Tuberculosis Program Guideline, 2018

Population and Public Health Division, Ministry of Health and Long-Term Care

Effective: January 1, 2018 or upon date of release
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1 Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health and Long-Term Care under the authority of section 7 of the Health Protection and Promotion Act (HPPA) to specify the mandatory health programs and services provided by boards of health. The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Guidelines are program and topic-specific documents which provide direction on how boards of health shall consider approaching specific requirement(s) identified within the Standards.

2 Purpose

The purpose of this guideline is to provide direction to boards of health to reduce the burden of tuberculosis (TB) through prevention and control.

To further support the clinical and public health management of TB cases and contacts, it is recommended that other published materials be utilized for further information, relevant definitions, and guidance, such as the most current version of the tuberculosis disease-specific chapter of the Infectious Diseases Protocol, 2018 (or as current), and the Canadian Tuberculosis Standards 7th Edition: 2014 [hereon referred to as the CTBS, 7th Edition].

3 Reference to the Standards

This section identifies the standard and requirement to which this guideline relates.

Infectious and Communicable Disease Prevention and Control

Requirement 12. The board of health shall facilitate timely identification of active cases of TB and referrals of persons through immigration medical surveillance in accordance with the Tuberculosis Prevention and Control Protocol, 2018 (or as current) and the Tuberculosis Program Guideline, 2018 (or as current), and shall provide or ensure access to TB medication at no cost to clients or providers.

4 TB: Ontario Context

4.1 TB Control Programs

Tuberculosis (TB) care and control in Ontario is decentralized. Independent clinicians diagnose and treat TB with no formal affiliation to public health TB control programs. Therefore, public health TB programs should collaborate and coordinate with various clinical partners to support good TB care.
Canada has national standards for TB diagnosis, treatment, and management detailed in the CTBS, 7th edition.4

4.2 Roles and Responsibilities in TB Control

4.2.1 Boards of Health

In addition to the requirements outlined in this guideline, the minimum requirements of Boards of Health are outlined in the Tuberculosis Prevention and Control Protocol, 2018 (or as current).3

4.2.2 Additional roles and responsibilities

For additional supporting information and the roles and responsibilities of the ministry, Public Health Ontario (PHO), and other stakeholders, see Appendix 1: Roles and Responsibilities in TB Control.

4.3 Surveillance and Reporting Requirements

Ontario’s infectious diseases control programs depends on maintaining accurate information about TB cases in the province and having the ability to transfer or share information when appropriate.

For details on the roles and responsibilities of boards of health with respect to surveillance, please refer to the provincial Tuberculosis Prevention and Control Protocol, 2018 (or as current).3

For published surveillance reports, please refer to Appendix 2: Surveillance Reports.

4.3.1 Case Definitions

Definitions for classifying cases as active TB (confirmed and suspect) and latent TB infection (LTBI), as well as for staging of confirmed cases (i.e., new or re-treatment) can be found in the Infectious Diseases Protocol, 2018 (or as current), Appendix B; Provincial Case Definitions for Reportable Diseases; Section 3.0, Tuberculosis.5

4.3.2 R.R.O. 1990, Regulation 569 under the HPPA

Provisions in the HPPA require physicians, practitioners and institutions to report TB to the local MOH. Paragraph 6 of section 5 of Regulation 569 made under the HPPA sets out the information that must be included in a report made in relation to TB by a physician or practitioner.6 In order to maintain the integrity of the reporting system, all parties involved must fulfill their roles and responsibilities.

4.3.3 The integrated Public Health Information System

The integrated Public Health Information System (iPHIS) is an electronic information system used for public health reporting and surveillance in Ontario. The TB Module in
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.

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
meet the requirements set out in the protocol, with support from evidence-based best practices.

For information to assist boards of health in their case investigations and management, see Appendix 6: Additional Tools for Case and Contact Management.

The board of health is responsible for home isolation and decisions around release from isolation according to the CTBS, 7th Edition guidelines (see CTBS, 7th Edition; Chapter 12: Contact Follow-Up and Outbreak Management in Tuberculosis Control). Infectious cases who reside in congregate settings (e.g., shelters, Long-Term Care Homes (LTCH), correctional facilities), should be removed from these settings and not returned to their congregate setting until they meet the criteria for release from isolation.

### 6.2 Directly Observed Therapy (DOT)

Directly observed therapy (DOT) is the most effective strategy available for ensuring adherence to treatment. In the most basic sense, DOT means that all doses of medications are swallowed in the presence of a trained observer. DOT programs also provide monitoring for side effects, emotional support and education, triage and referral (in collaboration with the multi-disciplinary team) and incentives/enablers.

In Ontario, there is no legislative requirement for DOT, so clients must consent to participate. However, DOT is the standard of care for all TB patients from the initiation through the completion of treatment. Additional information about DOT can be found in the CTBS, 7th Edition; Chapter 5: Treatment of TB Disease.

Recommendations for DOT are not based on the assumption that any particular patient may be non-adherent with treatment. Nevertheless, treatment regimens are always long, require the patient to take more than one drug, continue long after the patient feels well, and may even make them feel a little unwell. Even the most motivated individual often has difficulty completing a full treatment regimen under these circumstances.

Video Directly Observed Therapy (VDOT) is a viable option that can reduce the financial and physical resources required for boards of health, while maintaining adherence and completion rates. Boards of health are encouraged to assess new technologies to achieve this process, or to engage with health sector partners, such as the Ontario Telemedicine Network (OTN) to assist in developing their own operational policy for utilizing VDOT. More information about the list of services available at OTN can be found at Ontario Telemedicine Network and ‘The OTN hub’.

A sample assessment tool has been developed by the ministry and several boards of health to determine priorities (see Appendix 6.8: Sample DOT Assessment Tool). DOT should always be considered for any person who scores ‘YES’ on any category in this assessment tool, or a comparable tool developed using evidence-based best practices.
6.3 Tuberculosis Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program

For information on the TB-UP program, please see Appendix 7: Tuberculosis Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program.

7 Contact Management

The minimum standards required for boards of health to manage contacts of respiratory TB cases is outlined in “Identification, assessment, and management of contacts of respiratory TB” in the *Tuberculosis Prevention and Control Protocol, 2018* (or as current).

For additional, detailed information on the principles of an organized, systematic approach to contact investigation, refer to the *CTBS, 7th Edition; Chapter 12: Contact follow-up and outbreak management in TB control*.

For additional information on tools used in contact management in Ontario, see Appendix 6: Additional Tools for Case and Contact Management.

8 Immigration Screening for TB

8.1 Pre-entry TB screening

Under the *Immigration and Refugee Protection Act*, Immigration, Refugees, and Citizenship Canada (IRCC; formerly Citizenship and Immigration Canada [CIC]) has the mandate to assess applicants for residency in Canada on the basis of three health grounds for inadmissibility which include: danger to public health, danger to public safety, and excessive demand on health and social services. Individuals applying for a Canadian visa/ permanent residency/refugee status/citizenship have an Immigration Medical Exam (IME) in part to rule out active pulmonary TB disease. If active TB disease is ruled out but there is evidence of inactive pulmonary TB (see Section 8.1.2 – Immigration Medical Exam Process – TB Specific) the person receives medical clearance to go to Canada with a formal condition on their visa/immigration status that they must contact their local board of health upon entry for medical surveillance for inactive pulmonary TB (i.e., a second, post-landing assessment for pulmonary TB).

Individuals requiring an IME include:
1) Applicants for permanent residency (immigrants and refugees selected abroad)
2) Refugee claimants (i.e., those claiming refugee status in Canada)
3) Applicants for temporary residency (i.e., students, workers, and visitors) including:
   a) Those seeking to stay in Canada for more than 6 months and have spent 6 or more consecutive months in a country with high TB incidence during the 1 year immediately preceding the date application for residency is made;
b) Those seeking to work in occupations in which the protection of the public is essential regardless of length of stay and country of origin; and
c) Agricultural workers from a country with a high TB incidence.

8.1.1 Immigration Medical Exam Process – General

The IME may be performed in Canada or abroad, depending on where the individual makes their application for residency. The IME process is the same regardless of where it is performed.

