allow the client to appear by television monitor where available; and

(c) The court advises the person of the right to have counsel present. If the person is insolvent and unable to employ counsel, the court shall appoint legal counsel for the person pursuant to the indigence criteria in s. 27.52.

(4) An order requiring the hospitalization, placement in a health care facility or residential facility, or isolation from public in the home must expire no later than 180 days after the date of the order or when the physician charged with the care of the person determines that the person no longer poses a threat to the public health, if the determination is made before the end of the 180-day period. Orders for hospitalization of a person or placement in a facility or isolation in the home may not be renewed unless the person is afforded all rights conferred in subsections (2) and (3). A hearing must be held within 14 days before the expiration of the 180-day period to determine the necessity for the person's continued hospitalization or necessary care and treatment to cure after release. The person's records from the inception of the disease are admissible evidence in the hearing.

(5) If the department petitions the circuit court to order that a person who has active tuberculosis be hospitalized in a facility operated under s. 392.62, the department shall notify the facility of the potential court order.

(6) The circuit court, legal counsel, and local law enforcement officials, as appropriate, shall consult with the department concerning any necessary infection control procedures to be taken during any court hearing or detention.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 7, ch. 94-320; s. 106, ch. 2003-402; s. 120, ch. 2012-184.

392.565 Execution of certificate for involuntary hold.—When a person who has active tuberculosis or who is reasonably suspected of having active tuberculosis presents to a physician licensed under chapter 458 or chapter 459 for examination or treatment and the physician has reason to believe that if the person leaves the treatment location the person will pose a threat to the public health based on test results or the patient’s medical history and the physician has reason to believe that the person is not likely to appear at a hearing scheduled under s. 392.55 or s. 392.56, the treating physician shall request the State Health Officer or his or her designee to order that the person be involuntarily held by executing a certificate stating that the person appears to meet the criteria for involuntary examination or treatment and stating the observation upon which that conclusion is based. The sheriff of the county in which the certificate was issued shall take such person into custody and shall deliver the person to the nearest available licensed hospital, or to another location where isolation is available, as appropriate, for observation, examination, and treatment for a period not to exceed 72 hours, pending a hearing scheduled under s. 392.55 or s. 392.56. The certificate must be filed with the circuit court in which the person is involuntarily held and constitutes a petition for a hearing under s. 392.55 or s. 392.56.

History.—s. 8, ch. 94-320; s. 1042, ch. 95-148; s. 35, ch. 97-237.

392.57 Emergency hold.

(1)The department may file a petition before a circuit court requesting that an emergency hold order be issued for a person if the department has evidence that:

(a)The person has or is reasonably suspected of having active tuberculosis;

(b)The person poses a threat to the public health;

(c)The person who has active tuberculosis is not likely to appear at a hearing scheduled under s. 392.55 or s. 392.56;

(d)The person provides evidence by words or action of being likely to leave the jurisdiction of the court prior to the hearing date; or

(e)The person is likely to continue to expose the public to the risk of active tuberculosis until the hearing date.

(2)An emergency hold order may not be issued unless the court finds that:

(a)The department has requested a hearing under s. 392.55 or s. 392.56 to consider the examination, treatment to cure, or placement of the person who has or who is reasonably suspected of having active tuberculosis;

(b)The department presents competent evidence that a threat to the public

health exists unless the emergency hold order is issued;

(c)The department has no other reasonable alternative means of reducing the threat to the public health; and

(d)The department is likely to prevail on the merits in a hearing under s. 392.55 or s. 392.56.

(3)When issuing an order for an emergency hold, the court shall direct the sheriff to immediately confine the person who has active tuberculosis. The sheriff shall confine and isolate the person in such a manner as required by the court. The sheriff and the circuit court shall consult with the department concerning any necessary infection control procedures to be taken.

(4)In order to reduce the time before a full hearing may be held, the person confined under an emergency hold order, or the person's counsel, may waive the notice periods for hearings required under s. 392.55 or s. 392.56. An emergency hold order may not continue for more than 5 days or the time period necessary for conducting hearings under s. 392.55 or s. 392.56, whichever time period is shorter.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 9, ch. 94-320.

392.58 Service of notice and processes; duties of sheriff.

(1)All notices required to be given, warrants, petitions, processes issued, and orders entered pursuant to s. 392.55, s. 392.56, or s. 392.57 shall be served by the sheriff of the county in which the person alleged to be infected with tuberculosis resides or is found.

(2)The judge, in his or her order for hospitalization or placement in another health care or residential facility under s. 392.56, shall direct the sheriff of the county in which such person resides or is found to take the person into his or her custody and immediately deliver him or her to the director of the facility named in the order.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 698, ch. 95-148.

392.59Forms to be developed.—The department shall develop and furnish to the court all forms necessary under ss. 392.55, 392.56, 392.565, and 392.57, and the court may use such forms where appropriate.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 10, ch. 94-320.

392.60 Right of appeal; immediate release.—

(1)Any person who is aggrieved by the entry of an order under s. 392.55, s. 392.56, or s. 392.57 shall have the period of time provided by the Florida Rules of Appellate Procedure within which to appeal an order from the circuit court. Every

order entered under the terms of s. 392.55, s. 392.56, or s. 392.57 shall be executed immediately unless the court entering such order or the appellate court, in its discretion, enters a supersedeas order and fixes the terms and conditions thereof.

