

Tuberculosis Program Guideline, 2023

Effective: August 2023

ISBN : 978-1-4868-7290-9 [PDF]

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Citation : Ontario. Ministry of Health. Tuberculosis program
guideline, 2023. Toronto, ON : King's Printer for Ontario, 2023.

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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 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.^{1,2} 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 boards of health with direction for how to approach tuberculosis (TB) prevention and care through programs and services that work towards achieving the global goal of TB elimination (see the World Health Organization's [Global Tuberculosis Programme](#) for more details). The main sections of this guideline contain information related to various resources, policies, and programs available to support boards' of health TB programs whereas the appendices contain information to support the implementation of policies and programs described within the main sections.

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 and guidance, such as the most current version of the TB disease-specific chapter of the *Infectious Diseases Protocol, 2018* (or as current), and the [Canadian Tuberculosis Standards 8th Edition: 2022](#) [hereon referred to as the CTBS, 8th Edition].^{3,4} For relevant definitions, refer to [CTBS, 8th Edition: Appendix A - Glossary of terms.](#)

Provisions in the [HPPA](#) require physicians, practitioners, and institutions to report TB to the local medical officer of health (MOH). Paragraph 6 of section 5 of [Regulation 569](#) 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.

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 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants.

Requirement 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk in accordance with the *Tuberculosis Prevention and Control Protocol, 2018* (or as current).

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 Introduction

4.1.1 Impact of TB

In Ontario, the annual incidence of TB has fluctuated between 4.3 to 5.1 cases per 100,000 population since 2012 however there are pronounced disparities (i.e., inequitable impact of TB) in certain population subgroups and geographic regions in the province. The epidemiological trends presented at the [PHO Rounds: World Tuberculosis \(TB\) Day 2022: What's New with Latent TB Infection, Diagnosis and Management in the Updated Canadian TB Standards showed that](#) from 2017-2021:

- Most cases of active TB were diagnosed in individuals born outside of Canada (84.7%) who later immigrated to Canada from countries with much higher rates of TB,
- Canadian-born, non-Indigenous individuals accounted for 5.0% of active TB cases in the province, and
- Canadian-born, Indigenous peoples accounted for 1.9% of active TB cases.

However, Canadian-born, Indigenous peoples were disproportionately affected in northwestern Ontario accounting for 70.3% of all active TB cases diagnosed in the region. Individuals with unknown origin (8.3%) accounted for the remainder of active TB cases diagnosed in the province.

Compared to the epidemiological trends observed in Ontario, recent Canadian epidemiological trends have found that individuals born outside of Canada and Canadian-born, Indigenous peoples are disproportionately affected. The rate of active TB disease in Canada in 2020 was 4.7 per 100,000 population. The incidence rates among the different sub-populations in Canada are:

- Inuit communities – 70.3 per 100,000 population in 2020 (15 times higher than the overall Canadian rate)
- First Nations on-reserve populations – just under 20.0 per 100,000 population since 2017 (three times higher than the overall Canadian rate)
- First Nations off-reserve populations – about 10.0 per 100,000 population since 2013
- Métis – has varied between 2.2 and 3.7 per 100,000 population since 2012 (below the overall Canadian rate)
- Individuals born outside of Canada – 15.0 per 100,000 population since 2005 (constitutes the largest proportion of people reported with active TB disease in Canada), and
- Canadian-born, non-Indigenous populations – 0.2 per 100,000 population in 2020.

These findings further highlight the inequitably high incidence rates among Indigenous people compared to non-Indigenous, Canadian-born people, with different inequities among the Indigenous subgroups (e.g., highest rates among Inuit communities).

For additional information, see [Infectious Disease Trends in Ontario | Public Health Ontario](#) and [CTBS, 8th Edition; Chapter 1: Epidemiology of tuberculosis in Canada](#).

4.1.2. Serving Indigenous Peoples of Canada

Healthcare workers providing TB services are encouraged to educate themselves on Indigenous health as it pertains to TB. Boards of health should make specific considerations for case and contact management for First Nations, Inuit, and Métis communities, in dialogue with the communities and/or Indigenous health service providers. This should include respect of the principle of self-determination, to support ongoing surveillance and response that allows for differences in community needs, recognizes differential impacts to communities, and changing needs over time.

