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iPHIS can also be used for case and contact management, screening, and follow-up on clients on post-landing medical surveillance.

For the TB Module, there are seven content-specific user guides for iPHIS data entry available, including the following: I – Client Demographics, II – Medical Surveillance, III – Cases, IV – LTBI, V – Screening, VI – TB-UP, and VII – Contacts.

4.4 Transferring Information between Public Health Jurisdictions

People with active TB and contacts of active TB cases will often travel, either temporarily or permanently, from one jurisdiction to another. In this event, the relevant demographic or clinical information must be transferred to the public health authorities in the jurisdiction to which they have travelled (either within Ontario or outside of Ontario/Canada).

Under no circumstances should a person travel if they are still considered to be infectious. Should a board of health become aware that a person is planning to, or has already travelled while infectious, please notify PHO as soon as possible to coordinate the notification and necessary actions of the relevant authorities.

4.4.1 Within Ontario

Information on cases and/or contacts that live in Ontario but outside of the board of health can be sent via iPHIS to the appropriate responsible board of health (where the case/contact resides).

The receiving board of health should consider notifying the referring board of health if the patient is lost to follow- up in the transfer process. The receiving board of health is responsible for giving the referring board of health details about the case disposition as soon as they are available. Further information can be obtained from iPHIS bulletin #13 – Transfer Client Responsibility.[7]

4.4.2 Outside Ontario

To transfer information to jurisdictions outside of Ontario (including outside of Canada), boards of health should send the necessary information to PHO via iPHIS referral. The PHO information clerks receive the referrals and forward the content to the appropriate jurisdiction (following review by TB program staff).

If additional documentation is required, boards of health can scan and attach the files to the iPHIS referral (for more information, see the Weekly iPHIS Notice #322).[8]

5 TB Prevention

5.1 Prevention and Health Promotion

The Tuberculosis Prevention and Control Protocol, 2018 (or as current) requires that boards of health provide annual education to health care providers and/or community stakeholders, as needed, based on local epidemiology, about the following:

1) Considering TB in persons with compatible symptoms;
2) Reporting suspect and confirmed cases of TB according to the HPPA; and
3) Screening of high-risk groups, as per the CTBS, 7th Edition.

Boards of health are encouraged to develop their own stakeholder engagement strategies to meet these objectives. For more information about TB prevention and health promotion strategies, see Appendix 3: TB Prevention and/or the CTBS, 7th Edition.[4]

5.2 Screening of High Risk Settings and/or Populations

The Tuberculosis Prevention and Control Protocol, 2018 (or as current) requires that boards of health shall screen high-risk groups, in accordance with the CTBS, 7th Edition;

For more information related to screening recommendations, see Appendix 4: Screening of High Risk Settings and/or Populations and/or the CTBS, 7th Edition.

5.3 Early Diagnosis and Treatment

The Tuberculosis Prevention and Control Protocol, 2018 (or as current) requires that boards of health shall implement strategies to promote the early identification and treatment of persons with TB. Boards of health are encouraged to develop their own strategies to meet these objectives with support from evidence-based best practices.

For more information to assist Boards of Health in the early diagnosis and treatment, see Appendix 5: Diagnosis and Treatment and/or the CTBS, 7th Edition.

6 Case Management

6.1 Board of Health Roles and Responsibilities

The *Tuberculosis Prevention and Control Protocol, 2018* (or as current) outlines the minimum requirements for Boards of Health to manage TB cases in their jurisdiction. This includes monitoring treatment response, isolation and adherence, as well as collaborating with clinicians to manage issues (e.g., side effects), providing access to medications at no cost to the client, follow up testing, and assisting with social determinants of health needs relevant to the completion of TB treatment. Boards of Health are encouraged to develop their own case management strategies, granted they

Once assessment for active TB have been completed (utilizing information outlined in the CTBS, 7th Edition; Chapter 3: Diagnosis of Active Tuberculosis and Drug Resistance), the client can then be discharged from medical surveillance (i.e., does not require further public health follow up for the purposes of TB medical surveillance).[4] Any further clinical follow-up recommended by the assessing health care provider, including repeat radiology or LTBI treatment should be managed per usual board of health protocols for suspect/confirmed active TB or LTBI.

8.2.3 Common Issues in Immigration Medical Surveillance Follow-up

Person Changes Address Prior to Completing Medical Surveillance Requirement

If the person moves out of the country:

1) The board of health shall consider notifying PHO by updating the iPHIS medical surveillance episode (i.e., update the client's address and change the Episode Status to 'Closed: Referred to the ministry') and submit an MSRF to PHO via iPHIS; and
2) PHO will notify IRCC.

If person changes jurisdictions within Ontario:

1) The board of health shall consider notifying the receiving board of health by sending a referral including all pertinent information and send the MSRF via iPHIS; and
2) Remind the client of the need to provide updated address information to IRCC.

If the person moves out of Ontario but within Canada:

1) The board of health shall consider notifying PHO by updating the iPHIS medical surveillance episode (i.e., update the client's address and change the Episode Status to 'Closed: Referred to the ministry') and submit an MSRF to PHO via iPHIS;
2) Remind the client of the need to provide updated address information to IRCC; and
3) PHO will notify IRCC.

If person is pregnant:

1) The board of health shall consider completing a symptom review;
2) The board of health shall consider instructing the person to complete the medical assessment with their doctor. The clinician can determine the need for the chest x-ray depending on the clinical presentation;
3) If symptomatic, the board of health shall consider referral to a TB clinic; and
4) The board of health shall consider recalling the file for the end of the pregnancy and request a chest x-ray at that time, if not already done.

Repeat Medical Surveillance Referrals:

If person has changed their application status and is required to undergo another IME and is subsequently referred for medical surveillance again:

A section 35 order may be extended for not more than six months. Further motions to extend the order may be brought by the MOH who has jurisdiction where the person is detained. Each extension must not exceed six months.

A MOH having jurisdiction where the individual is detained may release a patient from the hospital or other facility prior to the expiry of the order. An attending primary care provider does not have this authority.

The release and early discharge of the individual is authorized by a Certificate of the Medical Officer of Health provided either of two conditions is met:

1) The individual is no longer infected (i.e., treatment is completed);
   OR
2) Release of an individual no longer presents a significant risk to the community.

Before discharging a patient from hospital, notify the MOH of the health unit where the patient will reside after discharge to support continuity of care and follow-up. If the person is in WPHC, see Appendix 6.4: West Park Healthcare Centre (WPHC) concerning discharging a patient from WPHC under a Section 35 order.

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Appendix 1: Roles and Responsibilities in TB Control

1.1 Additional Information for Boards of Health

Additional supporting information on the role of boards of health in TB control can be found in the Ontario Lung Association's TB: A Guide for Healthcare Professionals.[16]

1.2 The Ontario Ministry of Health and Long-Term Care (ministry)

To support boards of health in their efforts to control TB, the ministry's Disease Prevention Policy and Programs Branch (DPPPB) of the Population and Public Health Division (PPHD):

1) Establishes provincial standards for local TB Prevention and Control Programs and reviews and updates them, as required;
2) Designs and evaluates provincial TB control strategies. Implementation of these strategies is the responsibility of the local board of health with support from the ministry/Public Health Ontario (PHO) agency;
3) Administers the TB drug program;
4) Administers the TB-UP program, in conjunction with the Claims Services Branch (CSB) of the ministry; and
5) Liaises with federal, provincial and territorial TB Control Programs, in collaboration with Public Health Ontario (PHO) to:
    a) Develop and recommend national policies; and
    b) Facilitate the administration of TB Control Programs across boundaries.

This may include:

1) Consult with Immigration, Refugees, and Citizenship Canada (IRCC) on policies related to screening and follow-up on cases of inactive TB in immigrants, refugees, visitors, visa students and persons of undetermined immigration status; and
2) Provides consultation to other divisions within the ministry (e.g., Long-Term Care Homes, Health Services) and other provincial ministries (e.g., Ministry of Community Safety and Correctional Services, Ministry of Education, Ministry of Indigenous Relations and Reconciliation).

1.3 Public Health Ontario

1) Provides scientific and technical advice and support on case/contact and outbreak monitoring, management and tracking;
2) Assists with coordination of case and contact follow-up between boards of health within Ontario and with jurisdictions outside of Ontario, as appropriate;

3) Collects, analyzes and disseminates provincial data;
4) Maintains data and provides direction/guidance on utilizing the integrated public health information system (iPHIS);
5) Transmits and receives relevant case information to other jurisdictions via iPHIS and other mechanisms;
6) Develops, implements, and evaluates strategies and programs to prevent and control infectious diseases;
7) Manages referrals for post-landing TB medical surveillance received from IRCC via the Provincial and Territorial Public Health Authority web portal;
8) Reports TB data to the Public Health Agency of Canada (PHAC) in accordance with established data sharing agreements; and
9) Provides and supports educational updates to groups and individuals involved in TB control, as needed.