(2) Any person who is examined, treated, hospitalized, placed in another health care facility or residential facility, isolated in the home, or confined under an emergency hold order, as a result of an order entered under s. 392.55, s. 392.56, or s. 392.57, may at any time petition the circuit court for immediate release and termination of the order.

(3) The petition to the court for immediate release and termination of the order entered under authority of s. 392.55, s. 392.56, or s. 392.57 shall show that the person is entitled to relief from the original order pursuant to the Florida Rules of Civil Procedure, or that:

(a) There has been a substantial change in the original facts and circumstances upon which the order was issued;

(b) The person is cured and no longer poses a threat to the public health; or

(c) The person will continue with prescribed medications and treatment to cure, which includes the use of directly observed therapy, if medically necessary, to reduce the risk of infection to the public and the person has not exhibited past behavior that indicates a tendency toward noncompliance with treatment.

(4) When considering a petition for immediate release and before making any release, the court shall consult the department and the person's physician, if any, concerning the person's medical condition and any other related factors that may affect the present and future threat to the public health that may be caused by the release of the person.

(5) Upon granting a petition for immediate release, the court may impose those conditions it believes reasonably necessary to protect the public from active tuberculosis. History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 11, ch. 94-320.

392.61 Community tuberculosis control programs.

(1) The department shall operate, directly or by contract, community tuberculosis control programs in each county in the state.

(2) Community tuberculosis control programs shall have the following functions:

(a) Promotion of community and professional education about the causes and dangers of tuberculosis and methods of its control and treatment to cure;

(b) Community and individual screening for the presence of tuberculosis;

(c) Surveillance of all suspected and reported cases of active tuberculosis,

including contact investigation as necessary and as directed by the department;

(d) Reporting of all known cases of tuberculosis to the department;

(e) Development of an individualized treatment plan for each person who has active tuberculosis and who is under the care of the department, including provision of treatment to cure and followup, and the distribution of medication by means of directly observed therapy, if appropriate, to eligible persons under rules and guidelines developed by the department; and

(f) Provision of counseling, periodic retesting, and referral to appropriate social service, employment, medical, and housing agencies, as necessary for persons released from hospitalization or residential placement.

(3) This section does not prevent the department from operating regionally based tuberculosis control programs, if services are offered in each county.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 12, ch. 94-320; s. 82, ch. 2012-184.

392.62 Hospitalization and placement programs.

(1) The department shall contract for operation of a program for the treatment of persons who have active tuberculosis in hospitals licensed under chapter 395 and may provide for appropriate placement of persons who have active tuberculosis in other health care facilities or residential facilities. The department shall require the contractor to use existing licensed community hospitals and other facilities for the care and treatment to cure of persons who have active tuberculosis or a history of noncompliance with prescribed drug regimens and require inpatient or other residential services.

(2) The program for control of tuberculosis shall provide funding for participating facilities and require any such facilities to meet the following conditions:

(a) Admit patients voluntarily and under court order as appropriate for each particular facility;

(b) Require that each patient pay the actual cost of care provided whether the patient is admitted voluntarily or by court order;

(c) Provide for the care of patients in the program regardless of ability to pay;

(d) Require a primary clinical diagnosis of active tuberculosis by a physician licensed under chapter 458 or chapter 459 before admitting the patient; provided that there may be more than one primary diagnosis;

(e) Provide a method of notification to the county health department and to the patient's family, if any, before discharging the patient from the hospital or other facility;

(f) Provide for the necessary exchange of medical information to assure adequate community treatment to cure and followup of discharged patients, as appropriate; and

(g) Provide for a method of medical care and counseling and for housing, social service, and employment referrals, if appropriate, for patients discharged from the hospital.

(3) A hospital may, pursuant to court order, place a patient in temporary isolation for a period of no more than 72 continuous hours. The department shall obtain a court order in the same manner as prescribed in s. 392.57. Nothing in this subsection precludes a hospital from isolating an infectious patient for medical reasons.

(4) Any person committed under s. 392.57 who leaves the tuberculosis hospital or residential facility without having been discharged by the designated medical authority, except as provided in s. 392.63, shall be apprehended by the sheriff of the county in which the person is found and immediately delivered to the facility from which he or she left.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 13, ch. 94-320; s. 1043, ch. 95-148; s. 97, ch. 97-101; s. 36, ch. 97-237; s. 83, ch. 2012-184.

392.63 Temporary leave.—Any person who has been hospitalized, placed in another health care facility or residential facility, or isolated in the home may be granted a short-term temporary leave at the discretion of the department or its authorized representatives, if the department determines the temporary leave will be closely monitored and will not pose a threat to the public health. Temporary leave may be granted for therapeutic purposes, in the event of death or critical illness in the person's family, or for other emergencies.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 14, ch. 94-320.