The IME should be conducted by a panel physician (previously referred to as ‘designated medical practitioner’) who has been screened, trained, and authorized by IRCC. For a list of approved panel physicians in each country, see Find a Panel Physician.11

The IME consists of:
1) Medical history;
2) Physical examination;
3) Laboratory testing:
   a) Urinalysis for applicants > 5 years of age;
   b) Chest x-ray for applicants ≥11 years of age; and
   c) Syphilis and HIV serology for applicants ≥15 years of age.

Once the IME has been completed, the panel physician submits the results to IRCC, either electronically or by mail, through one of four Regional Medical Offices (RMOs) located in Ottawa, London (UK), New Delhi (India), and Manila (Philippines). Medical officers in each of the RMOs are responsible for reviewing the applicant’s IME results and providing their medical opinion regarding admissibility/inadmissibility on health grounds to the Visa/Immigration Officer. The results of the IME are valid for 12 months, however, if the applicant makes another application for a change in status (e.g., from temporary to permanent), then a new IME may be required (see Section 8.2.3 – Common Issues in Immigration Medical Surveillance Follow-up).

8.1.2 Immigration Medical Exam Process – TB Specific

All applicants ≥11 years of age must have a chest x-ray as part of the IME; children <11 years of age may also be required to have a chest x-ray if they present with symptoms suggestive of active TB, have been in close contact with an active TB case, or have a past history of treatment for TB. The objective of this exam is to detect active pulmonary TB. Chest x-rays are read by a local radiologist and reviewed by IRCC Medical Officers in the RMOs to assess for the presence of active or inactive pulmonary TB and determine if referral for medical surveillance is required.4

Active pulmonary TB

If active pulmonary TB is suspected, applicants are referred to a TB specialist for further investigation, including sputum collection for smear microscopy and culture, as well as repeat chest x-rays. For those applying for residency from overseas and confirmed as
having active TB, permission to enter Canada will be delayed until proof of the following have been submitted:
1) Successful treatment completion;
2) Three negative sputum smears and cultures, and
3) Stable and/or improving chest x-rays taken over a minimum period of 3 months.

Inactive pulmonary TB

Applicants identified as having inactive pulmonary TB (either non-urgent or complex/urgent – see definitions below) are permitted to enter Canada, however, they have a ‘condition of entry’ placed on their visa requiring them to complete post-landing TB medical surveillance (TBMS).

Non-Urgent Inactive Pulmonary TB is defined as:
1) A history of treated active TB and/or
2) An abnormal chest x-ray suggestive of TB and:
   a) Two chest x-rays taken at an interval of 3 months apart with stable appearance and three negative sputum smears and cultures; or
   b) Two chest x-rays taken at an interval of 6 months apart with stable appearance.
3) Complex/Urgent Inactive Pulmonary TB* is defined as:
   a) An applicant meeting the criteria for inactive pulmonary TB (see above) and presenting one of the following:
      i) Medical condition placing applicant at high risk for progression from inactive to active disease with a chest x-ray graded 4.1 to 4.7. These conditions include:
         I) HIV/AIDS;
         II) Transplantation with immunosuppressive therapy;
         III) End-stage renal failure (chronic failure/dialysis);
         IV) Any case of extra-pulmonary TB under treatment;
         V) Any other significant factors that can make the management of contacts in Canada more difficult if inactive progresses to active disease (e.g., drug resistance); and
         VI) A chest x-ray graded 4.5 to 4.7.
      ii) A known case of treated multi-drug resistant TB (MDR-TB).

8.2 Post-Landing TB Medical Surveillance

8.2.1 Responsibilities of the Board of Health

The board of health shall attempt to initiate and continue medical surveillance until the person has been discharged (i.e., until the assessment for active TB has been

* NOTE: In order for an applicant to be referred for complex/urgent inactive pulmonary TB, their IME file must be reviewed and assessed by two independent Medical Officers at the RMO
completed). The board of health is responsible for conducting medical surveillance with the primary goal of facilitating assessment and early diagnosis of active TB disease.

For roles and responsibilities of other stakeholders in the immigration medical surveillance process, see Appendix 8: Additional Roles and Responsibilities in Immigration Medical Surveillance.

When the board of health receives a TBMS referral from PHO via iPHIS, or a completed IMM 535 form from the person under medical surveillance (i.e., self-referral), the board of health shall consider:

1) Contacting the person by letter, telephone, e-mail or in person
   a) Confirming TBMS requirement (via IMM 535/In-Canada form)
      i) **NOTE:** If a client self-reports to the board of health for medical surveillance but the board of health has not received a referral from PHO via iPHIS (with the attached IMM0535B/Inland form) for this client, the board of health shall attempt to email the TB inbox (tb@oahpp.ca) and provide the client’s IRCC identification number (i.e., either UCI, IME, or application number) and PHO will confirm with IRCC whether or not the client requires medical surveillance. Do not create the medical surveillance episode for the client until their requirement has been confirmed. Note that this request also applies to clients who self-report and provide a copy of their IMM535/Inland form with a 2.02 or 2.02U requirement.
   b) If the client is unable to provide a valid IRCC identification number, the board of health shall email the TB inbox (tb@oahpp.ca) and request a return telephone contact in order to obtain the client’s name and date of birth. The board of health shall not send this identifying information via email.
   c) Confirming client’s demographics and contact information, including verifying if the client is reporting to correct board of health.
      i) If inconsistencies (i.e., "S" code missing, self-report with no documentation) are found, PHO does not need to be notified as long as the board of health updates the client’s demographics in iPHIS to reflect the correct name/DOB.
   d) Determining a suitable mechanism to provide the client with the required medical assessment form.
   e) If the board of health receives no response from the person by one month after the first contact attempt (by letter, phone or in person), the board of health shall consider making a second attempt to contact the client unless there is evidence that the client does not live at the address or phone number provided, and no forwarding information is available. In this event, the board of health shall update the client’s Episode Status to ‘Closed: Untraceable’ and submit the MSRF to PHO via iPHIS.

2) Advising/consulting the person on the following:
   a) Assess person for active TB by reviewing a checklist of symptoms;
   b) Counsel person regarding TB disease, transmission, treatment and LTBI treatment, including the symptoms of active disease (e.g., cough, weight loss,
fatigue, fever, night sweats, hemoptysis); and

c) Advise the person of the requirements of TB medical surveillance:
   i) Notify clients that TBMS aims to detect or rule out active TB and that clients can be discharged once they have met their medical surveillance requirement;
   ii) Advise the clients when to call the board of health (i.e., address change, symptoms, leaving the country) and when to seek medical attention; and
   iii) Any further follow-up is at the discretion of the client’s health care provider and/or local public health authorities (e.g., under the auspices of screening high risk populations). Furthermore, any additional follow-up for LTBI is not considered part of the IRCC medical surveillance requirement so reporting of compliance should not be delayed or postponed until this latter follow-up is completed.

d) Determine current immigration status, if not previously included in iPHIS referral (i.e. permanent resident, visitor, student, temporary worker);

e) The need for the person to contact the IRCC to provide any change of address, as boards of health and/or PHO are unable to provide information on behalf of the client (see Section 8.2.3 – Common Issues in Immigration Medical Surveillance Follow-up)

f) If there is an indication of active TB or if person is a recent contact of a case of TB and the person has no health insurance coverage, the board of health shall consider referring the person for active case management/contact management as per the Tuberculosis Prevention and Control Protocol, 2018 (or as current) and the CTBS, 7th Edition. This includes:
   i) Referring him/her to TB Diagnostic and Treatment Services for Uninsured Persons Program (“TB-UP”) for immediate medical assessment (see Appendix 7: TB Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program); or
   ii) If there is no indication of active TB, the board of health shall consider referring the person for medical assessment once Ontario health insurance coverage has been obtained; Provide instructions on how to obtain OHIP coverage.

3) Providing the person with a TB medical surveillance assessment form to be completed by their health care provider. The form/cover letter should include the following information:
   a) The IRCC requirements of medical surveillance;
   b) Complete TB history and physical examination results;
   c) Dates and results of chest x-ray and other appropriate radiological investigation;
   d) Sputum collection for smear and culture for MTB if clinically indicated;
   e) Other appropriate laboratory tests as deemed necessary by the health care provider;
   f) If available, medical information and chest x-rays from the Immigration Medical Examination (IME) (see Section 8.4 – Requesting Results from the Immigration Medical Exam);
   g) Reporting requirements under the HPPA if active TB disease or LTBI are
diagnosed;
h) Written recommendations regarding treatment/follow-up for LTBI†; and
i) Current recommendations if LTBI treatment is refused or is medically contraindicated.