For additional information, see [CTBS, 8th Edition; Chapter 12: An introductory guide to tuberculosis care to improve cultural competence for health care workers and public health professionals serving Indigenous Peoples of Canada](#) and [Relationship with Indigenous Communities Guideline, 2018](#) (or as current).

Note: Under the [Health Protection and Promotion Act \(HPPA\)](#), a band council may enter into an agreement with a local board of health for the provision of health programs and services in the community in exchange for the band council having representation on the local board of health.

For additional resources for on-reserve populations, refer to:

- [Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve](#)²³
- [Health Canada's Monitoring and Performance Framework for Tuberculosis Programs for First Nations On-reserve](#)²⁴

4.2 Public Health TB Prevention and Care Programs

TB prevention and care in Ontario is decentralized. Most cases of TB in Ontario are diagnosed and treated by health care providers who are not formally affiliated with a public health TB program, although partnerships vary between and within jurisdictions. Therefore, public health TB programs should collaborate and coordinate with various clinical partners to support optimal TB care.

For complex and/or difficult to treat TB cases, West Park Healthcare Centre (WPHC), located in Toronto, is the provincially designated inpatient treatment centre.

Canada has national standards for TB diagnosis, treatment, and management (including public health management) detailed in the [CTBS, 8th Edition](#), on which this guideline is largely based.⁴

The [CTBS, 8th Edition; Chapter 15: Monitoring tuberculosis program performance](#) has also identified program-level indicators which are helpful to consider for monitoring local TB program performance, where feasible.

4.3 Roles and Responsibilities

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), including data entry requirements for public health reporting and surveillance using the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health.

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

5 Diagnosis and Treatment

Early diagnosis and effective treatment of active cases are keys to the prevention and care 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 care programs are all essential components for preventing the transmission of TB.

5.1 Active TB

Active TB includes clinical disease that can present with a range of signs and/or symptoms. Active TB can be diagnosed in persons of any age and affect the lungs and/or tracheobronchial tree (i.e., pulmonary TB) or any other area of the body (i.e., extrapulmonary TB), or both. Please note, public health surveillance case definition nomenclature differs somewhat (i.e., refers to respiratory and non-respiratory disease).

For detailed information about the diagnosis and treatment of active pulmonary and extrapulmonary TB in adult and pediatric populations, including recommendations related to chest radiography, other radiologic testing, and microbiologic testing, please refer to the CTBS, 8th Edition:

- [Chapter 3: Diagnosis of tuberculosis disease and drug-resistant tuberculosis](#)
- [Chapter 5: Treatment of tuberculosis disease](#)
- [Chapter 7: Extra-pulmonary tuberculosis](#)
- [Chapter 8: Drug-resistant tuberculosis](#)
- [Chapter 9: Pediatric tuberculosis](#)
- [Chapter 10: Treatment of active tuberculosis in special populations](#)

Of note, there is ongoing scientific research to build understanding of intermediate states in TB pathogenesis, including **subclinical TB** (which involves no symptoms, but radiographic/microbiologic abnormalities), and their potential implications; evidence may continue to evolve in this area. For further information, see [CTBS 8th Edition; Chapter 2: Transmission and pathogenesis of tuberculosis](#).

5.2 TB Infection (TBI)

TB infection (TBI), also referred to as latent TB infection (LTBI), is the presence of latent or dormant infection with *Mycobacterium tuberculosis* with no evidence of clinical disease (i.e., no symptoms, no evidence of radiographic changes, and negative microbiologic tests). TBI is non-infectious.