1.4 Laboratories

Responsibilities of the laboratory/diagnostic facility in TB control:

1) Provide instructions to primary care providers/patients on the requirements for collection and submission of specimens for diagnostic testing;
2) Adhere to standards set by the Institute for Quality Management in Health Care (IQMH) – Centre for Accreditation in the collection, transportation, processing and retention of specimens;[17]
3) Report positive results promptly to the attending primary care provider and the Medical Officer of Health (MOH) of the jurisdiction where the laboratory is located and where the specimen was collected;
4) Refer all smear and/or culture and/or nucleic acid amplification test (NAAT) positive specimens to the Public Health Ontario Laboratories (PHOL); and
5) Interpret results for health professionals and board of health staff as required; and
6) Consult with and educate health care providers, as needed.

1.5 Federal Government

1.5.1 Legislative Background

The Federal *Quarantine Act*, revised in 2005, is a federal legislation. The purpose of the Act is "to protect public health by taking comprehensive measures to prevent the introduction and spread of communicable diseases."[18] It applies to all international travellers and conveyances arriving or departing from any port entry/exit in Canada.

The *Quarantine Act* covers a schedule of 25 diseases. It provides Quarantine officers with the ability to screen and assess international travellers. Further, Quarantine Offices can take various actions under the *Quarantine Act* in order to prevent the spread of communicable diseases. Further actions may consist of:

1) issuing a Report to Public Health Authority, when there is a suspicion of CD however, there is no immediate risk to public health or the traveler;
2) issuing an order to Undergo a Medical Examination, when the Quarantine Officer

suspects a communicable disease that may pose an immediate risk to public health or traveler; or
3) issuing a Detention Order: a Quarantine Officer may issue a Detention Order if the ill traveler is deemed non-compliant.

A dangerous disease is any disease that the federal Quarantine Officer suspects may pose a risk to public health.

Under the federal *Quarantine Act* in Canada, TB is considered to be one of the scheduled diseases of concern.

1.5.2 Management of Persons with Infectious TB Leaving or Entering Canada

Person with suspected or confirmed pulmonary TB leaving Canada while still infectious

If the local board of health is made aware that a person with infectious pulmonary TB is planning on leaving the country while still infectious, the board of health should consider educating the person on the risk of spread of TB and trying to persuade them to change their travel plans until they are no longer infectious. In most situations, the board of health can intervene with the airline to have booked tickets re-booked at no charge once the patient is no longer infectious and safe to fly.

For air travel, although the *Quarantine Act*[18] may not prevent a person leaving Canada with TB, individual airlines may decide not to allow a person with infectious TB to board the plane. Under the IHR, an air carrier should not board a traveler known to be ill with an infectious communicable disease. However, this action is at the discretion of the airline.

Note that public health legislation can only be used to prevent an infectious patient from flying – not to prevent a non-infectious patient from travelling against medical advice.

If a person with infectious pulmonary TB is planning to leave the country, the Public Health Agency of Canada (PHAC) can take various measures to prevent air travel. The following steps should be taken to initiate this process:

1) The local board of health should consider notifying Public Health Ontario - Communicable Diseases Unit, Communicable Diseases, Emergency Preparedness and Response of a person with infectious pulmonary TB with intentions to travel internationally;
2) Public Health Ontario will complete the Canadian Tuberculosis and Air Travel Reporting form available in the reporting forms section at PHAC's For health professionals: Tuberculosis (TB)[19] and send it to:
   a) During business hours: fax to (613) 947-3902 or email it to TB_travel-voyage@phac-aspc.gc.ca
   b) After hours and weekends/holidays: please call the Regional Quarantine Manager on call: (416) 626-2437
3) The TB Response Program (PHAC) /Regional Quarantine Manager will facilitate the review of the case to see if it meets the criteria to be added to the Airline

Restriction List; and

4) If the person with infectious pulmonary TB meets the PHAC criteria for airline restriction, Quarantine Services will contact the airline(s) at the departure point. The airline will contact Quarantine Services when the person tries to check-in. The airline will not issue a boarding pass. Quarantine Services can intervene and take the following steps:
   a) Contact the local board of health to let them know and discuss if a Quarantine Order is deemed necessary; and
   b) Issue a Quarantine Order to the ill traveler (if necessary).

Person with suspected or diagnosed TB attempting to enter Canada while still infectious

If a person with infectious pulmonary TB is planning to return to Canada while still infectious, the Public Health Agency of Canada (PHAC) can take various measures (Issue an IHR notification and/or place the person on a CBSA Lookout List). The following steps should be taken to initiate this process:

1) The local board of health should consider notifying Public Health Ontario - Communicable Diseases Unit, Communicable Diseases, Emergency Preparedness and Response of a person with infectious pulmonary TB with intentions to travel internationally;
2) Public Health Ontario will complete the Canadian Tuberculosis and Air Travel Reporting form available in the reporting forms section at PHAC's For health professionals: Tuberculosis (TB)[19]) and send it to:
   a) During business hours: fax to (613) 947-3902 or email it to TB_travel-voyage@phac-aspc.gc.ca
   b) After hours and weekends/holidays: please call the Regional Quarantine Manager on call: (416) 626-2437
3) The TB Response Program (PHAC) /Regional Quarantine Manager will facilitate the review of the case to see if it meets the criteria; and
4) PHAC can facilitate two actions:
   a) to complete an IHR notification; and/or
   b) to add the client to the CBSA Lookout List.

If the person with infectious pulmonary TB meets the PHAC criteria, Quarantine Services will facilitate the addition of this person's name to the CBSA Lookout List. When the person arrives in Canada, the person will be flagged by CBSA and Quarantine Services will be notified. Quarantine Services can intervene and take the following steps:

1) Conduct an assessment of the traveler; and
2) Issue a Quarantine Order to the ill traveler (if necessary).

1.6 First Nations and Inuit Health (FNIH) TB Control in Ontario Region: Multi-jurisdictional Partnerships in TB Control

Although health care is a provincial responsibility, Health Canada's First Nations and Inuit Health Branch (FNIHB) is responsible for ensuring access to, and provision of, the mandatory programs of Communicable Disease Control, Environmental Health and Emergency Response are in place for health protection in Indigenous communities.

For inquiries related to FNIHB Ontario Region TB Programming, please send by fax to 1-807-343-5348.

1.6.1 Communication between Local Board of Health and FNIH / Community Health Nurses

Communication between the respective federal and provincial partners is essential to support the appropriate and complete follow up of active TB cases or LTBI. Indigenous people who are diagnosed with either active TB or LTBI may live both on and off-reserve during their course of treatment and, as such, can easily be lost to follow up. This applies as well to a non-Indigenous individual living on-reserve, e.g., teachers or nurses. Therefore, communication between FNIHB CD Control staff, applicable First Nation Health Authority providers, the local board of health, and the treating primary care provider is essential for case management.

The follow up of TB cases and LTBI is the same both on- and off-reserve. FNIHB does not collect TB case and contact information through the provincial iPHIS data base. As such, exchange of information occurs through verbal or written reports between the board of health and Community Health Nurse.

All individuals living on-reserve and assessed on-reserve as having LTBI, as well as all probable/suspected and confirmed cases of active pulmonary and extra-pulmonary TB are to be reported to the respective provincial board of health by the Community Health Nurse as soon as possible.

All individuals living on-reserve and assessed off-reserve as having LTBI, as well as probable/suspected and confirmed cases of active pulmonary and extra-pulmonary TB are to be reported by the provincial board of health to the Community Health Nurse or the Regional CD Nurse if the Community Health Nurse is not available.

All infectious cases of active disease living off-reserve but known to have resided for a period of time on-reserve are to be reported to the provincial board of health, through communication with the Community Health Nurse and/or Regional CD Nurse where applicable.