392.64 Adherence to treatment; treatment plan; penalties.—

(1) The department, its authorized representatives, or a physician licensed under chapter 458 or chapter 459 shall prescribe an individualized treatment plan for each person who has active tuberculosis. The goal of the treatment plan is to achieve treatment to cure by the least restrictive means. The department shall develop, by rule, a standard treatment plan form that must include, but is not limited to, a statement of available services for treatment, which includes the use of directly observed therapy; all findings in the evaluation and diagnostic process; measurable

objectives for treatment progress; and time periods for achieving each objective. Each treatment plan must be implemented through a case management approach designed to advance the individual needs of the person who has active tuberculosis. The person's progress in achieving the objectives of the treatment plan must be periodically reviewed and revised as necessary, in consultation with the person.

(2)The department may petition a circuit court under s. 392.55, s. 392.56, or s. 392.57, as it deems appropriate, to require adherence to treatment plans prescribed under subsection (1).

(3)Any person who has active tuberculosis and who fails to comply with a treatment plan or any other requirement that is imposed by the court under s. 392.55, s. 392.56, or s. 392.57, or any minor's parent, guardian, or custodian who fails to comply with a treatment plan or any other requirement of the court, or any person who aids or abets in the failure to comply with treatment plans and other requirements of the court may be punished by contempt proceedings in addition to other penalties that may be imposed under s. 392.67.

(4)Contempt proceedings may be initiated by the department or its authorized representatives.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 15, ch. 94-320.

392.65Confidentiality.—

(1)All information and records held by the department or its authorized representatives relating to known or suspected cases of tuberculosis or exposure to tuberculosis shall be strictly confidential and exempt from s. 119.07(1). Such information shall not be released or made public by the department or its authorized representatives or by a court or parties to a lawsuit, except that release may be made under the following circumstances:

(a)When made with the consent of all persons to which the information applies;

(b)When made for statistical purposes, and medical or epidemiologic information is summarized so that no person can be identified and no names are revealed;

(c)When made to medical personnel, appropriate state agencies, or courts of appropriate jurisdiction to enforce the provisions of this chapter and related rules;

(d)When made in a medical emergency but only to the extent necessary to protect the health or life of a named person or group of persons; or

(e)When made to the proper authorities as required by chapter 39 or chapter 415.

(2)When disclosure is made pursuant to a subpoena, such information shall be sealed by the court from further disclosure, except as deemed necessary by the court to reach a decision in the proceeding, unless otherwise agreed to by all parties. Such information is exempt from s. 119.07(1).

(3)No employee of the department or its authorized representatives shall be examined in a civil, criminal, special, or other proceeding as to the existence or contents of pertinent records of a person examined or treated for tuberculosis by the department or its authorized representatives, or of the existence or contents of such reports received from a private physician or private health facility or laboratory, without the consent of the person examined or treated for tuberculosis, except in proceedings under s. 392.55, s. 392.56, or s. 392.57.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 13, ch. 90-344; s. 205, ch. 96-406; s. 139, ch. 98-403.

392.655Prisoners.—

(1)The department and its authorized representatives may, at its discretion, enter any state, county, or municipal detention facility to interview, examine, and treat any prisoner for tuberculosis. Any such state, county, or municipal detention facility shall cooperate with the department and its authorized representatives to provide such space as is necessary for the examination and treatment of all prisoners having or suspected of having tuberculosis.

(2)Nothing in this section shall be construed as relieving the Department of Corrections, counties, or municipalities of their primary responsibility for providing medical treatment for prisoners, including treatment for tuberculosis.

History.—s. 16, ch. 94-320.

392.66Rules.—The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this chapter. The rules must include requirements for tuberculosis treatment and provide consequences if a person who has active tuberculosis fails to comply with treatment requirements.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 97, ch. 98-200; s. 24, ch. 2000-242.

392.67Unlawful acts; penalties for violation.—

(1)It is unlawful for any person who has active tuberculosis and who knows or has been informed of that fact to willfully expose other persons to the disease.

(2)Any person who violates subsection (1) commits a misdemeanor of the

second degree, punishable as provided in s. 775.082 or s. 775.083.

(3) Any person who maliciously disseminates any false information or report concerning the existence of tuberculosis commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(4)(a) In addition to any administrative action authorized by chapter 120 or by other law, a person who violates any provision of the department's rules pertaining to tuberculosis or the requirements for reporting tuberculosis under s. 392.53 may be punished by a fine not to exceed \$500 for each violation. Any penalties enforced under this subsection shall be in addition to other penalties provided by this chapter.

(b) In determining the amount of fine to be imposed, if any, for a violation, the department shall consider:

1. The gravity of the violation, including the probability that death or serious physical or emotional harm to any person will result or has resulted, the severity of the actual or potential harm, and the extent to which the applicable law or rule was violated.

2. Actions taken to correct the violation.

3. Any previous violation.

(c) All amounts collected under this subsection shall be deposited into an appropriate trust fund of the department.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 67, ch. 91-224; s. 17, ch. 94-320.

392.68 Fees and other compensation.—

(1) For the services required to be performed under ss. 392.55, 392.56, 392.57, and 392.62, compensation shall be paid as follows:

(a) The sheriff shall receive the same fees and mileage as are prescribed for like services in criminal cases.