For detailed information about the diagnosis and treatment of TBI, please refer to the CTBS, 8th Edition:

- [Chapter 4: Diagnosis of tuberculosis infection](#)
- [Chapter 6: Tuberculosis preventive treatment in adults](#)
 - **Note:** Chapter 6 provides updated recommendations in support of shorter-duration rifamycin regimens as first-line options for TB preventive treatment.
- [Chapter 9: Pediatric tuberculosis](#)

5.3 Additional Considerations for TB Treatment in Ontario

5.3.1 Need for Referral/Consultation with TB Specialist

All persons with active TB should ideally be cared for by a specialist (i.e., respirologist or infectious diseases clinician) with specific training and experience in the care/management of TB. The board of health should also be made aware of any clinical decisions impacting the client's care. If access to a TB specialist in a geographic region is limited, the local board of health may support the most responsible clinician to connect with a TB specialist. [The Ontario eConsult Program](#) may be used when in-person appointments are not appropriate (e.g., client lives far away from a TB specialist) and in this way, TB specialists can bill for their consult and time in reviewing cases remotely.

A referral to a TB specialist should especially be sought for **any person with** TB who has, or may:

- 1) Have rifampin monoresistance;
- 2) Have resistance to more than one TB drug, resistance to isoniazid (INH) and rifampin (RMP) (i.e., multidrug-resistant [MDR]- or extensively drug-resistant [XDR]-TB);
 - a. **Note:** In this situation, treatment should be by, or under the advisement of, the TB specialists at WPHC.
- 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 or hepatic conditions which could make treatment fail;
- 7) Have a serious/complex TB diagnosis of TB meningitis, spinal TB (Pott disease), or disseminated TB;
- 8) Experiencing significant side effects to medications (e.g., requiring medication reintroduction and trialling), immune reconstitution inflammatory syndrome (IRIS) reactions, intolerance to rifampin or rifabutin, or intolerance to two or more other medications;
- 9) Be a child < 18 years of age;
 - a. **Note:** Treatment should be by, or under the advisement of, a pediatric TB specialist. 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.
 - b. If the child is < 5 years of age, the board of health shall consider a referral to the Hospital for Sick Children's (SickKids). Online referrals can be made through Sick Kids electronic system which electronically routes client referrals for review, triage and booking for clients who require referral to SickKids for screening, assessment, or treatment. This is available at: [How to refer a patient to SickKids](#). Refer to [Infectious Diseases | SickKids](#) for additional information.

- c. For jurisdictions outside of the Toronto area, the board of health should consider a referral to or consult with local pediatric hospitals where TB specialists are available (e.g., London Health Sciences Centre Children's Hospital, Children's Hospital of Eastern Ontario, etc.).
- 10) Be pregnant or breastfeeding; or
- 11) Have TB reactivation when there is a history of TB preventive treatment (TPT) for TBI, recurrence or at high risk of recurrence, or treatment failure:
- a. **Reactivation:** The development of active disease after a period of TBI.⁴
 - b. **Recurrence:** Client previously successfully treated (cure or completed) for active TB disease in whom active TB develops a second time, but without proof that this is the same organism.. Such cases are to be reported as a **re-treatment case**. People at high risk of recurrence may include:
 - i. people with extensive or disseminated disease,
 - ii. cavitory and smear or culture positive disease,
 - iii. drug-resistant disease,
 - iv. people with immune suppressing co-morbidities,
 - v. people with a history of treatment interruptions,
 - vi. non-adherence, or
 - vii. an atypical treatment regimen.⁴
 - c. **Treatment Failure (active non-MDR/XDR-TB):** Positive sputum cultures after 4 or more months of treatment or two positive sputum cultures in different months during the last 3 months of treatment, even if the final culture is negative and no further treatment is planned.⁴
 - d. **Treatment Failure (active MDR/XDR-TB):** Two or more of five cultures recorded in the final 12 months are positive, or any one of the final three cultures is positive, or a clinical decision has been made to terminate treatment early because of poor response or adverse events.⁴

5.3.2 Indications for Hospitalization

As per the [CTBS 8th Edition: Chapter 5: Treatment of tuberculosis disease](#), most people with active TB are managed in the outpatient setting. However, hospitalization may be required in the following situations:

- Investigation and treatment of symptoms and signs of severe or life-threatening TB disease (e.g., life-threatening hemoptysis, cachexia/malnutrition);
- Severe and morbid forms of TB, such as meningitis, cerebral, and pericarditis;
- Establishment of an acceptable drug regimen in clients with significant/severe drug-related adverse events or known/suspected multidrug-resistant disease;
- Drug desensitization;
- Management of co-morbid medical conditions whether related or unrelated to TB diagnosis (e.g., heart failure, respiratory failure, or recent solid organ transplantation);
- Institution of airborne isolation if this cannot be achieved in the outpatient setting; and/or
- Involuntary admission when all other measures are unsuccessful (should be an extremely rare event and performed as a last resort in consultation with the local board of health. See [Section 6.4 – Orders to Control TB under the Health Protection and Promotion Act](#)).⁴

5.3.3 Improving Adherence to Therapy

A person-centered approach should be used to assess for and remove barriers to treatment adherence. The board of health should consider using incentives and enablers, when possible, to help mitigate social and economic marginalization, as well as early and appropriate linkage to:

- Social workers;
- Governmental organizations; and

- Community organizations.

Examples of incentives and enablers that can be used include:

- Peer counseling;
- TB support groups (e.g., [TB People Canada](#));
- Client reminders and following up on missed appointments;
- Integration into primary or specialty care (e.g., HIV care, dialysis, mental health services, methadone delivery);
- Financial supports, including stipends, personal products, coupons, and gift cards;
- Social assistance for housing and to gain access to or funding of healthcare services;
- Assistance with transportation and childcare;
- Reminder systems for appointments;
- Field or home visits;
- Blister packing medications;
- Directly observed therapy or video directly observed therapy.⁴

For additional information, refer to the [CTBS, 8th Edition: Chapter 5: Treatment of tuberculosis disease](#) and [Chapter 6: Tuberculosis preventive treatment in adults](#).⁴

6 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. For the minimum requirements, see the [Tuberculosis Prevention and Control Protocol, 2018](#), (or as current).

Boards of health should ensure that prompt, accurate diagnosis and effective, person-centered treatment are initiated as soon as possible, where capacity and resources allow, as these are not only essential for good client care – they are the key elements in the public health response to TB and the cornerstone of TB elimination.

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. In addition to the minimum requirements, boards of health are encouraged to develop their own case management strategies to reflect their local community context, 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 2: Additional Tools for Case Management](#).

In community settings, the board of health is responsible for home isolation and decisions around release from isolation according to the CTBS, 8th Edition guidelines (see [CTBS, 8th Edition: Appendix B: De-isolation review and recommendations](#)).⁴ For information on prevention of transmission of TB within congregate settings (e.g., shelters, Long-Term Care Homes (LTCH), correctional facilities), including in circumstances where infectious cases cannot be effectively isolated within the setting, see [CTBS, 8th Edition: Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#).

6.2 Directly Observed Therapy (DOT) and Directly Observed Preventive Therapy (DOPT)

6.2.1 Directly Observed Therapy (DOT)

Boards of health are strongly recommended to provide capacity to deliver supportive care for people with TB disease. Supports should be individualized and may include directly observed therapy (DOT).⁴ DOT is the most effective strategy for ensuring adherence to treatment. In the most basic sense, DOT means that doses of medications are swallowed in the presence of a trained observer. DOT programs also provide monitoring for side effects, psychosocial support and education, triage, and referral (in collaboration with the multi-disciplinary team), and incentives/enablers. In addition, systematic reviews of observational studies have reported improved treatment outcomes with DOT in people living with HIV and people with multidrug-resistant TB, with limited data examining other populations at risk for adverse outcomes.⁴ Existing data highlight the need for DOT, at minimum, in populations at higher risk for adverse outcomes from TB therapy.⁴

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. VDOT may be considered an acceptable alternative to in-person DOT in some settings and should be considered an option within the larger program of supportive care for people with TB disease.⁴ Local medical officers of health are health information custodians under the [Personal Health Information Protection Act](#) (PHIPA) and should consult with legal counsel when considering new video technologies to ensure compliance with privacy laws. Boards of health are also encouraged 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](#).

The method and frequency of DOT and/or VDOT may vary depending on the board of health's capacity and the client's individualized support plan (e.g., access to and/or skills for using technology for VDOT). Populations at higher risk for adverse

outcomes from TB therapy should be considered for DOT as part of the client's individualized support plan.