Appendix 2: Surveillance Reports

2.1 Surveillance Reports

PHO routinely extracts TB surveillance data entered into iPHIS in order to generate monthly, annual, and ad hoc reports on the epidemiology of TB in the province. Recent publications include:

1) Estimating the burden of active Tuberculosis in long-term care facilities in Ontario using reportable disease data (March 2016);[20]
2) Reportable Disease Trends in Ontario: Technical Report (April 2016); and [21]
3) Tuberculosis and diabetes (March 2015).[22]

For a description of the epidemiology of TB in Canada, see the following Public Health Agency of Canada publications:

1) CTBS, 7th Edition; Chapter 1: Epidemiology of TB in Canada;[4]
2) Tuberculosis in Canada – Summary 2015;[23]
3) Tuberculosis in Canada: 2015 Supplementary data;[24] and
4) Tuberculosis: Drug resistance in Canada 2015.[25]

2.1 Epidemiology of TB in Ontario Indigenous Communities

For epidemiology of TB in Ontario Indigenous Communities, see TB in Canada: 2015 Supplementary data - CCDR: Volume 43-3/4, March 2, 2017: TB (TB).[24]

For information on the history and background of TB in Indigenous communities, see the CTBS, 7th Edition; Chapter 14: Tuberculosis Prevention and Care in First Nations, Inuit, and Métis Peoples.[4]

Appendix 3: TB Prevention

3.1 Prevention and Health Promotion

Principles of health promotion enable people to increase control over their health and improve their health status. It is an integral component of an effective and comprehensive approach to TB prevention and control. Boards of health will provide services that are accessible and equitable.

Essential to any health promotion strategy are community participation and access to education and information. These components serve to empower individuals, promote effective community participation and establish a sustainable health promotion program.

TB prevention and health promotion should be based on the local epidemiology of TB and the risk groups present in the population.

3.1.1 Health Education

Health education includes communication of information, as well as fostering motivation and skills necessary to take action and improve health. Board of health TB programs:

1) Ensure that the staff of the TB control program has adequate and current knowledge and skills related to TB including, but not limited to:
   a) Diagnosis;
   b) Treatment of active TB and latent TB infection (LTBI);
   c) Epidemiology of TB, particularly in the local jurisdiction;
   d) Social determinants of health (SDOH);
   e) Current issues;
   f) Risk factors for infection and disease;
   g) Risk factors for non-adherence with treatment;
   h) The role of public health in TB control;
   i) Drug resistance;
   j) TB-HIV co-infection;
   k) How to order TB medication;
   l) Use of iPHIS for TB reporting;
   m) TB reporting requirements;
   n) Immigration medical surveillance processes;
   o) TB specialists in the community; and
   p) Agencies in the community that can assist in the management of TB;
2) Support the provision of on-going TB education for health professionals;
3) Support the provision of on-going TB education for community groups, local agencies and institutions, at risk for TB; and
4) Make educational materials accessible to the community and relevant to the target population.

3.1.2 Community Systems Strengthening

Community development is a process by which the community defines its own health needs, considers how those needs can be met and decides collectively on priorities for actions. It is a commitment to equality, community participation, valuing of lay knowledge, viewing problems as shared and empowerment of individuals/communities through education, skills development and joint action.[26] TB Programs will utilize principles of community capacity building by enhancing skills, networking and developing partnerships with community members in order to foster leadership, empowerment, self-sufficiency and well-being; e.g., homeless populations and newcomers.[26]

3.1.3 Advocacy

The board of health shall attempt to mitigate the conditions, attitudes and beliefs that could lead to an increase in the risk of TB infection or its consequences by:

1) Supporting community agencies in improving social conditions such as poverty, homelessness, and overcrowding, which can be a factor in the spread of TB;
2) Supporting and promoting public policy aimed at addressing factors that contribute to the prevalence of TB; and
3) Helping people with TB access appropriate health care services for follow-up, regardless of their insurance status or ability to pay for these services.

3.1.4 Outreach

The board of health shall consider identifying and establishing relationships to increase the community's information and access to TB services, especially populations at highest risk.

3.1.5 Evidence-Based Practice

The board of health shall consider utilizing evidence-based practice (practice for which ideally a sound statistical basis can be demonstrated in the scientific literature) which establishes a link between practice and outcome of client care.

Appendix 4: Screening of High Risk Settings and/or Populations

4.1 Principles of Screening

For details on the definition, principles, and goals of screening for TB, refer to the CTBS, 7th Edition; Chapter 13: Tuberculosis Surveillance and Screening in Selected High Risk Populations.[4]

4.2 Screening Tools

For details on the tools used for TB screening (i.e., tuberculin skin test and interferon gamma release assays), refer to the CTBS, 7th Edition; Chapter 4: Diagnosis of Latent Tuberculosis Infection.[4] Boards of health should consider local epidemiology when planning their screening activities.

4.3 Screening in High Risk Settings

Health care organizations and individual health care workers (HCWs) have a shared responsibility to apply effective TB infection prevention and control measures. All health care settings should have a TB management program supported at the highest administrative level.

For details on prevention of TB in health care settings, refer to the CTBS, 7th Edition; Chapter 15: Prevention and Control of Tuberculosis Transmission in Health Care and Other Settings.[4]

4.3.1 Hospitals

See the Ontario Hospital Association's Tuberculosis Surveillance Protocol for Ontario Hospitals for the most recent protocol that affects all persons carrying on activities in a hospital, including employees, primary care providers, nurses, contract workers, students, post-graduate medical trainees, researchers and volunteers.[27]

Routine screening is not covered with the publicly-funded supply of TST. The publicly-funded supply should only be used for screening of contacts exposed to active TB in hospitals.

4.3.2 Long-Term Care Homes (LTCHs)

The legislative requirements for TB screening is found under Ontario regulation 79/10 of the *Long-Term Care Homes Act, 2007* (LTCHA) Paragraphs 1 and 4 of subsection 229(10) require that:

a) Residents must be screened for TB within 14 days of admission, unless the documented results of a TB screen within the last 90 days are available to the licensee of the home; and

b) Staff must be screened for TB in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.[28]

4.3.3 Retirement Homes

The legislative requirements for TB screening are found under Ontario regulation 166/11 of Retirement Homes Act (LTCHA) section 27.8, clauses b through c, require that:[29]

a) Each resident is screened for TB within 14 days of commencing residency in the home, unless the resident has been screened not more than 90 days before commencing residency and the documented results of the screening are available to the licensee;†††
b) Each member of the staff has been screened for TB and all other infectious diseases that are appropriate in accordance with evidence-based practices or, if there are no such practices, in accordance with prevailing practices; and
c) The screening for each of the infectious diseases described in clause (c) has been done using procedures that accord with evidence-based practices or, if there are no such practices, with prevailing practices.

Refer to the CTBS, 7th Edition; Chapter 15: Prevention and Control of Tuberculosis Transmission in Health Care and Other Settings, section 9.1 for recommendations on screening in long-term care homes for more details.‡‡‡ [4]

4.3.4 Shelters and Drop-In Centres for the Homeless

There are no legislative requirements for screening in shelters or drop-in centres for the homeless in Ontario. TB screening in urban homeless populations is generally focused on the detection of persons with active disease (case-finding). All shelter or drop-in centre users who show symptoms or signs of active TB should be placed in respiratory isolation and receive immediate medical assessment.

Incentives such as food and transit vouchers may increase adherence with screening programs. Refer to the CTBS, 7th Edition; Chapter 13: Tuberculosis Surveillance and Screening in Selected High-Risk Populations, section 7.1 for further details on TB screening of homeless people.[4]

Staff and volunteers working in homeless shelters and drop-in centres should be screened using a two-step TST to establish an accurate baseline. The board of health shall consider the need for routine or annual screening. See the table “Summary of recommendations for TB infection prevention and control measures in non-hospital settings” from the CTBS, 7th Edition; Chapter 15: Prevention and Control of Tuberculosis Transmission in Health Care and Other Settings.[4]

††† **NOTE**: The legislation does not stipulate what method should be used to screen clients/staff. Please refer to the CTBS, 7th Edition for recommendations on screening.

‡‡‡ **NOTE**: Routine screening for staff is not covered with the publicly-funded supply of TST.

4.3.5 Specialized Care Facilities

The board of health shall consider TB screening in specialized facilities, such as residential drug treatment centres, hospices, group homes etc., in consultation with each facility and shall consider all decisions based on local epidemiology, and the risk of TB transmission in selected populations. Additional risk information can be found in the Table "Recommendations of the Canadian Thoracic Society for groups for targeted LTBI screening" from the CTBS, 7th Edition; Chapter 13: Tuberculosis Surveillance and Screening in Selected High-Risk Populations.[4]

4.4 Screening of Other High Risk Populations

Refer to CTBS, 7th Edition; Chapter 13: Tuberculosis Surveillance and Screening in Selected High-Risk Populations for further details on screening of other high-risk populations.[4]

Appendix 5: Diagnosis and Treatment

Early diagnosis and effective treatment of active cases are keys to the prevention and control of TB. Screening of high risk populations and case-finding, rapid diagnostic testing, strong and enforceable public health legislation, universal and effective therapy, and comprehensive TB prevention and control programs are all essential components for preventing the transmission of TB.