4) Reporting the client’s compliance status via iPHIS:
   a) Medical assessment completed
      i) Once the board of health receives the completed medical assessment form from the health care provider, the board of health shall consider:
         I) Reviewing the results of the medical assessment;
         II) If active TB is diagnosed, entering the required information into iPHIS (see iPHIS User Guide TB Module Section III – Active/Suspect Cases);
         III) Contacting health care provider or person for further information, if necessary;
         IV) If person is on treatment for active disease or LTBI, monitoring as per guidelines;
         V) If person is not on treatment for either active disease or LTBI, follow-up should be at the discretion of the health care provider / board of health, but is not a requirement of TBMS; and
         VI) Notifying PHO by updating the client’s Episode Status to the appropriate selection (i.e., either ‘Open: Follow-up complete’ or ‘Closed: Follow-up complete’) and submitting a Medical Surveillance Reporting Form (MSRF) via iPHIS.
   b) Medical assessment is not completed
      i) If the board of health is unable to make contact with the client (i.e., evidence that client doesn’t live at address/phone number provided and no follow-up information available) then the board of health shall:
         I) Change Episode Status to ‘Closed: Untraceable’ and submit MSRF via iPHIS.
      ii) If the board of health determines that the client has left Ontario prior to being medically assessed (either temporarily or permanently) then the board of health shall:
         I) Update the client’s address in iPHIS as per iPHIS User Guide; and
         II) Change Episode Status to ‘Closed: Referred to ministry’ and submit MSRF to PHO via iPHIS.
      iii) If the board of health is able to make contact with the client but the client does not get medically assessed within 6 months.
         I) Change Episode Status to ‘Closed: Follow-up Incomplete’ and submit MSRF to PHO via iPHIS.
      iv) NOTE: The above situations are the only instances in which boards of health...

† NOTE: For health care providers, this is a clinical opportunity (rather than an IRCC/TB Medical Surveillance requirement) to consider LTBI testing and treatment, as appropriate and as per the Canadian TB Standards (CTBS, 7th Edition; Chapter 6: Treatment of Latent TB Infection)
need to submit MSRFs (and/or referrals) to PHO via iPHIS. Notification to PHO is not required when:
I) Medical Surveillance episode has been created for client in iPHIS (i.e., episode status ‘OPEN’);
II) The client self-reports to the board of health with copy of Medical Surveillance Undertaking form indicating an S-code of 2.02 or 2.02U. In this event, the board of health shall consider creating/updating the client in iPHIS and initiating medical surveillance as above;‡
III) The client leaves Ontario (either temporarily or permanently) after completing medical surveillance (i.e., compliance status has already been reported to PHO/IRCC);
IV) The client is diagnosed with LTBI or active TB disease;
V) The client is hospitalized and/or dies; or
VI) The client is lost to follow-up after completing medical surveillance (i.e., compliance status has already been reported to PHO/IRCC). Lost to follow-up only refers to clients who have already been medically assessed but have been lost during follow-up for LTBI. This does not need to be reported to PHO.

8.2.2 Definition of Compliance

In order to have the medical surveillance ‘condition of entry’ removed from their visa, IRCC must receive confirmation that the client has met their definition of compliance. In Ontario this means the client must:
1) Contact their local board of health as set out in the referral provided by IRCC; and
2) Attend their appointment with their health care provider.

In Ontario, the first appointment should include an assessment for active TB by a physician/health care provider. This assessment includes at minimum:
1) A TB symptom and physical assessment; and
2) A chest x-ray.
   a) If the chest x-ray is indicative of active TB or the client has TB symptoms, sputum samples are also required.

The clinician may also assess for LTBI, considering testing in those who may benefit from treatment, as per the Canadian TB Standards (See CTBS, 7th Edition; Chapter 4: Diagnosis of Latent TB Infection). Although this is encouraged, it is not a mandatory requirement of medical surveillance.⁴

At this point, the client has met IRCC’s medical surveillance requirement; the client’s Episode Status shall be updated accordingly and a Medical Surveillance Reporting Form (MSRF) should be submitted to PHO via iPHIS.

‡ NOTE: when creating/updating the client in iPHIS, please be sure to enter the Unique Client Identifier (UCI) in the field ‘Immigration File Number’.

⁴
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). 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:
1) PHO will still send the TBMS referral to the board of health, but will include a note in the Comments field of the referral to indicate that this is a repeat referral and it is at the board of health’s discretion to follow-up or not (further criteria that may inform this decision is below).

2) The board of health shall consider informing their decisions to follow-up based on criteria that include, for example, whether the IME was done in Canada, how recently the previous TBMS episode was completed, whether the client is symptomatic, and/or has no new risk factors for TB (e.g., travel/lived in high incidence country, exposure to case, etc.) since last assessment.

3) The board of health shall also consider checking iPHIS for previous medical surveillance episode:
   a) If there is no record of a previous medical surveillance episode, the person was untraceable, or non-compliant, the board of health shall consider initiating medical surveillance as per standard process to achieve compliance; and
   b) If a previous medical surveillance episode already exists in iPHIS and compliance has been reported to IRCC, then the board of health shall consider not following-up based on the existing record and submit the MSRF with Episode Status ‘Closed: Follow-up complete’.

8.3 Process for Clients Completing an IME in Canada

Individuals who have not had a pre-entry IME or whose IME was conducted more than 365 days previous and has expired may apply for Canadian visa/ permanent residency/refugee status/citizenship while within Canada. This requires them to complete an IME with a panel physician located in Canada. A list of panel physicians is available on IRCC’s website at: Find a Panel Physician. If the nearest panel physician offering services is located more than 250 kilometres or 4 hours from where the client lives, they can contact the IRCC Call Centre at 1-888-242-2100 to find out how to access immigration medical examination services.

Clients should have the following information for an alternative doctor when contacting the IRCC Call Centre in the above circumstance:
   1) the doctor’s name,
   2) address,
   3) telephone number,
   4) fax or email address, and
   5) preliminary agreement from the prospective doctor that they will perform the medical exam.

The panel physician will complete the IME and assess the individual to rule out active TB. Due to the fact that these persons are being screened only after arrival in Canada, active TB may be detected. In these instances:
   1) IRCC will notify PHO by forwarding an In-Canada Public Health Follow-up
Form for active TB (‘S’ code 2.01) via the web portal;
2) Upon receipt of this report, PHO will telephone the board of health involved to notify them of the person with active TB disease in their jurisdiction; and
3) The Inland form and all available documentation (i.e., IME results) will then be immediately sent to the respective board of health via iPHIS.

If IRCC notifies PHO that a client requires medical surveillance for inactive TB (by “S” code 2.02), the board of health may decide to not follow-up based on the results of the In-Canada IME (which has ruled out active TB) and submit the MSRF to PHO via iPHIS with Episode Status ‘Closed: Follow-up complete’.

8.4 Requesting Results from the Immigration Medical Exam

The board of health may, at the request of the health care provider assessing the person, request the results of the Immigration Medical Exam (IME) conducted either overseas or within Canada.

To make such a request, the board of health shall email the PHO TB Program at tb@oahpp.ca and providing the client’s unique client identifier (UCI) (or Immigration Medical Exam number [IME] if UCI not available). Do not include the client’s name, date of birth or any other identifying information in the email. In the event that the UCI and/or IME numbers are not available, the board of health shall consider emailing PHO and requesting a return telephone call in order to obtain the person’s name and date of birth.