A sample assessment tool has been developed by the ministry and several boards of health to determine priorities (see [Appendix 2.2: 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.

In Ontario, there is no legislative requirement for DOT, therefore the decision to use DOT, and the type of DOT, should be made in collaboration with the client to ensure that autonomy and trust are maintained.⁴ Additional information about DOT can be found in the [CTBS, 8th Edition; Chapter 5: Treatment of tuberculosis disease and](#) [CTBS, 8th Edition; Chapter 9: Pediatric tuberculosis](#).⁴

6.2.2 Directly Observed Preventive Therapy (DOPT)

Directly observed preventive therapy (DOPT) is a strategy available to ensure adherence to TB preventive treatment (TPT) for TBI and can be implemented in the same manner as DOT.

Currently, the first line recommendations for TPT include 4R (4 months of daily rifampin) or 3HP (rifapentine and isoniazid once weekly for 12 weeks).

The 4R regimen is usually given as self-administered therapy (SAT). However, if the board of health has capacity, certain populations, such as pediatric clients or people with risk factors for non-adherence, may benefit from TPT administration by DOPT.

Administration of 3HP should generally be given by DOPT, since administration by SAT is associated with a lower completion rate when compared to DOPT as shown in a randomized control trial comparing these two ways of administering the regimen (SAT's completion rate was 74%, vs 87% for DOPT).⁴ However, a preplanned subgroup analysis in the same study demonstrated that SAT was non-inferior to DOPT in the US sites.⁴ As there is some evidence that 3HP administered as DOPT achieves higher completion than SAT, 3HP should generally be administered as DOPT in Ontario. Additional information about the 3HP regimen, including evidence comparing DOPT and SAT, can be found in the [CTBS, 8th Edition; Chapter 6: Tuberculosis preventive treatment in adults](#).⁴

6.3 Tuberculosis Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program

For information on the TB-UP program, please see [Appendix 4: Tuberculosis Diagnostic and Treatment Services for Uninsured Persons \(TB-UP\) Program](#).

6.4 Orders to Control TB under the Health Protection and Promotion Act (Section 22 and Section 35 Orders)

Ontario's *Health Protection and Promotion Act* (HPPA) [R.S.O. 1990, c. H7, s2](#) provides the legislative mandate for boards of health. Where the public's health and safety are at risk and the situation is urgent, or if other reasonable measures to obtain voluntary compliance has failed, an MOH can and should utilize on the order-making provisions of the HPPA to implement appropriate treatment and medical follow-up for TB. For individuals living on reserve in a First Nations community, the board of health should contact and work with the local authorized body (e.g., band council, First Nation community) to seek consent for the board of health to issue orders or take actions to implement appropriate treatment and medical follow-up for TB.

For additional information, refer to [Appendix 2.5 Issuing Orders under the HPPA](#).

6.4.1 Section 22 Orders

For diseases designated as communicable under the [HPPA](#),² 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 specified in the order. 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.

6.4.2 Section 35 Orders

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, the MOH may apply to a judge of the Ontario Court of Justice to issue an order under [section 35 of the HPPA](#).² This section of the HPPA sets out when the court can make an order and the contents of the order. A section 35 order cannot be issued for any other requirements not specified in section 35 (e.g., failure to identify contacts).

Note: All cases who are being considered for a section 35 order from the Ontario Court of Justice under the HPPA should be reported to the ministry at IDPP@ontario.ca.

7 Contact Management

The minimum standards required for boards of health to manage contact persons of active pulmonary TB cases is outlined in the “Identification, assessment, and management of contacts of pulmonary TB” section of the [Tuberculosis Prevention and Control Protocol, 2018](#) (or as current).

For information on the principles of an organized, systematic approach to the contact investigation, refer to the CTBS 8th Edition:

- [Chapter 11: Tuberculosis contact investigation and outbreak management](#); and
- [Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#).

For additional information on tools used in contact management in Ontario, see [Appendix 3: Additional Tools for Contact Management](#).

7.1 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 from the Supplemental material section in the [CTBS, 8th Edition; Chapter 11: Tuberculosis contact investigation and outbreak management](#).⁴ For more information, contact Toronto Public Health at Targettb@toronto.ca. If adapted, please acknowledge Toronto Public Health.