(b) The counsel appointed by the court to represent an indigent person shall receive compensation as provided in s. 27.5304.

(2) All fees, mileage, and charges provided to the sheriff pursuant to paragraph (1)(a) shall be taxed by the court as costs in each proceeding and shall be paid by the board of county commissioners. All compensation provided to court-appointed counsel pursuant to paragraph (1)(b) shall be taxed by the court as costs and paid by the state.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 699, ch. 95-148; s. 69, ch. 2004-265.

392.69 Appropriation, sinking, and maintenance trust funds; additional powers of the department.—

(1)The Legislature shall include in its annual appropriations act a sufficient sum for the purpose of carrying out the provisions of this chapter.

(2)All moneys required to be paid by the several counties and patients for the care and maintenance of patients hospitalized by the department for tuberculosis shall be paid to the department, and the department shall immediately transmit these moneys to the Chief Financial Officer, who shall deposit the moneys in the Operations and Maintenance Trust Fund, which shall contain all moneys appropriated by the Legislature or received from patients or other third parties and shall be expended for the operation and maintenance of the state-operated tuberculosis hospital.

(3)In the execution of its public health program functions, notwithstanding s. 216.292(2)(b)2., the department is hereby authorized to use any sums of money which it may heretofore have saved or which it may hereafter save from its regular operating appropriation, or use any sums of money acquired by gift or grant, or any sums of money it may acquire by the issuance of revenue certificates of the hospital to match or supplement any state or federal funds, or any moneys received by said department by gift or otherwise, for the construction or maintenance of additional facilities or improvement to existing facilities, as the department deems necessary.

(4)The department shall appoint an advisory board, which shall meet quarterly to review and make recommendations relating to patient care at A. G. Holley State Hospital. Members shall be appointed for terms of 3 years, with such appointments being staggered so that terms of no more than two members expire in any one year. Members shall serve without compensation, but they are entitled to be reimbursed for per diem and travel expenses under s. 112.061.

History.—s. 1, ch. 88-389; s. 1, ch. 88-398; s. 17, ch. 96-418; s. 28, ch. 99-397; s. 57, ch. 2000-371; s. 411, ch. 2003-261; s. 50, ch. 2005-152.

Section 9 Appendices

Appendix A. Glossary of Terms Related to TB

TB Infection - A condition in which TB bacteria are alive but inactive in the body. People with TB infection have no symptoms, do not feel sick, cannot spread TB to others, and usually have a positive skin test reaction. However, they may develop TB disease later in life if they do not receive preventive therapy.

TB Disease - An illness in which TB bacteria are multiplying and attacking different parts of the body. The symptoms of TB disease include weakness, weight loss, fever, no appetite, chills, and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest, and coughing up blood.

TB Skin Test (Mantoux PPD Skin Test) - A test that is often used to detect TB infection. A positive reaction indicates TB infection.

TB Blood Test, Quantiferon (QFT) or T-Spot – A test, like the TB skin test that is used to detect TB infection. A positive result indicates TB infection.

Chest x-ray - A picture of the inside of your chest. An x-ray can show whether TB bacteria have damaged your lungs.

Contact - A person who has spent time with a person with infectious TB.

Sputum - Fluid from lungs which is tested to see whether there are TB bacteria present.

Isoniazid (INH) - A drug used to prevent TB disease in people who have TB infection.

Multidrug-resistant TB (MDR-TB) - TB disease caused by bacteria that are resistant to more than one of the drugs often used to treat TB.

Directly Observed Therapy (DOT): A strategic method of helping patients takes their medicines for TB. If you get DOT, you will meet with a health care worker every day or several times a week. You will meet at a place you both agree on. This can be the TB clinic, the shelter, under the freeway or any other location.

Appendix B .TB Screening, Follow-Up Evaluation, Care and Intervention

Florida Department of Health in Miami Dade County, Tuberculosis Control & Prevention Program provides education, TB targeted testing, chest x-rays, case management, treatment for latent TB infections and TB disease, including directly observed therapy and conducts TB contact investigations to control TB in Miami-Dade County. Medical clearance clinical diagnostic and treatment services are available to all residents and (visitors) of Miami-Dade County at the following TB clinic locations:

<http://www.dadehealth.org/tb/TBintro.asp>

Health District Center (Downtown)
1350 NW 14th Street, Miami, Florida 33125
Phone: (305) 575-5409

Little Haiti Health Center
300 NE 80th Terrace, Miami, Florida 33138
Phone: (305) 795-2100

West Perrine Health Center
18255 Homestead Avenue, Miami, Florida 33157
Phone: (305) 234-5400

Engineering Controls (Workplace Tools)

TB in Shelters: Reducing the Risk through Ventilation, Filters, and UV. Francis J. Curry National TB Center. <http://www.nationaltbcenter.edu>

Appendix C: Miami Dade County Homeless Shelters.

Homeless Helpline at 1-877-994-HELP (4357).