PHO will request the client’s IME documentation through IRCC’s web portal. Once the available documents have been uploaded by IRCC, PHO will send to the board of health via iPHIS referral. Note that complete IME results may not be available for all clients.§

9 Availability of Products for Preventing, Diagnosing, and Treating TB in Ontario

9.1 Vaccines

9.1.2 Bacille Calmette-Guérin (BCG)

Publicly-funded supply of Bacille Calmette-Guérin (BCG) is only available to select high-risk communities in Ontario, and does not currently have a Canadian manufacturer. For

§ NOTE: Request IME documents prior to submitting compliance status – once compliance is updated in IRCC’s web portal, the client is removed from the system. Requests for IME documents after this has occurred are much more difficult.
more information on the use of BCG, see CTBS, 7th Edition; Chapter 16: Bacille Calmette-Guerin (BCG) Vaccination in Canada.\textsuperscript{4}

To request vaccine in Ontario, please email IDPP@ontario.ca

9.2 Products for Diagnosing Latent TB Infection

9.2.1 Eligibility for Publicly Funded TST

The ministry’s Health Services Branch determines who is eligible for a publicly-funded TST based on a number of factors. This information is available in a health services provider INFOBulletin (Number 4692), available online at OHIP Bulletins: Physician Services (issued January 30, 2017).\textsuperscript{12}

Eligibility Criteria for Release of Publicly-Funded Supply of Tubersol:

Clients meeting the following criteria are eligible for publicly-funded Tubersol within Ontario:

(i) Contacts of cases of active TB\textsuperscript{**}
(ii) Tests deemed to be “medically necessary” by the client’s primary care provider or nurse practitioner, based on level of risk as identified in the CTBS, 7th Edition; Chapter 13: TB Surveillance and Screening in Selected High-Risk Populations.\textsuperscript{4}
(iii) Clients under the age of 65 who are entering long-term care facilities. Note: Screening via TST is not recommended for clients over the age of 65.
(iv) When required by an educational institution 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.

For common questions surrounding eligibility for publicly-funded TSTs, refer to Appendix 9: Additional Considerations for TB Treatment in Ontario.

9.2.2 Interferon Gamma Release Assays (IGRA)

IGRAs are blood tests which may be useful in the diagnosis of latent TB infection. In particular, they may have greater specificity for latent TB infection than the TST in BCG-vaccinated individuals. For more information of the use of IGRAs, consult the CTBS, 7th Edition; Chapter 4: Diagnosis of Latent TB Infection.\textsuperscript{4}

Any client seeking these tests should purchase them through a private laboratory or have them covered through their private insurance. However, IGRA lab facilities are not currently available in all communities. Ontario is currently assessing IGRA testing in select communities, but currently, there is currently no publicly-funded coverage for IGRA tests in Ontario.

\textsuperscript{**} There is NO COST associated with the testing of an individual who has been identified as a contact of a case of active TB. If you are aware of a primary care provider charging for this service, please have the individual make a collect call to: Health Services Branch at 1-866-684-8620.
9.3 Medications for Treating Active TB Disease

9.3.1 Dispensing of TB Drugs

The Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS) cannot legally label drugs with dispensing instructions. To confirm that the patient receives proper instructions, boards of health have three options:

1) The board of health may consider making arrangements with a local pharmacy to dispense the TB drugs at the pharmacy (including proper labelling, repackaging, and blister packing as required). All administrative costs incurred for these agreements are to be paid for by the board of health;††

2) The primary care provider or clinic who orders the drug, labels the drugs and gives them to the patient along with the relevant drug information sheets, including signs and symptoms of adverse drug reactions; or

3) A board of health staff registered nurse can provide the drugs directly to the patient, giving the patient the relevant drug information sheets, including signs and symptoms of adverse drug reactions. Any repackaging of the medication is considered dispensing and can only be done under the delegation of the MOH.

For current information about nurses’ responsibility in dispensing drugs, consult the College of Nurses of Ontario Practice Standard on medication, available at the College of Nurses of Ontario: Standards and Guidelines.13

9.4 Availability of ‘First-line’ TB Drugs

First-line TB drugs are available free of charge from the OGPMSS. To obtain these drugs, health care providers and/or hospitals should order through their local board of health.‡‡ Upon receipt of a prescription from the health care provider, boards of health can order the drugs using the Panorama inventory module.

The following first-line medications are available through OGPMSS:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethambutol (EMB)</td>
<td>100mg, 400mg</td>
</tr>
<tr>
<td>Rifampin (RMP)</td>
<td>150mg, 300mg</td>
</tr>
<tr>
<td>Isoniazid (INH)</td>
<td>100mg, 300mg, 10mg/ml (syrup)</td>
</tr>
<tr>
<td>Pyrazinamide (PZA)</td>
<td>500mg</td>
</tr>
<tr>
<td>Pyridoxine HCL (Vitamin B6)</td>
<td>25mg</td>
</tr>
</tbody>
</table>

†† The ministry will cover the cost of dispensing fees submitted for first-line medications, if they are done outside of the board of health or at a primary care provider’s clinic. Each pharmacy sets its own fees for filling prescriptions, not claimed under the Ontario Drug Benefits (ODB) program. This is called the ‘usual and customary’ dispensing fee. Your dispensing pharmacy must register this fee with the Ontario College of Pharmacists. The College, in turn, monitors all pharmacies in Ontario to ensure that fees are in a reasonable range.

‡‡ NOTE: In Toronto, some health care providers and hospitals may receive their drugs directly from OGPMSS through a special arrangement with Toronto Public Health.
9.5 Availability of ‘Second-line’ TB Drugs

Second-line drugs for the treatment of TB include the fluoroquinolones, all injectables (e.g., kanamycin, capreomycin, and amikacin) and many older TB drugs that have been largely abandoned because of relatively poor efficacy and/or greater toxicity. In cases of resistance to first-line medications however, primary care providers will often prescribe these alternative regimens to manage TB cases.

9.5.1 Reimbursement for Second-line Drugs

In circumstances where second-line drugs are required, a primary care provider will give the client a prescription to fill at a pharmacy designated by the board of health, which either will directly bill the board of health or the client, who the board of health will reimburse. The board of health can then submit the prescriptions to the ministry for reimbursement.

To seek reimbursement for second-line medications, boards of health can send the following information as part of an invoice to the ministry:

1) Drug name/type;
2) Strength/Dosage;
3) Quantity;
4) Cost to client (this is the amount the board of health reimbursed the client); and
5) iPHIS client ID number for each medication.

It is important to note that any information that is being shared with the ministry should be carefully redacted (i.e., ‘blacked out’) of all personal health information, in accordance with the Personal Health Information Protection Act (PHIPA).

Additional Reimbursement Information:

1) Reimbursement will include the dispensing fee and medication costs for second-line medications;
2) Multiple reimbursements can be included in a single invoice from the board of health, but should be submitted no later than 3 months after the time of purchase; and
3) Invoices should not be paired with other ministry reimbursement programs (e.g., leprosy medication reimbursement).

§§ Some clients may have private insurance that covers the bulk of their medication costs. If so, the board of health can cover the remaining costs of the medication and seek reimbursement from the ministry for these costs.
9.5.2 List of Second-line Drugs

The following medications can be submitted to the ministry for reimbursement:

<table>
<thead>
<tr>
<th>Drugs not requiring approval</th>
<th>Drugs requiring approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amikacin</td>
<td>Cycloserine</td>
</tr>
<tr>
<td>Aminosalicylic Acid</td>
<td>Ethionamide</td>
</tr>
<tr>
<td>Amoxicillin/Clavulin</td>
<td>Imipenem-Cilastatin</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>Levofloxacin</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>Linezolid</td>
</tr>
<tr>
<td>Moxifloxacin</td>
<td>Thalidomide</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>Vitamin D</td>
</tr>
</tbody>
</table>

In addition to these medications, all first-line medications requiring suspension can also be prepared at local community pharmacies and submitted to the ministry for reimbursement without prior approval.

9.6 Availability of other Anti-TB Drugs

Health care providers occasionally require drugs that are not approved in Canada for the treatment of TB. Health Canada’s Therapeutic Products Directorate has a mandate to authorize the sale of these drugs to practitioners which is managed by the Special Access Program (SAP). SAP is responsible for authorizing the sale of pharmaceutical, biologic, and radiopharmaceutical products that are not approved in Canada.

9.6.1 How to Request a Drug through the SAP

Health care providers may fax, phone or write to the SAP to request the medication (most requests can be handled by fax but urgent requests should be followed up by telephone). After consideration, an authorization may be granted, however, the manufacturer has the final word on whether or not the drug will be supplied.