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

8.1 Bacille Calmette-Guérin (BCG) Vaccine

Publicly funded supply of Bacille Calmette-Guérin (BCG) vaccine is only available to select high-risk communities in Ontario and does not currently have a Canadian manufacturer. For more information on the use of BCG, see [CTBS, 8th Edition; Chapter 9: Pediatric tuberculosis](#).⁴

To request BCG vaccine, please email IDPP@ontario.ca

8.2 Products for Diagnosing TB Infection

8.2.1 Eligibility for Publicly Funded Tuberculin Skin Test (TST)

The ministry's Health Services Branch determines who is eligible for a publicly funded tuberculin skin test (TST) based on several factors. The eligibility criteria is available in a health services provider [INFOBulletin \(Number 4692\)](#), available online at [OHIP Bulletins: Physician Services](#) (issued January 30, 2017).¹¹

Common Eligibility Considerations for Publicly Funded Tubersol

1. What if a TST is requested by someone other than a client or the client'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\(1.2\)](#).¹¹ In addition, more information related to OHIP insured TST is available in the [INFOBulletin \(Number 4692\)](#) posted at [OHIP Bulletins: Physician Services](#).¹¹ Publicly funded Tubersol may only be used if the TST is OHIP-insured.

2. 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 clinician and sold to the patient at a direct cost (with reasonable mark-up to account for any indirect costs (e.g., storage, administrative, etc.). Clinicians may contact their local board of health for information about ordering Tubersol or order through their routine process.

OR

- 2) Acquired by the patient from the pharmacy, via prescription provided by a clinician.
 - 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 "Purified Protein Derivative (PPD – Mantoux Test)" in the drop-down box).

Note: 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 clinician charging for this service, please have the individual make a collect call to: Health Services Branch, Commitment to Future of Medicare Program at **1-866-662-6613** or email protectpublichealthcare@ontario.ca.

3. 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 \(Number 4692\)](#) – both the TB test and completion of an immunization status report are insured.

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

International students are eligible to use the publicly funded supply of Tubersol for the test; however, the administration of the test, whether it is conducted by a physician or another healthcare practitioner, must be paid out of pocket. While students are covered for the test, as per Category 2 of the [INFOBulletin \(Number 4692\)](#), they are ineligible for administration of the test, as per category 4.

8.2.2 Interferon Gamma Release Assays (IGRA)

IGRAs are blood tests which are useful in the diagnosis of TBI. In particular, they may have greater specificity for TBI than the TST in BCG-vaccinated individuals. For more information of the use of IGRAs, consult:

- [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#), and
- Public Health Ontario's [Testing for Mycobacterium tuberculosis infection with interferon gamma release assays](#).⁴

Currently, there is **no publicly funded coverage** for IGRA tests in Ontario.

Therefore, any client seeking these tests must purchase them through a private laboratory or have them covered through their private insurance. Boards of health may also consider covering the cost of IGRA tests for specific client populations.

Note: IGRA lab facilities are not currently available in all communities.

8.3 Availability of First-line TB Drugs

First-line TB drugs are available free of charge from the Ontario Government Pharmaceutical and Medical Supply Service (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:

Drug	Strength(s)
Ethambutol (EMB)	100mg, 400mg
Rifampin (RMP)	150mg, 300mg
Isoniazid (INH)	100mg, 300mg, 10mg/ml (syrup)
Pyrazinamide (PZA)	500mg
Pyridoxine HCL (Vitamin B6)	25mg
Rifapentine (RPT)	150mg

Oral suspensions of first-line drugs can be prepared at community pharmacies that offer compounding services and are paid for by the board of health. Reimbursement for the cost of these drugs can be submitted to the ministry without prior approval and will be covered using the same reimbursement method used for all second-line medications (see [Section 8.8 – Reimbursement for TB Drugs](#)).

NOTE: In Toronto, some health care providers and hospitals may receive their drugs directly from OGPMSS through a special arrangement with Toronto Public Health.

