**ATTACHMENT B: Health Department Homeless TB Data Collection Instrument**

1. **Demographics and control program characteristics**

**Jurisdiction *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fill in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Population size of your jurisdiction *(check the appropriate box)***

|  |  |
| --- | --- |
| **Less than 50,000 people** |  |
| **Between 50,000 and 100,000 people**  |  |
| **Between 100,000 and 500,000 people** |  |
| **More than 500,000 people** |  |

**Number of TB cases in 2012 *\_\_\_\_\_\_\_\_\_Fill in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

1. **Please indicate how the TB program is organized within the health department:**

***(check the appropriate box)***

|  |  |
| --- | --- |
| **Stand alone** |  |
| **Integrated with other communicable diseases** |  |
| **Integrated with other program (specify)** |  |
| **Other (please specify)** |  |

1. **How many staff are solely dedicated to your TB Control Program? *\_\_\_\_\_\_***
2. **Please indicate how many staff members work in your TB control program, how much of their time is dedicated to working in the TB control program and if communicating with homeless service providers is part of their work responsibilities:**

***(please indicate how many staff in each category)***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Type of staff member*** | ***Number*** | ***Dedicated time to TB (%)*** | ***Designated to communicate with homeless service providers (Y/N)*** |
| **Medical Doctors** |  |  |  |
| **Registered Nurses** |  |  |  |
| **Licensed Practical Nurses** |  |  |  |
| **Medical Assistants or Technicians** |  |  |  |
| **DIS/DOT workers** |  |  |  |
| **Clinical/Public Health Investigators** |  |  |  |
| **Epidemiologists** |  |  |  |
| **Administrative staff members** |  |  |  |
| **Other** |  |  |  |

1. **What is your job title?­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­*\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fill in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
2. **Perception and assessment of the problem**
3. **Do you perceive TB among homeless persons is a problem in your jurisdiction?**

***Yes / No***

1. **How is the housing status of a TB patient assessed (for documentation on the RVCT)? *(Check all that apply)***

|  |  |
| --- | --- |
| **Interview** |  |
| **Chart review** |  |
| **Homeless registry (HMIS)** |  |
| **Other (please specify)** |  |

1. **Does your TB program have written guidance on addressing TB among the homeless?** *(For example, written policy or plan to address TB among the homeless, as described in CDC guidelines published by the Division of TB Elimination and the Advisory Council for the Elimination of TB in 1992).*

 ***Yes / No***

|  |  |
| --- | --- |
| ***Written policy*** | ***Yes / No*** |
| Do you have a written policy on TB case finding and treatment completion among homeless persons? |  |
| Do you have a written policy on Latent TB Infection (LTBI) screening and treatment for homeless persons if HIV infection or other medical condition existed that increases TB? |  |
| Do you have a written policy on examining and potentially retreating inadequately treated TB disease and infection among homeless persons? |  |
| Do you have a written policy on conducting contact investigations for cases reported as homeless, including shelter screenings?  |  |

**Please provide any additional details about use of written policies to address TB among homeless persons.**

|  |
| --- |
|  |

1. If no, do you employ guidance from other jurisdictions?

***Yes / No***

1. **Tuberculosis outbreaks**

Please indicate whether you have had any TB outbreaks involving any cases among homeless persons during the time period listed in the first column (mark zero if there have been no outbreaks involving homeless persons)

|  |  |  |
| --- | --- | --- |
| Time Period | Number of outbreaks among homeless persons | Shelter involved in the outbreak(s)?*Yes/No* |
| 2011–2013 |  |  |
| 2008–2010 |  |  |
| 2008–2005 |  |  |

1. **Working with health care for the homeless providers and shelters**
2. Please indicate the approximate frequency of meetings with homeless service providers (for example, monthly meetings with shelter directors or health care for the homeless providers): *(check the appropriate box)*

|  |  |
| --- | --- |
| **More than 1 each month** |  |
| **Monthly** |  |
| **Quarterly** |  |
| **2 times each year** |  |
| **Annually** |  |
| **Never** |  |

* 1. If you are conducting meetings, please check those who are invited to attend: *(check all that apply)*

|  |  |
| --- | --- |
| **Health Care for the Homeless clinic staff / representatives** |  |
| **Shelter directors** |  |
| **Shelter staff members** |  |
| **Homeless advocacy agency staff** **(e.g., Coalition for the Homeless)** |  |
| **Other (please specify** |  |

1. Please check if you have MOUs (memorandum of understanding) with homeless service agencies to provide TB care (for example, a health care for the homeless clinic to conduct TB screening): *(check all that apply)*

|  |  |
| --- | --- |
| **No memorandum of understanding** |  |
| **TB screening** |  |
| **Chest radiography** |  |
| **Treatment of latent infection** |  |
| **Treatment of active TB disease** |  |