5.1 Diagnosis and Treatment of Active TB

For detailed information about the diagnosis and treatment of active TB, please refer to the CTBS, 7th Edition; Chapter 3: Diagnosis of Active Tuberculosis and Drug Resistance.[4]

5.2 Diagnosis and Treatment of Latent TB Information

For detailed information about the diagnosis and treatment of latent TB, please refer to the CTBS, 7th Edition; Chapter 5: Treatment of Tuberculosis Disease.[4]

Appendix 6: Additional Tools for Case and Contact Management

6.1 Case Management

The basic principles of care for persons with, or suspected of having TB, are the same worldwide:

1) a diagnosis should be established promptly and accurately;
2) standardized treatment regimens of proven efficacy should be used with appropriate treatment support;
3) the response to treatment should be monitored; and
4) the essential public health responsibilities should be carried out.

Prompt, accurate diagnosis and effective treatment are not only essential for good patient care – they are the key elements in the public health response to TB and the cornerstone of TB control. Thus, all providers who undertake evaluation and treatment of patients with TB should recognize that not only are they delivering care to an individual, they are assuming an important public health function that entails a high level of responsibility to the community, as well as to the individual patient.[30]

6.1.1 Respiratory TB Cases

Conducting an Initial Public Health Investigation

1) The board of health shall contact the Primary care provider (or designate) and PHOL within one business day of notification of the case, to obtain the following details (including whether or not the individual is already in respiratory isolation, if necessary):
    a) Confirmation if treating clinically or if bacteriological evidence;
    b) Confirmation if they are treating the patient or if the patient has been/will be referred to a specialist;
    c) Patient demographics, including country of birth (if known);
    d) Language (e.g., if translation services required);
    e) Medical insurance status (IFH, need for TB-UP, etc.);
    f) Existing co-morbidities, including HIV status (if known) and current medications;
    g) Confirmation of who will be treating (i.e., whether referral to specialist has occurred/is planned);
    h) Treatment regimen;
    i) Plans to acquire laboratory results:
        i) Sputum smear microscopy for acid-fast bacteria (AFB);
        ii) Polymerase-chain reaction (PCR) tests;
        iii) Culture and/or pathology reports;
        iv) Drug susceptibility testing;

v) Initial liver function tests (LFTs); and
vi) Pathology.
j) Radiography results (within last three months);
k) Has patient been informed of diagnosis and isolation needs; and
l) Next appointment date.

2) The board of health shall contact the patient as soon as possible to arrange a home visit[§§§] to assess, educate, and counsel the patient focusing on the items below:
   a) Explain the board of health role and collaboration with treating clinician and provide contact information
   b) Assess patient understanding of their diagnosis, treatment regimen, and isolation needs and answer any questions they have. Provide emotional support.
   c) Assess patient social supports and social determinants of health and any assistance they may require to adhere to treatment (e.g., transportation to medical appointments)
   d) Collect relevant demographic information, including eligibility for medical insurance
      i) Refer to Appendix 7: TB Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program for information on services available for clients not covered by provincial insurance;
   e) Assess for history of previous active TB and treatment;
   f) Assess symptoms and date of onset and medical history;
   g) Obtain information pertinent to contact tracing;
   h) Assess the patient's understanding and beliefs about TB;
   i) Advise about side effects of TB medication;
   j) Assess the patient's ability to adhere with medication and medical follow-up;
   k) Assess need for directly observed therapy (DOT) using available tools listed in Appendix 6: Additional Tools for Case and Contact Management.
   l) If infectious, explain the need for isolation precautions and process for discontinuing isolation precautions;
   m) Where possible, educate the patient and family about:
      i) The disease process, including communicability and transmission factors:
   n) The need for isolation in cases of suspected active TB;
   o) Treatment protocol and side effects;
   p) Necessity of adherence with treatment;
   q) Purpose of directly observed therapy(DOT) if indicated;
   r) Necessity of continuing public health supervision; and
   s) The importance of identifying and screening high risk and close contacts.

[§§§] Whenever possible, the first visit with the patient contact should be conducted face-to-face in a well-ventilated area. As long as the patient remains infectious, an N95 respirator, which has been fit tested, should always be worn by board of health staff.

For additional information on the diagnosis and treatment of active TB and/or latent TB infection, see Appendix 5: Diagnosis and Treatment.

Ongoing Follow-up

Frequency of follow up is dependent on each individual patient's needs. The following is the minimum for patients stable and adherent on their TB treatment.

1) Contact the Patient[****]

The board of health shall consider maintaining contact with patients who are not on DOT (as assessed on an individual basis) no less than the following:

a) At one month: Interview the patient, preferably in person, or, alternatively, by telephone. The following should be reviewed:
   i) Adherence with drug treatment;
   ii) Clinical status;
   iii) Attendance at medical follow-up appointments;
   iv) Treatment side effects; and
   v) DOT reassessment.
b) **The CTBS recommends** routine outpatient monthly follow-up during treatment for active TB disease. Follow-up during active TB should be at least monthly, to assess adherence and response to therapy, and to detect adverse events: response to treatment should be gauged clinically, radiologically, and microbiologically.[5]

2) Contact the Treating Primary care provider or their designate to obtain/discuss/review

a) The board of health shall consider contacting the treating primary care provider or their designate monthly (strongly recommend that patients with active TB be assessed by their clinician a minimum of every 4-6 weeks throughout treatment as per CTBS) in order to obtain/discuss/review:
   i) Any changes in the treatment regimen;
   ii) LFT results (if patient is experiencing symptoms suggesting hepatotoxicity);
   iii) Confirm the treatment regimen is consistent with recommendations of the *CTBS* and is based on results of sensitivity testing;
   iv) Chest x-ray results;
   v) Eye examination results;
   vi) Attendance record at follow-up appointment;
   vii) Smear and culture results; and
   viii) Provide any public health feedback on patient status, including DOT adherence.

[****] **NOTE**: Cases that are more complicated (i.e., have adherence concerns, experience side-effects) may require additional follow-up and should be assessed on an individual basis. Such patients, however, should be prioritized for DOT.

b) When the MOH has issued a section 22 on a non-compliant patient for whom other voluntary adherence methods have failed or where a Judge has issued a section 35 order, the board of health shall work in conjunction with the attending primary care provider to confirm that the requirements of the orders are being complied with (see Section 10 – Issuance of Orders to Control TB under the Heath Protection and Promotion Act).

If a patient who resides outside Toronto is issued a Section 22/35 order and is admitted to West Park Health Care Centre (WPHC), Toronto Public Health is to be notified as soon as possible (see Section 10 – Issuance of Orders to Control TB under the Heath Protection and Promotion Act and Appendix 6.4: West Park Healthcare Centre
(WPHC)).

6.2 Non-Respiratory TB Cases (Non-Infectious)

6.2.1 In a child less than 5 years of age

When active TB (whether pulmonary or extra-pulmonary) is diagnosed in any child under 5 years old, an immediate search for an infectious source case close to the child is recommended. For further details, refer to the CTBS, 7th Edition; Chapter 12: Contact follow-up and outbreak management in Tuberculosis control.[4]

The board of health shall consider consulting the Hospital for Sick Children's (Sick Kids) online system which electronically routes patient referrals for review, triage and booking for clients who require referral to Sick Kids for screening, assessment, or treatment,. This is available at: How to refer a patient to SickKids.

6.2.2 In Older Children (≥ 5 years of age) and Adults

Non-respiratory TB is not usually infectious, unless there is concurrent respiratory involvement, and this should always be ruled out. Nonetheless, it may be life threatening because of a delay or failure to make the diagnosis. The board of health shall consider the approach outlined above for respiratory TB as appropriate for the particular case. Source case investigation should generally not be undertaken for children or adults over 5 years as the yield is very low.

Aside from contact investigations, follow-up should include all components noted above for respiratory cases.

6.3 Long distance public transportation

6.3.1 Air Travel

If during the course of the contact investigation the case reports having travelled by air while infectious, the board of health shall complete the 'Canadian TB and Air Travel Reporting Form' and send to PHO via iPHIS. For more detailed information on air travel contact notifications, refer to the CTBS, 7th Edition; Chapter 12: Contact Follow-Up and Outbreak Management in Tuberculosis Control.[4]

Additional resources include the WHO's Tuberculosis and Air Travel Guidelines for Prevention and Control, 3rd Edition, and the Canadian TB and Air Travel Guidelines, Version 2.0, 2009.[31,32]

6.3.2 Train or Bus contacts

If during the course of the contact investigation the case reports having travelled by public conveyance (i.e., bus, train) while infectious, the board of health shall notify PHO's TB program immediately by email and/or telephone.