8.4 Rifapentine for 3HP TB Preventive Treatment (TPT)

The 3HP (Rifapentine and isoniazid once weekly for 12 weeks) regimen is recommended as one of the first-line regimens for TPT in the [CTBS, 8th Edition; Chapter 6: Tuberculosis preventive treatment in adults](#). Rifapentine is not licensed for sale by Health Canada but has been available through the [Access to Drugs in Exceptional Circumstances Regulations via the List of Drugs for an Urgent Public Health Need](#). Rifapentine is available free of charge from OGPMS and should be used for the indication as listed on the Urgent Public Health Need List to be in compliance with the regulations.

The information needed to monitor key indicators of the 3HP regimen (i.e., the number of clients started on 3HP, treatment completion, and reason for discontinuation) can be captured in iPHIS. The board of health should ensure that a client's 3HP TPT details are entered into the system's mandatory and recommended fields in the LTBI episode, as per the iPHIS User Guide. For additional information on the use and monitoring of the 3HP regimen, see PHO's [Use of rifapentine and isoniazid combination therapy for the treatment of latent tuberculosis infection in Ontario](#).

8.4.1 Uptake of 3HP

Implementation of 3HP varies across boards of health, with 3HP being offered on a small scale or in a limited capacity to persons identified as high-risk, in populations with historical difficulties with treatment adherence, or offered in partnership with a community clinician.

The decision to use 3HP should be made in collaboration between the client and the clinician, ideally as DOPT, considering individual circumstances, as well as minimum clinical criteria outlined in PHO's [Use of rifapentine and isoniazid combination therapy for the treatment of latent tuberculosis infection in Ontario](#).

8.4.2 Ordering Rifapentine

To obtain rifapentine, clinicians should contact their local board of health to initiate the ordering process. Boards of health should request the “OCMOHPH Requisition for Rifapentine” form from the ministry at IDPP@ontario.ca and complete the requisition form for each new order. The completed requisition form should then be submitted to the ministry at IDPP@ontario.ca.

Once the request is approved by the ministry, boards of health can place their order for rifapentine in Panorama using the inventory module to order the medication from OGPMS.

8.4.3 Reporting Severe Side Effects

Severe side effects must be reported to the ministry at IDPP@ontario.ca in addition to completing an online report to Health Canada, as per: [Report a side effect of a health product, drug or medical device - Canada.ca](https://www.healthcanada.ca/eng/health_products/drugs_medical_devices/reporting_side_effects/index.php); generally this would be side effects that are considered Grade 3 (inability to perform work or normal daily activities), Grade 4 (life threatening or disabling) or Grade 5 (death).

8.5 Dispensing of TB Drugs for Treating Active TB Disease

The OGPMS 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;[†]

[†] The ministry will cover the cost of dispensing fees (e.g., proper labelling, repackaging, blister packing) submitted for first-line medications, if they are done outside of the board of health

- 2) The clinician 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 or registered practical nurse can dispense the drugs directly to the patient when there is an appropriate authorizing mechanism in place (e.g., direct order or directive). Relevant drug information sheets, including signs and symptoms of adverse drug reactions should be provided to the patient.
 - a. 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

8.6 Availability of Second-line TB Drugs

Second-line drugs are used as part of alternative regimens for the treatment of TB when there is resistance and/or intolerance to first-line TB drugs. Second-line drugs should be used on a case-by-case basis in consultation with a respirologist or infectious disease physician specializing in TB.

- **Note:** The treatment of MDR-TB and XDR-TB cases should be by, or under the advisement of, the TB specialists at WPHC and the local board of health should be consulted.

The [World Health Organization, operational handbook on tuberculosis – Module 4: treatment - drug-resistant tuberculosis treatment, 2022 update](#) has classified second-line drugs into three groups:

or at a clinician'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.

- Group A – drugs found to be highly effective at reducing risks of treatment failure/relapse and death;
- Group B – drugs that can be orally ingested and that reduce risks of treatment failure or relapse, but whose effectiveness for lowering the risk of death was less certain; and
- Group C – anti-TB drugs, as well as repurposed medications, with less certainty on their effectiveness for MDR-TB or that require parenteral administration.⁴

Second-line drugs that are authorized for sale in Canada and found in the [Drug Product Database](#) can be ordered from community pharmacies. However, most second-line drugs are currently not approved in Canada and must be accessed through Health Canada's Special Access Program (SAP). See [Section 8.6.2 - Special Access Program for other Anti-TB Drugs](#).