9.6.2 Special Access Program Forms

These forms are available on the Health Canada website at: Drugs - Special Access to Drugs and Health Products.¹⁵

The board of health shall include the following information when requesting a drug from the SAP:

1) Practitioner’s name and phone number;
2) Address of physician’s office or hospital pharmacy where the drug is to be delivered;
3) The name of the drug and the dosage;
4) Manufacturer’s name;
5) Total quantity of the drug requested;
6) Intended dosage;
7) Patient’s initials, date of birth and sex; and
8) The medical indication for the drug.
9.7 Availability of Adjunct Therapies

Occasionally, clients may require additional medications to assist in the management of their TB treatment that are not included on the list of first- or second-line drugs. The board of health can seek pre-approval to purchase these medications by contacting the ministry. If granted approval, medications will be covered using the same reimbursement method used for all second-line medications (see Section 9.5.1 – Reimbursement for Second-line Drugs).***

9.8 Provision of TB Medications for Persons Leaving Ontario

9.8.1 Persons with Active TB Disease

Persons with active TB disease should be strongly encouraged to re-schedule their travel plans until their treatment has been successfully completed, as travel disrupts continuity of TB care. They must NOT be infectious at the time of travel (see Appendix 6.3: Long Distance Public Transportation). While the ministry will consider exceptions to providing additional medication in extenuating circumstances, only one month’s supply of medication should be given to a person with active TB who is leaving Ontario, ideally to confirm that the person will seek follow-up care in order to continue treatment. At the discretion of the board of health, in consultation with the client’s clinician, more than one month’s supply of medication can be provided if concerns about treatment adherence exist. Treatment details should accompany the patient.

PHO can assist the board of health in ensuring continuity of care by sending an interjurisdictional notification (IJN) to the appropriate public health authority in the province/territory in which the person is travelling to. If the person is travelling outside of Canada, PHO will contact the Public Health Agency of Canada (PHAC) who will notify the national TB program in the country they are travelling to in order to establish continuity of care. To consult with PHO regarding a client intending to travel while on treatment or to initiate an IJN, either email PHO at tb@oahpp.ca or send the case and/or contact’s demographic and clinical details to PHO via iPHIS referral. The board of health shall consider obtaining contact information for patients who will be travelling while on TB treatment (e.g., cell phone number, email, Facebook, new address, etc.).

If the person indicates that they intend to return to Ontario, but does not return to Ontario when expected, the board of health may notify PHO (see Section 4.4.2 – Transferring Information outside Ontario). The patient may have run out of medication and become infectious (or resistant to the existing treatment). PHO can notify the necessary public health authorities as deemed necessary. The person may be denied re-entry into

*** NOTE: The ministry is currently reviewing a list of commonly used adjunct therapies that will not require additional approval. Until further notice, please consult ministry TB program staff for necessary approvals.
Canada until they provide documented proof of successful treatment completion and that they are not infectious.

### 9.8.2 Persons with Latent TB Infection

While it is not necessary to hold to a stringent rule of "only one month’s supply of drugs" for LTBI as for active TB, since the implications for persons lost to follow-up for treatment and incorrect dosing are very different, dispensing medications for treatment should take into account a number of alternative factors before releasing supply. Decisions about quantity of drug to supply should be individualized based on patient adherence, need for laboratory monitoring based on clinical status and co-morbidities, anticipated delay in linking with a primary care provider in a different jurisdiction, and likelihood of return to Canada.

### 9.9 Additional considerations

For additional considerations relating to anti-TB products in Ontario, see Appendix 9: Additional Considerations for TB Treatment in Ontario.

### 10 Issuance of Orders to Control TB under the Health Protection and Promotion Act

For background on the MOH’s authority to issue orders, please see Appendix 10: Legislative Authority to Issue orders under the HPPA.

#### 10.1 Section 22 Orders

#### 10.1.1 Section 22 Orders for the Purposes of TB Prevention and Control

The following situations illustrate (but do not limit) the kind of situations potentially appropriate for issuing a Section 22 order:

- Consistent/Persistent refusal or demonstrated inability to comply with:
  - Isolation measures as directed by the attending primary care provider and/or public health staff during the period of communicability;
  - Medical appointments and/or diagnostic tests as recommended by the attending primary care provider or other specialist involved in the client’s care;
  - Taking anti-tuberculous therapy as prescribed;
  - Directly observed therapy arrangements;
- Explicit refusal to co-operate in providing names and contact information for identifiable household and close non-household contacts;
- Explicit refusal, by a symptomatic contact, to follow-up with a primary care provider to rule out active TB disease; and/or

10.2 Section 35 Orders

10.2.1 Section 35 Orders for the Purposes of TB Prevention and Control

When a MOH is considering applying to Court for a section 35 order, the board of health shall:

1) Notify the MOH or designate in Toronto Public Health (where West Park Healthcare Centre is located), and the West Park Healthcare Centre’s TB Service;

2) Send a copy of any section 35 orders to the ministry at IDPP@Ontario.ca;

3) If outside the Toronto area, identify a local hospital (pending transfer to West Park Healthcare Centre) that meets the following criteria:
   a) Can provide the required medical care/expertise and treatment;
   b) Has a secure bed where the patient may be kept without the possibility of leaving; and
   c) Can provide negative pressure ventilation;

4) Both the local hospital and West Park Healthcare Centre must be included in the (draft) section 35 order presented to the judge;

5) A judge may not sign an order unless they are satisfied that the hospital is able to provide detention, care and treatment. Therefore, it is critically important to discuss the security, care and treatment arrangements with hospital administration and the attending physician before applying for the order; and

6) West Park Healthcare Centre (WPHC) is the only healthcare facility in Ontario that is able to detain persons with TB that are held under a section 35 order under the HPPA (see Appendix 6.4: West Park Healthcare Centre (WPHC). WPHC can only admit patients during the week during business hours, and ideally not on Fridays. If a patient is apprehended under a section 35 order outside of these times, and/or cannot be moved to West Park Healthcare Centre within these times, the board of health will have to make alternative arrangements to detain and isolate the patient until WPHC is able to admit him/her.

10.2.2 Extending a Section 35 Order/Certificate of MOH

A section 35 order is in force for a period of up to six months from the date it is served. It may be extended by a judge, upon application by the MOH serving the health unit, in which the hospital or appropriate facility is located (normally Toronto/West Park Health Care Centre). An order may be extended if the court is satisfied that:

1) The person continues to be infected with an agent of a virulent disease; and

2) The discharge of the person from the hospital or appropriate facility would present a significant risk to the health of the public (Health Protection and Promotion Act, R.S.O. 1990, c. H7, s. 35(11)).
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);
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.
References


29. GENERAL, O Reg, 166/11, s27. Available from: https://www.ontario.ca/laws/regulation/110166


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;\(^\text{17}\)
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.”\(^\text{18}\) 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 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) 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) 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 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. 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.

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](#).\(^4\)

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\(^{†††}\) **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.**

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 Health 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 Health 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. 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.
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 arrangements 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
- Health Canada’s Monitoring and Performance Framework for Tuberculosis Programs for First Nations On-reserve
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.

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

The following services and service providers will not be covered under the TB-UP
program:
1) Any services/expenses for uninsured persons who receive hospital in-patient
services unrelated to the diagnosis or treatment of TB or LTBI;
2) Services provided by primary care providers or other service providers (i.e.,
laboratories and radiology facilities) who are normally compensated through a
global budget or an alternative payment process through an organization/agency,
and are not paid on a fee-for-service basis; and
3) At present, inpatient stay/services are not routinely covered by the TB-UP
program, though coverage for these costs may be assessed prior to services
rendered, and considered for reimbursement through alternative mechanisms on a
case-by-case basis. The board of health shall consider contacting the ministry to
discuss the possibility of coverage for such cases.