1. **Screening**
2. **Do you perform tuberculosis screening for individuals currently experiencing homelessness?**

***Yes / No***

* + 1. ***If yes, please indicate screening location(s) (check all that apply)***

|  |  |
| --- | --- |
| ***Location*** |  |
| **Public health (TB) clinic** |  |
| **Community Health Centers** |  |
| **Health Care for the Homeless clinics** |  |
| **Homeless shelters** |  |
| **Mobile clinic** |  |
| **Street outreach** |  |
| **Health fairs** |  |
| **Other (please specify)** |  |

* + 1. **If yes, what TB screening tests are used to screen homeless individuals?**

***(check all that apply)***

|  |  |
| --- | --- |
| **Tuberculin skin test** |  |
| **IGRA** |  |
| **Symptom screen** |  |
| **Chest radiograph** |  |
| **Sputum examination (AFB smear)** |  |

* 1. **Do you perform HIV screening for individuals currently experiencing homelessness?**

***Yes / No***

1. **TB Control Program Interventions**
	1. Contact investigations
		1. How often are contact investigations conducted once a contagious TB patient is identified? *(check the appropriate box)*

|  |  |
| --- | --- |
| **None or rarely (0%)** |  |
| **As needed (25%)** |  |
| **Sometimes (50%)** |  |
| **Almost always (75%)** |  |
| **Always (>90%)** |  |

* + 1. How often are contact investigations conducted once a contagious TB patient with a history of homelessness or is currently homeless is identified?

*(check the appropriate box)*

|  |  |
| --- | --- |
| **None or rarely (0%)** |  |
| **As needed (25%)** |  |
| **Sometimes (50%)** |  |
| **Almost always (75%)** |  |
| **Always (>90%)** |  |

|  |  |
| --- | --- |
| ***In the last year,*** |  |
| **Has a contact investigation been deemed not feasible for a homeless TB patient?**  | ***Yes/ No*** |
| **Have location based investigations followed after identifying a homeless TB person in your jurisdiction*?*** | ***Yes / No*** |
| **How many homeless TB patients had at least 1 name based contact?** | ***Number*** |
| **How many homeless TB persons had 4 or more name based contacts?** | ***Number*** |

* 1. Housing as a TB control program intervention
		1. **How often are homeless TB patients provided housing after diagnosis in your jurisdiction? *(check the appropriate box)***

|  |  |
| --- | --- |
| **None or rarely (0%)** |  |
| **As needed (25%)** |  |
| **Sometimes (50%)** |  |
| **Almost always (75%)** |  |
| **Always (>90%)** |  |

* + - 1. **Please list the top 5 types of facilities/organizations that provide housing for homeless TB patients in your jurisdiction (examples: hotel, motel, nonprofit organization like American Lung Association, local hospital)**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* + - 1. For what period of time are homeless TB cases housed after diagnosis?

*(check all that apply)*

|  |  |
| --- | --- |
| **While infectious (i.e., smear or culture positive)** |  |
| **During intensive phase (i.e., 2 months)** |  |
| **Based on patient need** |  |
| **Until treatment is completed** **(i.e., 6–9 months)** |  |
| **Until the patient is otherwise housed** |  |
| **Other (specify)** |  |

* 1. Treatment
		1. Do you ever provide treatment for LATENT TB infection to your homeless patients? ***Yes / No***
		2. **What regimens are used to treat latent TB infection among the homeless?**

***(check all that apply)***

|  |  |
| --- | --- |
| ***LTBI treatment regimen*** |  |
| **9 months INH** |  |
| **6 months INH** |  |
| **12 weeks INH/Rifapentine** |  |
| **Biweekly INH for 9 months** |  |
| **4 months Rifampin** |  |
| **Other (please specify)** |  |

* + 1. **If yes, is the treatment directly observed?**

***(check all that apply)***

|  |  |
| --- | --- |
| ***Directly Observed Treatment for:*** |  |
| **All homeless patients** |  |
| **Pediatric patients** |  |
| **Patients on 12 weeks isoniazid (INH)/Rifapentine** |  |
| **Patients on biweekly INH for 9 months** |  |
| **Patients on 4 months Rifampin** |  |
| **Never** |  |
| **Other (please specify)** |  |

* 1. Providing incentives
		1. Are any incentives (monetary or in-kind) used with homeless patients during treatment for ACTIVE TB disease?

 ***Yes / No***

* + 1. Are any incentives (monetary or in-kind) used with homeless patients during treatment for LATENT TB infection?

***Yes / No***