<p>Beckham Hall Shelter for Men Camillus House 2375 NW 10th Avenue Miami FL 33127 Telno: 305-634-2294</p>	<p>Safe Space Department of Human Services, Miami Dade Tel no: 305-285-5900</p>
<p>Brother Harbison Camillus House 1603 NW 7th Avenue Miami FL 33136 Tel No: 305-374-1065</p>	<p>Mother Theresa's Family Shelter Mother Theresa Mission of Charity 724 NW 17th Street, Miami FI 33136 Tel No: 305-326-0032</p>
<p>Chapman Center, North Chapman Partnership 1550 North Miami Avenue, Miami FL 33136 Tel No: 305-329-3000</p>	<p>Emergency Housing Program The Salvation Army 1907 NW 38th Street Miami, FI 33142 Tel No: 305-637-6720</p>
<p>Chapman Center, South Chapman Partnership 28205 SW 124th Court, Homestead, FL 33033 Tel 305-329-3000</p>	<p>Women of Power Restoration Program 12100 SW 218th Street, Miami Florida 33170 Tel No: 786-226-7883</p>
<p>Miami Bridge Youth Shelter, North 2810 NW South River Drive Miami FL 33125 Tel No 305-635-8953</p>	<p>Victims Response, Inc. The Lodge P.O. Box 470728 Miami, FL 33147 Tel No: 305-693-1170 info@thelodgemiami.org</p>
<p>Miami Bridge Youth Shelter, South 326NW #rd Avenue Homestead FL 33030 Tel No 305-635-8953</p>	
<p>Chapel Miami Rescue Mission 2020 NW 1st Avenue Miami, FL 33127 Tel No: 305-571-2250</p>	
<p>Miami Rescue Mission Women's Family Shelter 2050 NW 1st Avenue Miami FL 33127 Tel No: 305-571-2250</p>	

Appendix D .National Homeless Resources

American Affordable Housing Institute P.O. Box 118 New Brunswick, NJ 08903	Habitat for Humanity 121 Habitat Street American, GA 31709-3498 Tel:912-924-6935
California Coalition for the Homeless 1010 S. Flower Street Los Angeles, CA Tel: 213-746-7677	Homelessness Information Exchange 1830 Connecticut Avenue Washington, DC 20009 Tel:202-462-7551
Church & Temple Housing 502 1/2 S. Main Street Los Angeles, CA 90013 Tel:213-627-3832	House Pins, Inc. 80 Second Street South Portland, ME 04106 Tel:207-799-6116
Coalition for the Homeless 500 Eight Avenue New York, NY 10018 Tel:212-695-8700	IMPACT 110 Maryland Avenue, NE Washington, D.C. 20002 Tel:202-544-8636
Common Cents New York, Inc. 500 Eighth Avenue New York, NY 10018 Tel:212-736-6437	Interfaith Coalition for Housing United Methodist Church 100 Maryland Avenue, NE Washington, D.C. 20002 Tel:202-488-5653
Community for Creative Non-violence 425 Second Street, NW Washington, D.C. 20001 Tel:202-393-4409	Interfaith Council for the Homeless of Union County 724 Park Avenue Plainfield, NJ 07060 Tel:908-753-4001
Community Workshop on Economic Development 100 S. Morgan Street Chicago IL. 60607	The Interfaith Nutrition Network 148 Front Street Hempstead, NY 11550 Tel:516-486-8506
Dayspring Center 1537 N. Central Indianapolis, IN 46202 Tel:317-635-6785	MAZON, A Jewish Response to Hunger 2940 Westwood Blvd., Suite 7 Los Angeles, CA 90064
Enterprise Foundation 505 American City Building Columbia, MD 21044 Tel:301-964-1230	McAuley Institute 1320 Fenwich Lane Silver Spring, MD 20910 Tel:301-588-8110
The Ford Foundation 320 East 43 Street New York, NY 10017	Metropolitan New York Coordinating Council On Jewish Poverty 9 Murray Street New York, NY 10007-2296 Tel:212-267-9500
Friends Committee on National	The National Alliance to End

Legislation 245 Second Street, NE Washington, D.C. 20002-5795	Homelessness 1518 K Street, NW Suite 206 Washington, D.C. 20005 Tel:202-638-1526
Goddard-Riverside Community Center 593 Columbia Avenue New York, NY 10024 Tel: 212-873-6600	The National Coalition Against Domestic Violence P.O. Box 34103 Washington, D.C. 20043-4103 Tel:202-638-6388
National Coalition for the Homeless 1621 Connecticut Avenue, NW Washington, D.C. 20009 Tel:202-460-8112	Legal Action Center for the Homeless 220 E.44th Street New York, NY 10009 Tel:212-529-4240
National Congress for Economic Community Development 1612 K Street, NW, Suite 510 Washington, D.C. 20006	Local Initiatives Support Corporation 733 Third Avenue, Eighth Floor New York, NY 10017 Tel:212-529-4240
National Interfaith Hospitality Networks 121 Morris Avenue Summit, NJ 07901 Tel:908-273-1100	Network, A National Catholic Social Justice Lobby 806 Rhode Island Avenue, NE Washington, D.C. 20018 Tel:202-526-4070
The Partnership for the Homeless 305 Seventh Avenue New York, NY 10001 Tel:212-645-3444	Religious Action Center of Reform Judaism 2027 Massachusetts Avenue Washington, D.C. 20036 Tel:202-287-2800
Rotocare c/o Dr. Mark Campbell 69 E. Hamilton Avenue Campbell, CA 95008	Salvation Army 799 Bloomfield Avenue Verona, N 07044 Tel:201-239-0606
Second Harvest 116 South Michigan, Suite 4 Chicago, Il 60603 Tel:312-263-2303	Travelers Aid International 1001 Connecticut Avenue Washington, D.C. 20036 Tel:202-659-9468
United States Catholic Conference 1312 Massachusetts Avenue, NW Washington, D.C. 20005-4105 Tel:202-541-3185	United States Conference of Mayors 1620 Eye Street, NW Washington, D.C. 20006 Tel:202-293-7330