7.2 Roles and Responsibilities of the Local
Board of Health for the TB-UP Program

1) The board of health shall:
a) Be notified of uninsured persons requiring TB services either from the
patient themselves, or from a service provider or service agency (see
Appendix 7.6: Registration into the TB-UP Program);
b) Assess if the patient is eligible for coverage under the TB-UP program (see
Appendix 7.6: Registration into the TB-UP Program);
c) Verify the patient’s identification;
d) Obtain the TB-UP application and consent for the TB-UP program from the patient
and manage the TB-UP withdrawal from the TB-UP program as required;
e) Register eligible individuals into the TB-UP program and assign a TB-UP
registration number (see Appendix 7.6: Registration into the TB-UP Program);
f) Confirm the appropriate number of health care provider claim forms have been
issued for each TB-UP patient (see Appendix 7.7 – Board of Health Distribution of
Claim Forms); and

g) Collect and submit TB-UP data via iPHIS for the purposes of program monitoring
and evaluation.
7.3 Roles and Responsibilities of the Primary Care Providers:

Service providers should be licensed within their province of practice to be eligible for payment under the TB-UP program.††††

If a patient presents at the office of a service provider (e.g., due to symptoms compatible with active TB) and has not notified the board of health, the attending primary care provider will:

1) Verify the patient’s OHIP status and personal identification; and
2) Notify the board of health of the uninsured person who has either suspect/active TB or who is a contact of an active TB case and request a TB-UP application and consent form for this patient; and

All persons who are infected with TB or who have TB disease are to be reported to the local medical officer of health, as required under the requirement of the Health Protection & Promotion Act.²

1) Return (fax/mail) the patient signed TB-UP application and consent form to the board of health (TB control program staff), who will then register the patient into the TB-UP program, assign a TB-UP registration number and initiate first mailing of health care provider claim forms.

For all TB-UP patients registered in the TB-UP program (i.e., who have a TB-UP registration number and claim form), the attending primary care provider will:

1) Confirm that the TB-UP registrant’s name, date of birth, gender, registration number and eligibility expiry date (i.e., Part A of the claim form) has been completed by the board of health on all health care provider claim forms. Incomplete health care provider claim forms will be returned to the service provider by the CSB (see Appendix 7.7: Board of Health Distribution of Claims Forms);
2) Confirm the primary care provider’s OHIP billing number is entered into the “Provider Number” number (Provider Number = Group Number – code used for billing purposes);
3) Complete Part B of the health care provider claim form and include only those services which are related to the investigation and/or treatment of TB disease/infection or complications that arise as a result of treatment for TB disease/LTBI. The diagnosis and treatment of unrelated diseases are not covered for payment under the TB-UP program;
4) Submit completed health care provider claim form(s) to the CSB, for assessment

†††† NOTE: Primary care providers who have opted out of OHIP can participate in the TB-UP program. However they should submit the health care provider claim form to the Ministry of Health and Long-Term Care, Claims Services Branch (CSB) for payment. These primary care providers should not bill the patient directly, as CSB will not reimburse the individual TB-UP patient.
for payment and processing of payment under the TB-UP program (see Appendix 7.7: Board of Health Distribution of Claims Forms);
5) Notify the board of health (TB control program staff) of the patient’s treatment plan and request the required number of health care provider claim forms to cover subsequent visits for the next four week period. Claim forms will be issued monthly by the board of health on a request basis (see Appendix 7.7: Board of Health Distribution of Claims Forms); and,
6) Return all health care provider claim forms that have not been used to the local board of health.

7.4 Roles of Responsibilities of the Ministry of Health and Long-Term Care:

7.4.1 Claims Services Branch:
The Claims Services Branch will:
1) Act as the claims payment-processing agent for the TB-UP program;
2) Check each claim received to determine whether the patient is eligible for payment through OHIP and, if so, advise the service provider;
3) Verify claims received to confirm the following:
   a) Patient eligibility (as per the TB-UP registration information received from boards of health);
   b) OHIP eligibility;
   c) Service claim code eligibility (claim code is listed in the OHIP Schedule of Benefits);
   d) Service eligibility (e.g., service is rendered prior to the eligibility expiry date on the claim form);
   e) Provider eligibility (as per the Corporate Provider Database); and
   f) Completeness of claim (i.e., claim form includes all required information).
4) Assess and process claim payments for services rendered under the TB-UP program. Services provided will be paid at same rate as the schedule of benefits fee value for the same service provided to an insured person.

Health Care Provider Claim Payment under the TB-UP Program by CSB
CSB will assess and process claim payments for services rendered under the TB-UP program. Services provided will be paid at same rate as the schedule of benefits fee value for the same service provided to an insured person. Service providers will receive payment for processed claims on a regular schedule. Payments for services under the OHIP and the TB-UP programs will be included in a single remittance to the provider. The payment details for the amount paid under the TB-UP program will be included in detail line under TB-UP. Best efforts will be made on behalf of the CSB to confirm that claims will be paid to service providers who provide services under the TB-UP program within eight weeks of receipt.
Service providers should submit all claims to the CSB within six months of the date of service. This includes original claims and resubmitted claims, e.g., if original was lost. Payment for claims submitted more than six months following the date of service will be refused unless the CSB service manager is satisfied that there are extenuating circumstances or an approval letter is provided by the DPPPB.

Once the CSB has processed the health Care Provider Claim forms submitted by service providers, a copy (pink) of the claim form will be sent to the appropriate board of health. This copy of the paid form will be retained by the board of health in the TB-UP patient’s file.

### 7.4.2 Disease Prevention Policy and Programs Branch

The Disease Prevention Policy and Programs Branch (DPPPB) will:

1. Establish provincial standards (i.e., TB-UP policies and procedures) for the TB-UP program, and review and update as required;
2. Produce and distribute the following forms (via the Government of Ontario’s central forms repository) to the board of health:
   a) TB-UP Application form;
   b) TB-UP Consent form; and
   c) TB-UP Withdrawal form.
3. Cover costs of monies paid to service providers by CSB for all eligible claims through the TB-UP program;
4. Utilize the information received monthly from CSB for the financial monitoring of the TB-UP program expenditures;
5. Provide program consultation to boards of health, other Ontario Ministry of Health and Long-Term Care branches (e.g., Claims Services Branch) and other stakeholders (e.g., Ontario Medical Association) as needed;
6. Monitor and evaluate the TB-UP program, based on information received from boards of health and CSB;
7. Determine eligibility for exceptional services and provide Boards of Health and Services Providers with exception letters on a case-by-case basis;
8. Provide the final decision in a dispute resolution process if the board of health or the CSB is unable to resolve disputes related to their respective areas of responsibility regarding the TB-UP program; and
9. Provide support and educational updates to groups and individuals involved in TB control.

**Final Decision Regarding Unresolved Disputes**

The DPPPB will provide a final decision in unresolved disputes. This would include escalated disputes which the board of health or CSB is unable to resolve.
7.5 Roles and Responsibilities of Public Health Ontario:

7.5.1 TB-UP Data Transfer

On a monthly basis, PHO will submit a list of TB-UP registrants and their iPHIS numbers to the CSB. A cumulative database of all TB-UP registrants, both current and discharged, will be maintained by CSB. The CSB will use the TB-UP registrant information from the database to confirm that the TB-UP patient information on the submitted claim form corresponds to the patient information provided through the health care provider claims. This information will assist the CSB staff in verifying patient registration in the TB-UP program by a board of health.

7.6 Registration into the TB-UP Program

7.6.1 Patient Referral to the TB-UP Program

The board of health may be notified of a potential TB-UP patient through one of the following mechanisms:

1) Patient contacts the board of health directly, either by coming in person to the board of health or by phone; or
2) Board of health is notified by way of service provider or service agency.

If the TB-UP patient does not have a primary care provider, the TB control program staff at the local board of health will assist him/her in finding a primary care provider.

7.6.2 Assessment of Potential TB-UP Patient by the Board of Health to Determine Eligibility for the TB-UP Program

To be eligible for coverage under the TB-UP program, the patient must meet the following criteria, with respect to both their:
1) TB status; and
2) Medical insurance coverage status.

1) Board of health staff shall interview the patient, in person or by phone, to determine the patient’s eligibility for coverage under the TB-UP program by:
   a) Assessing the patient’s TB status (i.e., risk of active TB). The TB-UP patient must be one of the following:
      i) Active/suspect case of TB (pulmonary or extra-pulmonary);
      ii) A contact of an active case of TB; or
      iii) Any other person at high risk for developing active TB as determined by the TB control program staff.
   b) Determining the patient’s medical insurance coverage status.
   c) Patients are eligible if they are currently in Ontario, meet one of the TB status requirements above, and are not covered by any medical health insurance for TB services. These persons would not have coverage for TB diagnostic or treatment
services under OHIP, the IFH program, medical insurance plan of another province/territory, private medical insurance or other medical insurance plan. This includes persons such as the following:

i) Persons currently in the 3 month waiting period for OHIP (e.g., landed immigrant, live-in caregiver such as a nanny);
ii) Homeless and without OHIP coverage, IFH or other medical insurance coverage for TB services;
iii) Foreign student without OHIP coverage, IFH or other medical insurance coverage for TB services;
iv) Visitor without medical insurance coverage for TB services*;
v) Persons who do not have legitimate immigration status (long-term visitor); or
vi) Persons who have been discharged from prison but are not currently eligible for OHIP.