6.4 West Park Healthcare Centre (WPHC)

6.4.1 Introduction

Toronto's West Park Healthcare Centre (WPHC) TB Service is the only provincially-designated inpatient treatment centre for complex and/or difficult to treat TB. WPHC also runs an outpatient TB clinic for management of patients with active TB, latent TB, and non-tuberculous mycobacterial (NTM) lung disease, who do not require inpatient care.

Referrals to WPHC's TB Service must be 16 years of age and older with a diagnosis of suspect or confirmed TB or other mycobacterial infections. Patients that are usually seen at WPHC typically include those:

1) With drug-resistant, polyresistant, multidrug-resistant (MDR), extensively drug-resistant TB (XDR), or completely drug-resistant TB.
2) Co-infected with TB and HIV or other medical conditions complicating treatment with First-line TB drugs (e.g., diabetes, Hepatitis B, Hepatitis C, etc.)
3) Experiencing side effects from TB medication and are unable to take regular first-line TB drugs;
4) Not responding to treatment;
5) With a section 35 order served to them under the *Health Protection and Promotion Act* (HPPA) to be confined to hospital under guard; and/or
6) Living in congregate settings (e.g., long-term care) or who are under-housed (i.e. homeless persons).

WPHC is also the designated healthcare facility in Ontario for detaining persons with TB under a section 35 order. Patients may be detained in an alternate acute care facility while waiting for an available bed at WPHC; in such cases both the acute facility and WPHC should be identified on the section 35 order.

The WPHC TB Program also manages patients with uncomplicated TB, as well as those with latent TB infection and NTM.

WPHC is located at:
82 Buttonwood Avenue, Toronto, M6M 2J4

6.4.2 West Park Healthcare Centre's Admission Policy

For Patients Not Under Section 35 Orders

Inpatient

To refer a patient to WPHC, a completed and up-to-date TB inpatient referral form should be faxed to the Care Coordinator, TB Service at 416-243-3684. The referral should include all available consult notes as well as any additional supporting documentation listed on the application form. Once received, the referral will be reviewed by the clinical team. Admissions to WPHC occur Monday to Friday at this time. Weekend admissions are reviewed on an urgent basis.

Outpatient TB Clinics

For referrals, please contact Dawn Thomas, Unit Clerk, at (416) 243-3600, ext. 2180 (or current contact).

For clinical questions please contact Jane McNamee, Nurse Practitioner, at (416) 243-3600, ext. 4405 (or current contact). Clinics are held on Monday afternoons, Tuesday mornings and the third Thursday of every month, WPHC Main Building, Main Floor, Room 136.

West Park Healthcare Centre's Admission Policy for Persons Admitted under a Section 35 Order

It is important that WPHC be notified in advance when a TB patient is being considered for a HPPA section 35 order to be detained and treated at the centre.

The following admission procedure confirms that the necessary planning and communication have taken place in order that WPHC can arrange for the appropriate care and services for TB patients detained there:

1) The Medical Officer of Health (MOH) of the jurisdiction applying for a section 35 order contacts the WPHC TB Service Care Coordinator and advises of the pending order.

The referring MOH will arrange a teleconference to alert the TB unit of the ministry, the Toronto Public Health AMOH-TB, the primary care provider currently treating the patient and the TB Service Primary care provider in Charge of the impending admission.

A formal intake process is initiated. The referring board of health is advised of the information and documentation required by WPHC to assess whether the TB service is the most appropriate facility to detain and treat the patient at the current time given the patient's condition/situation.

The information/documentation required to organize a plan of care includes:

1) History of facts leading to the issuing of the section 35 order;
2) History of previous TB;
3) Patient demographic information (i.e., gender, age); health coverage or lack thereof;

4) Patient's first language; patient's ability to communicate in English;
5) If the patient is apprehended and is found intoxicated, injured, or in an acute psychiatric state, then assessment at an acute care facility/emergency room will be necessary to determine the patient's medical stability and immediate need for treatment (injuries, withdrawal prevention) prior to admission or readmission to WPHC. Copies of any relevant information from this assessment must be forwarded to WPHC;
6) Patient's housing status/homelessness, current living arrangements, presence of children or elderly persons in the household; and
7) Information on any pre-existing conditions or known history of:
    a) Psychiatric disorder;
    b) Cognitive impairment;
    c) Substance abuse and current management;
    d) Violent or criminal behaviour; or
    e) Previous incarceration;
    f) Current mental status and evaluation of any current psychiatric symptoms;
    g) Forensic psychiatric assessment, if indicated;
    h) Patient's willingness to undergo TB assessment and to take TB medications as prescribed by the WPHC TB Service Primary care provider; and
    i) Potential for discharge barriers (e.g., homelessness, financial problems).

The Care Coordinator receives this information which is then reviewed by the TB Clinical team for admission. The WPHC primary care provider and the clinical team determine if the patient being served with the section 35 order can be safely managed and cared for at WPHC and the MOH is informed accordingly.

1) If it is determined that the patient has a psychiatric condition or behavioural problems, a full psychiatric assessment is required prior to admission. If the psychiatric status of the patient cannot be managed safely at WPHC, the primary care provider at WPHC will discuss this with the referring MOH so alternative plans can be made.

Once the patient is accepted for admission, WPHC is listed as the detaining facility in the section 35 order. The Care Coordinator at WPHC and the board of health work together to coordinate the actual date and time of the admission. It is the responsibility of WPHC to make all arrangement s for the necessary security guard services. A copy of the section 35 order will be faxed then mailed to WPHC.

Role of Toronto Public Health and WPHC with regard to Section 35 Order Patients

All patients at WPHC who are under a section 35 order become the responsibility of Toronto Public Health (TPH) as the hospital is within TPH's jurisdiction. Therefore, if a patient being detained under a section 35 order leaves hospital property without permission, WPHC should notify TPH. TPH will then attempt to locate the patient. WPHC will also notify the police of the missing patient.

In the event a TB patient goes absent without leave (AWOL), WPHC and the TPH TB unit will jointly review appropriate options for the patient including readmission and/or alternate disposition.

TPH is the designated board of health responsible for applying for an extension of the order or the rescinding of the order. It is essential that TPH be informed and aware of all section 35 order persons being detained at WPHC as soon as a section 35 order/Admission is being considered (see admission procedure described above in Appendix 6.4 – West Park Healthcare Centre's Admission Policy). TPH will review Section 35 orders that are nearing expiry and arrange extensions of the orders, if necessary, in consultation with primary care provider at WPHC and the originating board of health.

6.4.3 Discharge Planning for All Patients from WPHC

Discharge planning begins as soon as a person is admitted to WPHC. Most persons are admitted due to complex medical and/or social problems that render TB treatment more difficult. Discussions with WPHC and the health unit where the patient is going to live after discharge should begin prior to admission in order to clarify and explore options, so that there is ample time to arrange for the patient's care in the community, including directly observed therapy (DOT). It is important that planning start early to confirm that the person's treatment after discharge is not interrupted.

Because such care is often complex, it is essential that the MOH of the jurisdiction in which the person is going to reside is:

1) Involved with the discharge planning; and
2) Confirms that the referring board of health will supervise the treatment via DOT in its jurisdiction.

Patient transport from WPHC back to the originating health unit is the responsibility of that board of health.

WPHC will notify the originating/receiving board of health of pending discharges in a timely manner to assist in making the necessary arrangements for follow-up and DOT. The board of health will be provided with a detailed summary identifying salient clinical and discharge information. Unless clinical follow up is otherwise arranged, patients will return to WPHC Outpatient TB Clinic four weeks after discharge and every four weeks thereafter until treatment is completed.

6.5 Ontario Universal Typing – Tuberculosis (OUT-TB) Web

6.5.1 What is OUT-TB Web?

OUT-TB Web is a secure, internet-based GIS (map-based) application, designed to assist TB case management, investigation, and surveillance activities. OUT-TB Web is a custom-built application that links client data from iPHIS with the genotyping and other

laboratory information of the first *Mycobacterium tuberculosis* (*M. tuberculosis*) complex isolate from each new case as part of the OUT-TB program. This program assists TB control programs by providing information that bridges across board of health borders, identifying cases of tuberculosis caused by genotypically identical and related strains of *M. tuberculosis*, and helping to confirm suspected transmission, epidemiological links, and identify unsuspected transmission events.

6.5.2 Who can use OUT-TB Web?

Board of health staff with access to the iPHIS TB module may be granted access to OUT-TB Web upon completion of a user form with their manager's signature for approval.

6.5.3 How can access to OUT-TB Web be obtained?

To request a user form, the board of health will send an email with the staff name, position, and board of health to lab.data@oahpp.ca ensuring that a delegated board of health manager is also copied.