Appendix E. Who is Homeless? Published by the National Coalition for the Homeless, *July 2009*

DEFINITIONS

According to the Stewart B. McKinney Act, 42 U.S.C. § 11301, et seq. (1994), a person is considered homeless who "lacks a fixed, regular, and adequate nighttime residence; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The term "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law." 42 U.S.C. § 11302(c)

The education subtitle of the McKinney-Vento Act includes a more comprehensive definition of homelessness. This statute states that the term 'homeless child and youth' (A) means individuals who lack a fixed, regular, and adequate nighttime residence... and (B) includes: (i) children and youth who lack a fixed, regular, and adequate nighttime residence, and includes children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; (ii) children and youth who have a primary nighttime residence that is a private or public place not designed for or ordinarily used as a regular sleeping accommodation for human beings... (iii) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings, and (iv) migratory children...who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii). McKinney-Vento Act sec. 725(2); 42 U.S.C. 11435(2).

Other federal agencies, such as the Department of Housing and Urban Development (HUD), interpret the McKinney-Vento definition to include only those persons who are on the streets or in shelters and persons who face imminent eviction (within a week) from a private dwelling or institution and who have no subsequent residence or resources to obtain housing. This interpretation of homelessness serves large, urban communities where tens of thousands of people are literally homeless. However, it may prove problematic for those persons who are homeless in areas of the country, such as rural areas, where there are few shelters. People experiencing homelessness in these areas are less likely to live on the street or in a shelter, and more likely to live with relatives in overcrowded or substandard housing (U.S. Department of Agriculture, 1996).

DEMOGRAPHICS

Two trends are largely responsible for the rise in homelessness over the past 20-25 years: a growing shortage of affordable rental housing and a simultaneous increase in poverty. Persons living in poverty are most at risk of becoming homeless, and demographic groups who are more likely to experience poverty are also more likely to experience homelessness. Recent demographic statistics are summarized below.

AGE

In 2003, children under the age of 18 accounted for 39% of the homeless population; 42% of these children were under the age of five (National Law Center on Homelessness and Poverty, 2004). This same study found that unaccompanied minors comprised 5% of the urban homeless population. However, in other cities and especially in rural areas, the numbers of children experiencing homelessness are much higher. According to the National Law Center on Homelessness and Poverty, in 2004, 25% of homeless were ages 25 to 34; the same study found percentages of homeless persons aged 55 to 64 at 6%.

GENDER

Most studies show that single homeless adults are more likely to be male than female. In 2005, a survey by the U.S. Conference of Mayors found that single men comprised 51% of the homeless population and single women comprised 17% (U.S. Conference of Mayors, 2005).

FAMILIES

The number of homeless families with children has increased significantly over the past decade. Families with children are among the fastest growing segments of the homeless population. In its 2005 survey of 25 American cities, the U.S. Conference of Mayors found that families with children comprised 33% of the homeless population, a definite increase from previous years (U.S. Conference of Mayors, 2005). These proportions are likely to be higher in rural areas. Research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Vissing, 1996). As the number of families experiencing homelessness rises and the number of affordable housing units shrinks, families are subject to much longer stays in the shelter system. For instance, in the mid-1990s in New York, families stayed in a shelter an average of five months before moving on to permanent housing. Today, the average stay is seven months, and some surveys say the average is closer to a year (U. S. Conference of Mayors, 2005 and Santos, 2002). For more information, see our fact sheet on Homeless Families with Children.

ETHNICITY

In its 2004 survey of 27 cities, the U.S. Conference of Mayor found that the homeless population was 49% African-American, 35% Caucasian, 13% Hispanic, 2% Native American, and 1% Asian (U.S. Conference of Mayors, 2001). Like the

total U.S. population, the ethnic makeup of homeless populations varies according to geographic location. For example, people experiencing homelessness in rural areas are much more likely to be white; homelessness among Native Americans and migrant workers is also largely a rural phenomenon (U.S. Department of Agriculture, 1996).

VICTIMS OF DOMESTIC VIOLENCE

Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). A 2003 survey of 100 homeless mothers in 10 locations around the country found that 25% of the women had been physically abused in the last year (American Civil Liberties Union, 2004). In addition, 50% of the 24 cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 2005). Studying the entire country, though, reveals that the problem is even more serious. Nationally, approximately half of all women and children experiencing homelessness are fleeing domestic violence (Zorza, 1991; National Coalition Against Domestic Violence, 2001). For more information, see our fact sheet on Domestic Violence and Homelessness.