The TB-UP program will not issue retroactive payments for persons who receive TB diagnostic and/or treatment services prior to registration in the TB-UP program, unless proper approval has been granted by the Ministry of Health and Long-Term Care.

7.6.3 Application and Consent Procedure for the TB-UP Program

In order to obtain coverage under the TB-UP program, eligible patients should first apply for coverage and provide consent to share information among boards of health, service providers and the Ministry of Health and Long-Term Care.

7.6.4 Obtaining Application and Consent for the TB-UP Program

The patient should apply to the TB-UP program at the board of health. If the patient applies at the service provider’s office, see Appendix 7.6: Registration into the TB-UP Program for more details.

1) The board of health shall review the TB-UP application and consent form with the patient by phone or in person. The patient must sign the TB-UP application and consent form to be registered in the TB-UP program. The patient can sign the form either at the office of the board of health, attending primary care provider’s office, home or hospital if client is on isolation. The patient must be informed that by signing the TB-UP application and consent form, the patient:
   a) Confirms that they do not have OHIP, IFH or any other form of health insurance to cover TB related diagnostic or treatment services;
   b) Requests to be registered in the TB-UP program;
   c) Provides authority to the board of health, health care providers working under the TB-UP program, PHO, and the ministry to collect, use, share and disclose the TB-UP patient’s personal health information among themselves for the purposes of the TB-UP program; and
   d) Agrees to the release of their health number to health care providers providing TB
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. **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. **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. **radiology services**.

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
board of health staff to provide an update of the TB status and treatment plan for the
patient. At this time, the primary care provider’s office will request the estimated number
of health care provider claim forms needed to cover primary care provider visits and/or
further laboratory/radiology services, for the next four week period.

7.7.4 Health Care Provider Claim Forms for Subsequent
Visits to Primary care provider’s Office/Clinic

Once the attending primary care provider has provided an update of the patient’s TB
status and treatment plan, the board of health will mail out the estimated number of
additional health care provider claim forms requested by the primary care provider’s
office/clinic. The board of health can send out additional claim forms on a monthly basis
as requested by the attending primary care provider.

For all other subsequent primary care provider visits, the board of health may provide
health care provider claim forms to the primary care provider’s office directly. The
number of claim forms provided each time should only be the number required to cover
the next four week period of visits, as outlined in the treatment plan or updates from the
attending primary care provider.

The board of health should consider including the information listed in Appendix 7.7.1:
Information to be included on the Health Care Provider Claim Form prior to distribution
on all health care provider claim forms before issuing to the primary care provider’s
office/clinic.

The board of health should also consider advising the primary care provider’s office/clinic
that only original Health Care Provider Claim forms, not photocopies,§§§§ should be
submitted to the CSB for assessment and payment under the TB-UP program.

The service provider will return all health care provider claim forms that have not been
used to the local board of health. The board of health will retain these unused claim
forms in the TB-UP patient’s file for further use until the patient is discharged from the
TB-UP program. Once the TB-UP patient is discharged, the board of health shall destroy
all unused health care provider claim forms made out to the specific TB-UP patient. The
board of health should consider deleting unused and/or destroyed health care provider
claim forms that were recorded as issued on the iPHIS TB-UP claim form details screen.

§§§§ Photocopies of the health care provider claim form may be accepted by the CSB in exceptional circumstances
(e.g., lost in mail). However, the copy must clearly state “duplicate” and have an original, not photocopied, signature
by the service provider.
7.7.5 Submitting and Processing of Claims for the TB-UP Program

Health Care Provider Claim Submission by Service Provider

Claims will be submitted by service providers to the CSB for assessment for payment under the TB-UP program using the health care provider claim - diagnostic and treatment services for uninsured persons form.

Returned Health Care Provider Claim Forms by the CSB: Reasons for a Health Care Provider claim form to be returned

The CSB may return a claim submitted by a service provider for reasons such as the following:
1) Patient was not enrolled in the TB-UP program at the time the TB service was rendered;
2) Patient is covered under OHIP or through the Interim Federal Health Program (IFHP);
3) Claim form is not complete or information is missing;
4) TB-UP Registration Number has been altered;
5) Claim form is a photocopy;
6) Claim is stale dated, i.e., claim received more than 6 calendar months after date of service;
7) Service code submitted does not correspond to the service code in the OHIP Schedule of Benefits for Physicians’ services and/or Schedule of Benefits for Laboratory Services; or
8) Service provider is not listed in the ministry provider database.

Process for re-submission of returned Health Care Provider Claim forms

If a health care provider claim form requires correction, CSB will return it to submitting primary care provider/facility and will provide the necessary information to correct the claim. The primary care provider/facility may then re-submit to the CSB for payment under the TB-UP program.

If the service provider cannot provide the necessary information then the service provider will need to contact the board of health for assistance. If the service provider has questions related to claim payments they can contact Claims Services Branch directly.

Claims for service providers licensed outside Ontario

In order to receive payment through the TB-UP program, claims submitted by service providers licensed outside the province of Ontario should include an original letter signed by the local Medical Officer of Health (MOH) or designate authorizing the out of province

----- An exception letter from the Medical Officer of Health/ designate must accompany a claim for services that are rendered outside the province of Ontario by a service provider licensed within their province of practice (see Appendix 7.7.5: Submitting and Processing of Claims for the TB-UP Program).
TB related service(s) for the uninsured patient. Service providers must be licensed within their province of practice to be eligible for payment under the TB-UP program (see 7.1.2: Eligible services and service providers covered under TB-UP).

In the event that a service provider disagrees with the decision from the MOH/designate regarding non-approval of TB-UP services rendered outside Ontario, the MOH/designate will consult with the DPPPB TB staff to discuss the specific issue (see Appendix 7.11: Dispute Resolution).

7.8 iPHIS TB-UP Screen Data Entry by the Board of Health

The board of health shall open a TB episode for the patient by entering the required patient information into the integrated Public Health Information System (iPHIS) TB module. The following information should be entered into iPHIS: patient’s name, address, telephone number, date of birth, gender, as well as status at time of arrival, i.e., immigrant, visitor, etc. as per regular iPHIS reporting and management of a TB case.

The board of health shall obtain the following information from the patient and record the information into the iPHIS TB uninsured person registration details screen. This data will be included in the regular iPHIS reporting to the ministry for the purpose of monitoring and evaluating the TB-UP program.

7.8.1 Mandatory Fields for iPHIS Entry:

**TB-UP Status**

1) Not eligible for program;
2) Eligible/active patient; or
3) Discharged.

**Medical Coverage Status at time of registration**

1) Persons in the 3 month waiting period for OHIP;
2) Homeless without OHIP, IFH or other health insurance for TB services;
3) Persons who have been discharged from prison but are not currently eligible for OHIP;
4) Visitor without health insurance for TB services;
5) Foreign student without OHIP, IFH or other health insurance for TB services; or
6) Persons who do not have legitimate immigration status (long-term visitor).

**TB-UP Consent Signed/Start Date**

Enter the date when the patient signed the TB-UP Application and Consent form and was registered in the TB-UP program.

**TB-UP End Date**

Enter the date when it is anticipated the patient should be discharged from the TB-UP program, i.e., expiry date. When the patient is actually discharged from the TB-UP
program this will become the discharge date and should be updated appropriately. The TB-UP end date should be entered as a date 4 months from the start date during the initial save in iPHIS.

**Reason for Referral**

1) Active case;  
2) Suspect case; or  
3) Contact of case.

**On Medical Surveillance**

1) Yes; or  
2) No.

**Invoice Number***

Enter pre-printed number on claim forms in the TB Uninsured Person Claim Form Details screen.

**Invoice Given To**

1) Patient;  
2) Initial primary care provider;  
3) Subsequent primary care provider; or  
4) Parent/guardian.