6.5.4 User Accounts, Genotype Interpretation, General Questions/Comments:

All questions related to OUT-TB can be directed to lab.data@oahpp.ca and will be processed within two business days.

6.6 Toronto Public Health Contact Screening Parameters Tool

An evidence based tool widely used in the province to prioritize contact investigations is the Contact Screening Parameters Tool and can be obtained by contacting Toronto Public Health at Targettb@toronto.ca.

6.7 Additional Resources for On-Reserve Populations

- Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve[33]
- Health Canada's Monitoring and Performance Framework for Tuberculosis Programs for First Nations On-reserve[34]

6.8 Sample DOT Assessment Tool

The board of health shall consider assessing the need for DOT initially and on an ongoing basis (at least monthly or as often as necessary). The board of health shall use these or comparable assessment factors, as well as a comprehensive assessment when determining the need for DOT. The higher the risk of non-adherence or the potential for disease progression, the more important it is for the person to be on DOT.

ASSESSMENT FACTOR FOR DOT	NO	YES
MDR resistant (resistant to INH and Rifampin)		
Resistant to more than one TB drug		
Resistant to one TB drug		
AFB positive and culture positive pulmonary TB		
AFB negative culture positive pulmonary TB		
Non-adherent with treatment		
Substance abuse (e.g., alcohol or drugs)		
Slow progress with treatment (e.g., person with repeat positive culture on treatment)		
Other comorbidities (e.g., cancer, CRF on HD, etc.)		
Transient/homeless/under-housed		
Persons who are too frail, elderly, impaired or forgetful to manage own care; no caregiver; mental illness		
Previous long term treatment failure e.g. diabetes or hypertension medication non adherence		
Prescription for intermittent therapy		
Flight risk		
Child/adolescent		
Person whose TB has reactivated		
Person who denies diagnosis of TB		
Person recently discharged from correctional facility		
Person who has difficulty swallowing pills		
Person who avoids gov't or authorities for fear of revealing immigration status		
Person under Section 22 Order or Section 35 Order under the HPPA		
Non-compliant with appointments		
Side effects with TB medications		
HIV positive		
Lack of trust of health care professionals		
No family MD or consistent care provider		
Immune Compromised e.g., diabetes or cancer		
Inadequate social supports; financial difficulties		
Language Barriers		

Appendix 7: TB Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program

7.1 Introduction

The purpose of the TB Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program is to:

1) Facilitate the early diagnosis of TB and initiation of treatment (as required) for uninsured persons residing in or visiting Ontario who are not covered by the Ontario Health Insurance Plan (OHIP), Interim Federal Health (IFH) or any other provincial/territorial/private health insurance plan;
2) Eliminate the financial barrier to obtaining TB diagnostic and treatment services for uninsured persons in Ontario, by ensuring the availability of these services specifically for these persons; and
3) In fulfilling (a) above, reduce the public health risk due to transmission of TB (TB) from these persons within Ontario.

The TB-UP program consists of processing payments to primary care providers, laboratories and radiology service providers, for treating uninsured individuals. This specifically refers to those who require assessment and/or treatment for active/suspect TB, including contacts of infectious TB. The program is intended to facilitate prompt assessment, diagnosis, and treatment for the uninsured individual. This will reduce the risk of transmitting TB from these persons to other Ontario residents, as well as the related costs to OHIP.

The board of health shall consider assisting clients in acquiring the required follow-up so that the appropriate course of treatment is completed.

7.1.1 Eligible persons covered under the TB-UP program

The TB-UP program is available for persons who are uninsured and one of the following:

1) an active case or potential/suspect case of TB (pulmonary or extra-pulmonary);
2) a contact of an active TB case; or
3) any other person at high risk of developing active TB as determined by the TB Control program staff of the board of health.

7.1.2 Eligible services and service providers covered under TB-UP

The following services and service providers will be covered under the TB-UP program:

1) Out-patient Services:
   a) Out-patient medical clinical (primary care provider) services (provided by primary care providers who are paid on a fee-for-service basis), as well as

diagnostic and treatment services in the event that they are or become insured under OHIP.

2) Additionally, the board of health shall verify the individual's personal identification before the patient signs the TB-UP application and consent form for the TB-UP Program. Acceptable forms of personal identification include:
    a) Passport;
    b) Landed immigration papers/student visa/work permit; or
    c) Confirmation/referral from service agency (e.g., homeless persons).

Process if patient declines signing the TB-UP Application and Consent form for the TB-UP Program

The patient cannot be registered in the TB-UP program if they do not sign the TB-UP application and consent form for the TB-UP Program. The board of health cannot assign a TB-UP program registration number or provide any health care provider claim forms without a signed TB-UP application and consent form. Without a signed TB-UP application and consent form, there is no mechanism for the CSB to pay the claims submitted by service providers.

7.6.5 Assigning the TB-UP Registration Number

Once the board of health has received the signed TB-UP application and consent form and the patient meets the eligibility criteria, the Board of Health can proceed with registering the patient in the TB-UP program and assigning a TB-UP registration number.

1) The board of health shall:
    a) Search for and select the patient in iPHIS TB module; and
    b) Enter the detailed information about the TB-UP registration in the iPHIS TB Uninsured Person Registration Details screen and save.

The system will auto-generate a TB-UP registration number after the information in the TB Uninsured Person Registration Details screen is saved (i.e., by clicking on the SAVE button). The iPHIS TB-UP registration number is in numeric format. The 8-digit TB-UP registration number should be entered on each health care provider claim form (Part A) prior to issuing to the service provider or patient.

PHO will notify the CSB of the patient's registration in the TB-UP program through the monthly data transfer.

7.6.6 Registration from the TB-UP Program from the Service Provider's Office/Clinic

The initial service provider may see an uninsured person in their office or clinic (i.e., a person may present due to symptoms compatible with TB). The attending primary care provider will call the board of health to determine if this person would be eligible for coverage under the TB-UP program.

In general, the eligible patient should register at the board of health office during regular business hours. However, under exceptional circumstances (e.g., a highly infectious TB case) the patient may register while at the primary care provider's office/clinic.‡‡‡‡ In this situation, the attending primary care provider will verify with the patient that they are not covered under OHIP, IFH or any other provincial/territorial or private health insurance. The primary care provider will call the local board of health to notify of uninsured persons with either suspect/active TB or contact of active TB and request a TB-UP application and consent form. The board of health can fax a blank TB-UP application and consent form to the attending primary care provider's office or hospital out-patient clinic. The TB Control Program staff at the board of health should consider confirming that the primary care provider, or their support staff, verified the individual's personal identification (acceptable forms of personal identification are the same as indicated in previous section). The attending primary care provider, or their support staff, will review the TB-UP application and consent form with the patient and request the patient's signature.

Once the consent form is signed it can either be mailed or faxed to the board of health for retention in the patient's file. A faxed TB-UP application and consent form with the patient's signature will be adequate for the board of health to register the patient in the TB-UP program and initiate first mailing of the health care provider claim forms.

7.7 Board of Health Distribution of Claims Form

7.7.1 Information to be included on the Health Care Provider Claim Form prior to distribution

1) The board of health shall complete Part A on ALL health care provider claim forms before claim forms are issued. This includes the following:

a) Program Identification Code (i.e., TB-UP);
b) Disease Under Investigation/Treatment (i.e., Active TB);
c) Referring board of health, Name of TB Control Staff Person, Telephone Number;
d) Patient's Name, Date of Birth and Sex;
e) Registration Number (i.e., TB-UP Registration Number); and
f) Eligibility Expiry Date (i.e., TB-UP End Date).

7.7.2 Distribution of Health Care Provider Claim Forms

1) Once the patient is registered in the TB-UP program (i.e., assigned a TB-UP registration number), the board of health shall distribute a package of health care provider claim forms to the attending primary care provider. The board of health will either:

a) Give the package of health care provider claim forms to the patient (in person) to take to their primary care provider; or

‡‡‡‡ **NOTE**: The preferred method for registration is at the board of health. However, if the patient presents at the office/clinic of a service provider and has not previously contacted the board of health, this procedure should be followed.

b) Mail the package of health care provider claim forms directly to the attending primary care provider's office/clinic.

7.7.3 Health Care Provider Claim Forms for the First and Second Visit to Primary care provider's Office/Clinic

As noted above, the board of health can provide the required number of the health care provider claim forms to the patient directly or send by mail to the attending primary care provider. This initial claim form package will consist of 7 health care provider claim forms and a health care provider claim form instruction sheet for each claim form. The seven health care provider claim forms will cover the following services:

1) three health care provider claim forms for primary care provider services (two forms to cover first and second (follow-up) visit with the attending primary care provider and one form to cover radiologist services);
2) three health care provider claim forms for laboratory services (a separate claim form must be submitted for each date of service; three claim forms may be required if three sputum specimens are obtained and tested on different days); and
3) one Health Care Provider Claim form for the radiology facility.