VETERANS

Research indicates that 40% of homeless men have served in the armed forces, as compared to 34% of the general adult male population (Rosenheck et al., 1996). In 2005, the U.S. Conference of Mayors' survey of 24 American cities found that 11% of the homeless populations were veterans – however, this does not take gender into account (U.S. Conference of Mayors, 2005). The National Coalition for Homeless Veterans estimates that on any given night, 271,000 veterans are homeless (National Coalition for Homeless Veterans, 1994). For more information, see our fact sheet on Homeless Veterans.

PERSONS WITH MENTAL ILLNESS

Approximately 16% of the single adult homeless population suffers from some form of severe and persistent mental illness (U.S. Conference of Mayors, 2005). According to the Federal Task Force on Homelessness and Severe Mental Illness, only 5-7% of homeless persons with mental illness require institutionalization; most can live in the community with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992). For more information, see our fact sheet on Mental Illness and Homelessness.

PERSONS SUFFERING FROM ADDICTION DISORDERS

Surveys of homeless populations conducted during the 1980s found consistently high rates of addiction, particularly among single men; however, recent research has called the results of those studies into question (Koegel et al., 1996). Briefly

put, the studies that produced high prevalence rates greatly over represented long-term shelter users and single men, and used lifetime rather than current measures of addiction. While there is no generally accepted "magic number" with respect to the prevalence of addiction disorders among homeless adults, the U.S. Conference of Mayors' number in 2005 was 30%, and the frequently cited figure of about 65% is probably at least double the real rate for current addiction disorders among all single adults who are homeless in a year. For more information, see our fact sheet on Addiction Disorders and Homelessness.

EMPLOYMENT

Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent.¹ (National Low Income Housing Coalition, 2001). In fact, in the median state a minimum-wage worker would have to work 89 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing (National Low Income Housing Coalition 2001). Thus, inadequate income leaves many people homeless. The U.S. Conference of Mayors' 2005 survey of 24 American cities found that 13% of the urban homeless population were employed (U.S. Conference of Mayors, 2005), though recent surveys by the U.S. Conference of Mayors have reported as high as 25%. In a number of cities not surveyed by the U.S. Conference of Mayors - as well as in many states - the percentage is even higher (National Coalition for the Homeless, 1997). For more information, see our factsheets on Employment and Homelessness and Why Are People Homeless?.

IMPLICATIONS

As this fact sheet makes clear, people who become homeless do not fit one general description. However, people experiencing homelessness do have certain shared basic needs, including affordable housing, adequate incomes, and health care. Some homeless people may need additional services such as mental health or drug treatment in order to remain securely housed. All of these needs must be met to prevent and to end homelessness.

FOOTNOTES

1. FMRs are the monthly amounts "needed to rent privately owned, decent, safe, and sanitary rental housing of a modest (nonluxury) nature with suitable amenities." Federal Register. HUD determines FMRs for localities in all 50 states.

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- 4) Homes for the Homeless. Ten Cities 1997-1998: A Snapshot of Family Homelessness Across America. Available from Homes for the Homeless & the Institute for Children and Poverty, 36 Cooper Square, 6th Floor, New York, NY 10003; 212/529-5252.
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- 10) Santos, Fernanda and Robert Ingrassia. "Family surge at shelters." New York Daily News, August 18th, 2002. Available at www.nationalhomeless.org/housing/familiesarticle.html.
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- 14) Urban Institute, The. A New Look at Homelessness in America. February 01, 2000. Available from the Urban Institute, 2100 M Street, N.W. / Washington, DC 20037 or on the website at www.urban.org.
- 15) Vissing, Yvonne. Out of Sight, Out of Mind: Homeless Children and Families in Small Town America, 1996. Available for \$16.95 (paperback) from The University Press of Kentucky, 663 S. Limestone St., Lexington, KY 40508-4008; 800/839-6855.
- 16) Zorza, J. "Woman Battering: A Major Cause of Homelessness," Clearinghouse Review, 25(4) (1991). Qtd. In National Coalition Against Domestic Violence, "The Importance of Financial Literacy," Oct. 2001.

Section 10: Sample Forms

A. Sample Symptoms Questionnaire

Tuberculosis Screening for Staff

Annual Symptom Check Sheet

Every employee must fill out this questionnaire on annual basis. The employee should remain alert for these symptoms and contact their health care provider if these symptoms occur at any time

Date _____

Name _____

Questions	Yes	No
Have you had a new cough for the last 3 weeks?		
If you have a chronic cough, has it changed or become worse in the last 6 months?		
Do you ever cough up blood?		
Have you had unplanned weight loss in the last 3 months		
Do you sweat a great deal at night?		
Have you had unexpected fevers in the last 3 months?		
Have you had unusual tiredness or fatigue?		
Do you have chest pain?		
Do you have shortness of breath?		
Do you know someone who has same symptoms?		
History of treatment of treatment of active TB disease		

If the answer is yes to any of these questions, employee will bring a written statement from her/his health care provider indicating that s/he is free from communicable disease.

I have answered these questions honestly and to the best of my ability.