### 7.8.2 Additional Fields for iPHIS Entry:

**Status Review Date (SRD)**

The status review date (SRD) is the date when the insurance status of the patient should be checked by board of health staff to determine ongoing eligibility for the TB-UP program. The SRD:

1) Will default to 90 days from the date on which the patient was registered in the TB-UP program (i.e., 90 days from the date indicated in the Consent Signed/Start Date field); this date should be 30 days prior to the TB-UP End Date; or  
2) Can be set at one year from the program registration date for active/suspect TB cases, e.g., visitors or foreign students, since active TB treatment may take one year or longer.

The board of health should consider reviewing the TB-UP patient file two weeks prior to the SRD to determine if the patient is now covered by OHIP or any other health insurance. Once the patient is covered for TB service under OHIP or any other health insurance plan, they will no longer be eligible for coverage under the TB-UP program. The patient will then be discharged from the TB-UP program (see Appendix 7.9: Withdrawal of Patient from the TB-UP Program).

The SRD can be extended at the discretion of the board of health (i.e., If the patient has not received OHIP coverage within 90 days and/or treatment for TB has been extended beyond the review period). The board of health should consider updating the health care
provider claim form if extending the SRD results in the extension of the end date (i.e., expiry date). The board of health should consider indicating the extended SRD and, if necessary, revising the TB-UP end date in the iPHIS TB uninsured person registration details screen. The new SRD will be reported to the CSB by updating these details.

**Diagnostic Outcome**

1) Active pulmonary TB;  
2) Active extra pulmonary TB;  
3) LTBI on treatment;  
4) LTBI without treatment;  
5) Assessment complete findings negative; or  
6) Assessment not complete, further assessment results required.

**Available Reasons for Discharge**

1) Medically assessed – no further follow-up;  
2) Medically assessed – on treatment;  
3) Medically assessed – treatment completed;  
4) Consent withdrawn;  
5) Deceased;  
6) Moved outside Ontario; or  
7) Patient covered by OHIP, IFH or other medical insurance for TB services.

**Invoice Given to Primary care provider**

Only appears if ‘initial primary care provider’ or ‘subsequent primary care provider’ is selected from the Invoice Given To drop list above. Select the name of primary care provider to whom claim forms were sent.

**Invoice Paid Date**

Enter the date when the invoice was paid. Obtain this from the claim forms that were returned to the board of health from CSB (i.e., pink copy).

### 7.9 Withdrawal of Patient from the TB-UP Program

#### 7.9.1 Process for Discharging the Patient from the TB-UP Program

The patient should withdraw from the TB-UP program at the board of health. If the patient withdraws at the service provider’s office, see Appendix 7.9: Withdrawal of Patient from the TB-UP Program for more details.

Patient may request to be withdrawn from the TB-UP program or the board of health may initiate discharge due to one of the following reasons:  
1) Completed treatment;  
2) Is deceased;
3) Moved outside of Ontario;
4) Completed assessment and findings were negative; or
5) Is covered under medical insurance, such as OHIP or IFHP.

The TB-UP patient may contact the board of health directly to request to be withdrawn from the TB-UP program. The board of health program staff will consider reviewing the TB-UP withdrawal form with the patient. The patient should be informed that once they have signed the TB-UP withdrawal form, the patient is agreeing to withdraw:

1) Registration from the TB-UP program;
2) Authorization for the board of health, health care providers providing services under TB-UP and the ministry to collect, use, share and disclose personal information among 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.

Once the patient has signed the TB-UP withdrawal form, the board of health TB control program staff will discharge the patient from the TB-UP program. The signed TB-UP withdrawal form will be retained by the board of health in the patient’s file. The board of health will consider updating the iPHIS TB uninsured person registration details and the TB uninsured person claim form details screen. The board of health should attempt to contact the attending primary care provider to inform them of TB-UP patient’s discharge from the TB-UP program.

If the TB-UP patient is to be discharged by the board of health, the board of health shall confirm the following fields in the iPHIS TB uninsured person registration details screen are completed (see Appendix 7.8: iPHIS TB-UP Screen Data Entry by the Board of Health):

1) TB-UP end date;
2) TB-UP diagnostic outcome; and
3) Reasons for discharge.

The board of health shall consider confirming that claim information, such as invoice paid date, from all paid claims sent by CSB for services rendered prior to the patient’s discharge, is entered into the TB uninsured person claim form details screen. The board of health will consider updating the iPHIS TB uninsured person registration details to signify withdrawal from the program. The board of health shall contact the attending primary care provider to inform them of TB-UP patient’s discharge from the TB-UP program.

Upon withdrawal from the program, PHO will notify the CSB of the patient’s discharge from the TB-UP program via the TB-UP registrant report sent monthly to the CSB.
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). In addition, more information related to OHIP insured TST is available in the INFOBulletin Number 4692 posted at OHIP Bulletins: Physician Services. Publicly funded Tubersol may only be used if the TST is OHIP-insured.

Can the Tubersol provided by the government 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 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.
9.4 Therapeutic Drug Monitoring for TB Medications

Therapeutic drug monitoring involves the measurement and interpretation of serum drug concentrations drawn at specific times relative to dose administration. The assessment of serum levels and subsequent dosing recommendations requires an understanding of a drug’s pharmacokinetics; the timing of samples; the infection being treated; and the patient’s clinical status, comorbidities and concomitant drug therapy.

Therapeutic drug monitoring for most TB medications is not currently available in Ontario or Canada. The only North American laboratory that does this testing is located at the University of Florida. Information about test handling and the necessary requisition forms can be found online at Infectious Disease Pharmacokinetics Laboratory - Forms and Catalog.

It is important to note that because this service is only available outside of Canada, a pre-approval must be granted to cover the costs of the service. If a primary care provider seeks to access serum drug level testing to assist in optimizing antimicrobial as part of a client’s treatment, a request can be made to the Laboratories and Genetics Branch, Out of Country Program at the ministry to access services outside of Canada.

To make a request for consideration, the board of health can:

1. Go to Government of Ontario - Central Forms Repository and search for “4521-84” This will bring up a “Request for Prior Approval for Full Payment of Insured Out-of-Country (OOC) Health Services for Diagnostic Laboratory Testing.” Select the link and open the subsequent PDF.

   The form should open in your Adobe reader (or similar PDF reader).

2. Ensure that the attending primary care provider fills out the application on this form electronically, and submits it to the ministry by faxing it to 416-326-2211 or 1-844-642-0202 for consideration.
Appendix 10: Legislative Authority to Issue Orders under the HPPA

Ontario’s *Health Protection and Promotion Act* (HPPA) provides the legislative mandate for boards of health. The purpose of the HPPA, as set out in section 2 of the Act, is to provide for the organization and delivery of public health programs and services, for the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario ([R.S.O. 1990, c. H7, s2]).

The Medical Officer of Health (MOH) is an important statutory official under the HPPA and possesses authority under HPPA to take action to prevent the spread of disease, decrease the effects of health hazards and protect the public’s health. Part IV of the Act sets out the duties of the medical officer of health with regard to communicable and virulent diseases, including the issuance of orders.

MOHs can issue communicable disease orders under [section 22 of the HPPA](#). The legislation gives:

1) The medical officer of health the authority to issue orders against, amongst other persons, anyone who may have a communicable disease, such as TB, and who is putting others at risk; and

2) People with a communicable disease the right to appeal an order issued by a medical officer of health; however the order remains in force pending the appeal.

Where the public’s health and safety are at risk and the situation is urgent, or if other voluntary measures to achieve compliance has failed, an MOH can and should rely on the order-making provisions of the HPPA. It has been customary practice for an MOH to use all reasonable measures to obtain voluntary compliance before using the more intrusive statutory powers of the MOH to confirm appropriate treatment and medical follow-up for TB.

### 10.1 Section 22 Orders

#### 10.1.1 Background

For diseases designated as communicable under the *HPPA*, a MOH has the power under section 22(1) of the HPPA to issue a written order requiring an individual to take or to refrain from taking certain actions where the test under section 22 of the HPPA has been met. This power is discretionary, not mandatory; if the situation can be resolved without a section 22 order, the MOH is not obliged to write one. A section 22 order can be issued when the MOH is of the opinion, based upon reasonable and probable grounds, that:

1) A communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the MOH.

2) The communicable disease presents a risk to the health of persons in the health unit served by the MOH and that the requirements specified in the order are
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. 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).