An instruction sheet should accompany each health care provider claim form. The instruction sheet will provide assistance to the service provider as to how each claim form should be used.

At the first visit, the attending primary care provider will keep two health care provider claim forms for billing services for the first and second (follow-up) visit. The attending primary care provider should order the required laboratory tests or x-rays using the standard requisition form. The following claim forms should be attached to the standard requisition form:

1) Laboratory requisitions attach:
   a) three health care provider claim forms to bill laboratory services and the health care provider claim form instruction sheet.
2) Radiology requisitions attach:
   a) one health care provider claim form for radiologist (primary care provider) services and a health care provider claim form instruction sheet; and
   b) one health care provider claim form for the radiology facility and a health care provider claim form instruction sheet.

The TB-UP patient will take the remaining five health care provider claim forms and the Instruction sheets along with the standard requisition to the laboratory and/or radiology facility as required.

The attending primary care provider can bill the second (follow-up) visit using the additional health care provider claim form for primary care provider services. On the second visit the primary care provider will review the results of the initial TB work up (e.g., TST, chest x-ray, and laboratory tests) with the patient and determine whether further follow-up is required. The primary care provider's office/clinic will contact the local

7.9.2 Withdrawal from the TB-UP Program from the Service Provider's Office/Clinic

The TB-UP patient may request to withdraw from the TB-UP program while in the service provider's office. The attending primary care provider may direct the TB-UP patient to the board of health for withdrawal. Alternatively, the attending primary care provider may contact the local board of health to inform of patient's wish to withdraw from the TB-UP program and request a TB- UP withdrawal form. The board of health will fax/e-mail a blank TB-UP withdrawal form to the attending primary care provider's office. The attending primary care provider, or their support staff, will review the form with the patient and explain that by signing the TB-UP withdrawal form, the patient agrees to withdraw:

1) Registration from the TB-UP program;
2) Authorization given to the board of health, health care providers under TB-UP, and the ministry, to collect, use, share and disclose personal information amongst themselves for any purpose relating to the TB-UP program; and
3) Coverage under the TB-UP program for diagnostic and/or treatment services for TB.

The signed TB-UP withdrawal form can be mailed or faxed[†††††] to the board of health for retention in the patient's file. A faxed withdrawal form with patient's signature will be adequate to initiate discharge from the TB-UP program. The board of health will update the iPHIS TB uninsured person registration details, the TB uninsured person claim form details screen, and send notification to the CSB.

7.10 TB-UP Form Production, Distribution, Control and Retention

7.10.1 Invoice Numbers on TB-UP Forms

Each health care provider claim form will have a pre-printed, sequential number called the "invoice number." This will be used for monitoring and tracking claim forms within the iPHIS TB uninsured person claim form detail screen. This number should not be altered by the board of health or service provider, unless extenuating circumstances have been outlined by staff at the Ministry of Health and Long-Term Care.

7.10.2 Process for the Board of Health to obtain TB-UP Forms

Health care provider claim forms can be ordered from the Service Ontario Central Forms Repository. Board of health staff can order these forms electronically by following these steps:

1. Please go to Government of Ontario - Central Forms Repository and search for "0350-93."

[†††††] Fax may be used if the receiving Board of health has sufficient privacy controls over their fax machines, in accordance with the requirements under the *Personal Health Information Protection Act.*

- This will bring up a “Forms Order Request.” Select the link and open the subsequent PDF.
- The form should open in your Adobe reader (or similar PDF reader).
- You will be required to fill out some delivery information on this form, and it will allow you request as many forms as you deem necessary. For TB-UP, it is worth having some extras on hand.

2. Select the forms that you want to order:
   - **4289-64:** TB – UP Application and Consent: Application and Authorization for the TB Diagnostic and Treatment Services for Uninsured Persons Program
   - **4290-64:** TB – UP Withdrawal: Withdrawal of Application and/or Authorization for the TB Diagnostic and Treatment Services for Uninsured Persons Program
   - **3977-84:** Health Care Provider Claim—Diagnostic and Treatment Services for Uninsured Persons

There is a review button at the bottom of the form which will allow you to look over your order. You can then submit the form by e-mail through the button available, or you can print the form and fax it (although the former option is preferred and likely to be processed much quicker).

NOTE: Due to the ongoing review of the TB-UP program, paper forms have not been updated to provide the new recipient address (in London as opposed to the Toronto address listed on the forms). To confirm that health care provider claims are sent to the appropriate location, please confirm that all claim forms are addressed to the following address:

Ministry of Health and Long-Term Care
Direct Services Division
Claims Services Branch
130 Dufferin Avenue, Floor 4
London, ON N6A 5R2

Attn: TB-UP

7.10.3 TB-UP Forms Control

The board of health offices shall control the distribution of claim forms to service providers. Each health care provider claim form has a pre-printed unique invoice number. The board of health shall enter this unique invoice number into the iPHIS TB uninsured person claim form details screen for each claim form issued. The board of health shall also attempt to indicate, in the iPHIS TB uninsured person claim form details screen, the person to whom they gave the claim forms. For example, if the board of health issued the claim form to the attending primary care provider then the name of the primary care provider receiving the claim form should be included in the iPHIS TB uninsured person claim form details screen.

The individual TB-UP application and consent form and the TB-UP withdrawal form *will not* be tracked by the Ministry.

7.11 Dispute Resolution

7.11.1 Policy and Program Inquiries

Inquiries relating to the TB-UP policy or program procedures will first be directed to the local boards of health for resolution.

For escalated inquiries the board of health will discuss with the ministry, who may consult with the ministry's Health Services Branch as necessary.

7.11.2 Payment Inquiries

Inquiries relating only to claim payment will be directed to the Ministry of Health and Long-Term Care, London District Office (LDO) of the Claims Services Branch by phone at (519) 873-1303.

Appendix 8: Additional Roles and Responsibilities in Immigration Medical Surveillance

8.1 Immigration, Refugees, and Citizenship Canada (IRCC)

8.1.1 Notification to Applicant of TBMS Requirements

1) Following review and assessment of the IME file by IRCC's Medical Officers, applicants are notified, either in person, by mail, or other method, that they are being referred for post-landing TB medical surveillance (TBMS) as a 'condition of entry' on their visa. A *Medical Surveillance Undertaking* form (i.e., the IMM0535B form for those applying from overseas, or the In-Canada form for those applying from within Canada) is given to the applicant, along with instructions. For those applying from overseas, Canada Border Services Agency (CBSA) officials are alerted of the person's referral for TBMS and on arrival to Canada, will send a copy of a person's IMM0535B form to IRCC's national headquarters in Ottawa. If the client does not have a copy of their IMM0535B, the CBSA official will also re-issue the individual a copy of their IMM0535B form for their records.
2) The *Medical Surveillance Undertaking* form (IMM0535B or Inland) indicates if the person has been referred for non-urgent (S-code 2.02) or complex/urgent (S-code 2.02U) inactive pulmonary TB. Those referred for non-urgent TBMS are instructed to contact the board of health in the jurisdiction in which they will reside within 30 days of arrival to initiate medical surveillance. Those referred for complex/urgent TBMS are instructed to report within 7 days of arrival.
3) Note that there is no timeframe stated in which the client must be assessed in order to be considered compliant. However, if the client has not complied with their surveillance requirement and they apply to extend or change their visa status, their application could be delayed and/or denied. Also, if the client has not complied and leaves Canada temporarily, they may be re-issued their *Medical Surveillance Undertaking.* See below for further instructions regarding compliance.

8.1.2 Notification to PHO of Persons referred for TBMS in Ontario

Staff within the Migration Health Branch of IRCC uploads the *Medical Surveillance Undertaking* forms for those required to undergo post-landing TBMS in Ontario (i.e., those who provide an Ontario residential address as their intended location) to the Provincial/Territorial Public Health Authority web portal.

For those referred for urgent/complex inactive pulmonary TB, IRCC also provides the available results from the IME (e.g., chest x-ray, laboratory results, medical history etc.) at the time of the referral.

8.2 Public Health Ontario

Public Health Ontario (PHO) downloads the *Medical Surveillance Undertaking* forms from the web portal and creates the initial client record in iPHIS (or updates the existing information if client is already in iPHIS). PHO is responsible for ensuring that the Medical Surveillance Undertaking forms received from IRCC have complete, accurate information (i.e., an Ontario residential address and an accurate “S” code). PHO maintains the availability and accuracy of immigration data for boards of health and the ministry. Any data inconsistencies are resolved between IRCC and PHO. Once the information is verified and the client is created in iPHIS, PHO sends the *Medical Surveillance Undertaking* form (and the accompanying IME documentation if urgent/complex, if available) to the appropriate board of health via iPHIS referral.