Employee signature _____

B. Sample Tuberculosis Skin Testing Client Questionnaire

Name	Date of Birth
Address	Tel:

CIRCLE ANY OF THE BELOW SYMPTOMS YOU HAVE TODAY

Cough Coughing up blood Fever
 Weight loss Tiredness Night sweats

PLEASE ANSWER THESE QUESTIONS

Question	YES	NO
Have you ever had a positive TB skin test or TB blood test?		
Have you had a severe reaction to a TB skin test?		
Have you ever taken medication for tuberculosis?		
What country were you born in?		
If you were not born in the U.S., when did you come here?		
Have you had the BCG vaccine?		
Have you been in contact with someone who has TB disease?		
Have you ever used injection drugs?		
Do you have HIV/AIDS?		
Do you have any diseases that could affect your immune system such as cancer, leukemia or other?		
Do you have diabetes?		
Do you have severe kidney disease?		
Are you underweight or do you have a disease which affects how you absorb food and nutrients?		
Have you had an intestinal bypass or gastrectomy?		
Do you take any prescription medications? List them below		
Have you been in Jail, prison, or a nursing home?		
Have you ever been told you have an abnormal chest X-ray?		

Signature: _____

Date: _____

C. Sample TB Policy for Homeless Agencies

[Name of Agency]

Policy: Tuberculosis

Date:

PURPOSE:

TB is both preventable and curable if diagnosed and treated in a timely fashion. Therefore, to ensure to the best extent possible the safety of staff, volunteers and clients, **[name of agency]** has instituted the following guidelines.

POLICY:

All staff, volunteers, and clients are required to have tuberculosis (TB) screening and appropriate follow-up. In addition to this policy, the agency promotes education and practices to minimize the risk of infection.

PROCEDURES:

Staff screening and education:

1. All staff and volunteers must have (1) a TB skin test and (2) a symptom assessment prior to starting work and annually thereafter.
 - a. *Two step testing:* Staff or volunteers that have not had documented TB screening with a skin test within the last 12 months are requested to undergo two-step baseline TB skin testing (1-3 weeks apart) *if possible*.
 - b. *Positive test:* If the TB test is positive (or if documented previous positive), new employees must have a chest x-ray and/or a statement from a physician indicating that he/she is free from communicable disease.
 - c. *Annual screening for employees with previous positive tests:* If there is no documentation, the skin test should be repeated.

For all employees: S/he should fill out a TB symptom assessment (questionnaire attached to TB policy) to identify any symptoms of active TB and have it evaluated by a health care provider. *Employees with suspected pulmonary TB will be excluded from work until a written physician clearance is obtained.*

2. All staff and volunteers will be provided information prior to the first day of work about the increased risk of exposure to TB when providing services to homeless clients. They will also be provided with a list of medical conditions that increase one's risk of developing active TB so that each person can make their own personal assessment of risk.

3. Results of TB screening remain strictly confidential and are treated as personal medical information.
4. All staff will instruct coughing persons to cover their mouths and offer masks and/or tissues.
5. All staff and volunteers are required to attend an annual TB prevention training from a community provider or agency staff person. Documentation of attendance at training will be kept on agency file.
6. All new staff and volunteers will be provided a copy of the **[agency name]** TB policy within two weeks of hire and will view the video, "Shelters and TB: What Staff Needs to Know" produced by the Curry National TB Center.
7. **[Name of person]** is the TB Liaison and serves as a health resource for staff and clients, coordinates client TB training, and orders and distributes TB educational materials.

Client/guest assessment and monitoring:

8. To assist clients in meeting their health needs, all clients shall receive an initial health assessment regarding TB and other health issues. The health assessment will be conducted by _____.
9. Identify and appropriately refer clients with symptoms of TB.
 - a. All staff must be proactive in identifying a person who is coughing or who has TB-like symptoms. Symptoms of TB are a progressive cough lasting three weeks or more, fever, fatigue, night sweats, unexplained weight loss and coughing up blood.
 - b. Immediately provide this person with tissues or a mask to cover their cough and notify the agency's designated TB liaison person.
 - c. Conduct interviews with clients with TB-like symptoms in a well-ventilated room or outside. Suggested symptom assessment questions to ask are:
 - i. Have you had a new cough for the last 3 weeks?
 - ii. If you have a chronic cough, has it changed or become worse in the last 3 months?
 - iii. Do you ever cough up blood?
 - iv. Have you lost weight in the last 3 months?
 - v. Do you sweat a great deal at night?
 - vi. Have you had fevers in the last 3 weeks?
10. TB education for clients/residents will be provided annually and educational posters will be placed where clients can see them.

Environmental policies:

11. Environmental measures to reduce the risk of TB transmission will be followed:

- order and stock tissues, masks, and place plastic-lined waste baskets in convenient locations
- open doors and windows to allow for adequate ventilation as much as possible
- position beds head-to-foot where possible
- arrange for regular maintenance of ventilation system
- replace lint air filters with pleated type filters.

I have read and understand the above TB policy.

Signature: _____ Date: _____

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<http://www.kingcounty.gov/healthservices/health/communicable/TB/providers.aspx>

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