When PHO receives the Medical Surveillance Reporting Form (MSRF) from the board of health confirming the client’s medical surveillance condition has been/has not been met, PHO notifies IRCC (either directly in the web portal, by mail, or by other pre-approved processes) so that the condition of entry can be removed from their immigration file.

Appendix 9: Additional Considerations for TB Treatment in Ontario

9.1 Need for Referral/Consultation with TB Specialist

Ideally, all patients with active TB should be cared for by a Specialist (respirologist or infectious diseases) with specific training and experience in the care/management of TB. A referral with a TB specialist should be sought for any TB patient who has, or may:

1) Have resistance to more than one TB drug;
2) Have resistance to INH and RMP (MDR- or XDR-TB) – in this situation, treatment should be by, or under the advisement of, the TB specialists at West Park Healthcare Centre;
3) Have cavitation on initial or subsequent chest x-rays;
4) Have a positive TB culture on a sample collected after 2 months of effective treatment;
5) Be HIV-positive;
6) Have a condition such as end stage renal disease which could make treatment fail;
7) Be a child < 18 years of age. Because of the high risk of disseminated TB in infants and children < 18 years of age, treatment should be started as soon as the diagnosis of TB is suspected. Treatment should be by (or under the advisement of) a pediatric TB specialist;
8) Have liver disease;
9) Be pregnant or breastfeeding; or
10) Have relapsed/reactivated TB/ treatment failure:
    a) Relapse: Patient becomes and remains culture negative during therapy but becomes culture positive again; or has evidence of radiographic deterioration consistent with active TB (this usually occurs within the first 6-12 months after completion of therapy);

Treatment Failure: continued or recurrently positive cultures during the course of anti-TB therapy. This may be due to non-adherence, drug resistance, malabsorption of drugs, or extreme biological variation in response.[36]

9.2 Improving Adherence to Therapy

For information on improving adherence to therapy, consult the CTBS, 7th Edition; Chapter 5: Treatment of TB Disease and Chapter 6: Treatment of Latent TB Infection.[4]

9.3 Common Eligibility Considerations for Publicly-Funded Tubersol

What if a TST is requested by someone other than a patient or the patient's representative, for example, solely for employment purposes?

Whether the TST or the documents required are insured or uninsured depends on the specific circumstances. Please refer to the *Health Insurance Act* (HIA) Regulation 552, s. 24(1), 24(1.1) and 24(1.2).[37] In addition, more information related to OHIP insured TST is available in the INFOBulletin Number 4692 posted at OHIP Bulletins: Physician Services.[12] Publicly funded Tubersol may only be used if the TST is OHIP-insured.

Can the Tubersol provided by the government for be used for uninsured TSTs?

The Tubersol provided by the government is not to be used for uninsured TSTs. When uninsured testing is performed, the testing solution should be either:

1) Acquired by a primary care provider and sold to the patient at a direct cost (with reasonable mark-up to account for any indirect costs (e.g., storage, administrative, etc.)
   OR
2) Acquired by the patient from the pharmacy, via prescription provided by a primary care provider.
   a) To search for a pharmacy that carries Tubersol®, patients can be directed to the Ontario College of Pharmacists' website Find a Pharmacy or Pharmacy Professional tool.
   b) To search for clinics that provide TSTs, patients can be directed to Vaccines 411 (enter postal code, click on to the "travel" category and select PPD (Mantoux testing) in the drop down box).

Are secondary students who are completing volunteer requirements in a facility which requires TB screening able to receive the supply, as part of their high school volunteer requirement?

Students looking to complete their volunteer hours to graduate high school would fall under category 2 in the INFOBulletin – both the TB test and completion of an immunization status report are insured.

Are international students attending programs in Ontario that require a TST for admission or continuation in a day care or pre-school program, or a program of study in a school, community college, university or other educational institution

International students are eligible to use the publicly-funded supply of Tubersol for the test however, the administration of the test, whether it is conducted by a physician or another health care practitioner, must be paid out of pocket. While students are covered for the test, as per Category 2 of the INFOBulletin, they are ineligible for administration of the test, as per category 4.

necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

3) A section 22 order may specify the time or times when or the period or periods of time within which the person to whom the order is directed must comply with it.

Pursuant to section 22(4), an order pertaining to a communicable disease, may include, but is not limited to, requiring the person to do the following:

1) Submit to an examination by a physician and to deliver to the MOH a report by the physician as to whether or not the person has a communicable disease or is or is not infected with an agent of a communicable disease;
2) Isolate themselves and remain in isolation from other persons;
3) Immediately place themselves under the care and treatment of a physician, and to attend medical appointments and appointments with public health departments (i.e. DOT appointments);
4) Identify all contacts and provide comprehensive contact information;
5) Conduct themselves in such a manner as not to expose another person to infection; and/or
6) Any other requirement that will decrease or eliminate the risk of TB infection to the public.

Pursuant to subsection 22(5.0.1) of the HPPA, an order may be directed to a person or a class of persons who reside, or are present in the health unit served by the MOH. Notice of the order made to a class of persons must be delivered to each member of the class where it is practicable to do so in a reasonable amount of time, pursuant to section 22(5.0.2) of the HPPA.

10.1.2 Process for Appealing a Section 22 Order

Health Services Appeal and Review Board (HSARB) is a tribunal of record and all written documentary evidence is available to anyone who is a party to the proceedings. Any person against whom an order is issued must be informed of their right to appeal to HSARB (Health Protection and Promotion Act, R.S.O. 1990, c. H.7, s. 44).[2]

1) The person may request a hearing by the HSARB by written notice to the MOH and HSARB within 15 days after the order is served. Anyone served with an order by an MOH can request a hearing from the HSARB;
2) The hearing must occur within fifteen working days after receipt by the board of a notice requesting the hearing;
3) Although the order takes effect when served, a person who requests a hearing may seek a stay of the order from HSARB to prevent the order from taking effect until the hearing has taken place and a determination has been made as to its validity;
4) The person may appeal the decision of the HSARB to Divisional Court and that right to appeal is broad, allowing the Divisional Court:
   a) To confirm, alter or rescind the decision of HSARB;
   b) To exercise all of the powers of HSARB to confirm, alter, or rescind the order as the court considers proper; or

c) To refer the matter back to the HSARB for re-hearing in whole or in part, in accordance with such directions as the court considers proper.

The HSARB generally holds a pre-hearing teleconference for all parties to clarify the situation / issues and try to achieve a voluntary resolution. If this is unsuccessful, the full hearing proceeds.

To learn more about the HSARB appeal process, please consult their website at Ontario Health Services Appeal and Review Board.

10.2 Section 35 Orders

10.2.1 Background

When a person who has a communicable disease that is designated as a virulent disease fails to comply with certain provisions in a section 22 order namely requirements that the person: i) isolate himself or herself and remain in isolation from other persons; ii) submit to an examination by a physician; iii) place himself or herself under the care and treatment of a physician; or iv) conduct himself or herself in such a manner as not to expose another person to infection, the MOH may apply to a judge of the Ontario Court of Justice to issue an order under section 35 of the HPPA.[2]

A section 35 order cannot be issued for any other requirements not specified in section 35(e.g., failure to identify contacts).

Under section 35, a judge may order the person who has failed to comply with the section 22 order of the MOH:

1) To be taken into custody and admitted to and detained in a hospital or other appropriate facility named in the order;
2) To be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
3) To be treated for the disease if found, on examination, to be infected with an agent of a virulent disease.

Section 35 orders are generally drafted by the board of health and signed (with or without amendments) by the judge at the conclusion of the section 35 application and provided to legal counsel for the MOH and the respondent.

A copy of the order should be served on the respondent.

The person may be detained for not more than six months however, the order may be extended by a judge following an application for extension by the MOH.

The MOH in the health unit where the hospital (or other facility) is located must apply to the Ontario Court of Justice for an order to extend the period of detention, if necessary. The judge must be satisfied that the person continues to be infected with an agent of a virulent disease and that discharging him/her from hospital would present a significant risk to the health of the public.

A section 35 order issued by the Ontario Court of Justice may be appealed to the Superior Court of Justice.

It is recommended that any MOH considering a section 35 order notify the ministry and the Associate Medical Office of Health (AMOH) of the TB Toronto (since TB patients under a section 35 order are almost always held/treated at West Park Healthcare Centre, in Toronto).

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