8.6.1 Second-line TB Drug Coverage

Second-line drugs classified in the [World Health Organization's Groups A, B, and C](#), as well as new drugs and new regimens for MDR-TB listed in the [CTBS, 8th Edition: Chapter 8: Drug-resistant tuberculosis](#), generally do not require pre-approval from the ministry to cover the medication costs.

- **Note:** Boards of health should **notify** the ministry at IDPP@ontario.ca prior to purchasing a second-line drug if the:
 - Cost of the second-line drug exceeds \$25,000 for the duration of treatment.
- **Note:** Boards of health should **seek pre-approval** from the ministry at IDPP@ontario.ca prior to purchasing a second-line drug if the:
 - Second-line drug is not classified in the World Health Organization's Groups A, B, or C or listed in the [CTBS, 8th Edition: Chapter 8: Drug-resistant tuberculosis](#).

Invoices for the purchase of second-line drugs, whether obtained from a community pharmacy or from the drug manufacturer via the SAP, should be submitted to the ministry for reimbursement. See [Section 8.8 - Reimbursement for TB Drugs](#) for additional details.

8.6.2 Special Access Program (SAP) for other Anti-TB Drugs

Clinicians occasionally require drugs that are not approved in Canada for the treatment of TB. Health Canada's [Pharmaceutical Drugs Directorate](#) has a mandate to authorize the sale of these drugs to practitioners which is managed by the SAP. SAP is responsible for authorizing the sale of pharmaceutical, biologic, and radiopharmaceutical products that are not approved in Canada. Many second-line drugs used for the treatment of MDR-TB and XDR-TB are acquired through the SAP.

Clinicians may fax, phone, or write to the SAP, using the [SAP request form](#), 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.

Once the SAP application is approved, the clinician can order the medication from the manufacturer and the drug will be sent to the clinician's office or a pharmacy. See [Section 8.6.1 - Second-line TB Drug Coverage](#) to determine if the board of health should send a notification and/or request to the ministry for pre-approval to purchase the drug. Medications will be covered using the same reimbursement method used for all second-line drugs (see [Section 8.8 - Reimbursement for TB Drugs](#)).

- **Note:** The OGPMSS is not involved in purchasing medications approved through SAP.

8.7 Availability of Adjunct Therapies

Occasionally, clients may require additional medications to assist in the management of their TB treatment (i.e., management of side effects from TB drugs). Generally, pre-approval from the ministry for the board of health to purchase these medications is not needed. If the cost of the medication exceeds \$25,000 for the duration of treatment, the board of health should notify the ministry at IDPP@ontario.ca prior to purchasing the adjunct therapy. The medications will be covered using the same reimbursement method used for all second-line medications (see [Section 8.8 - Reimbursement for TB Drugs](#)).

8.8 Reimbursement for TB Drugs

In circumstances where first-line oral suspension drugs, second-line drugs, and/or adjunct therapies are required, a clinician 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. Some clients may have private insurance that covers the bulk of their medication costs. If the medications are not fully covered by private insurance, the board of health can cover the remaining costs of the medication and seek reimbursement from the ministry for these costs. The board of health can then submit an invoice for reimbursement to the ministry at IDPP@ontario.ca. The medication receipts and following information should be included as part of an invoice:

- 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 **personal health information** on documents that are being shared with the ministry **should be carefully redacted** (i.e., 'blacked out') in accordance with the [Personal Health Information Protection Act \(PHIPA\)](#).¹⁴

Additional Reimbursement Information:

- 1) Reimbursement will include the dispensing fee and medication costs for the 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).

8.9 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 client's clinical status, comorbidities, and concomitant drug therapy. For information on therapeutic drug monitoring, see [CTBS, 8th Edition: Chapter 5: Treatment of tuberculosis disease](#).

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](#).

8.9.1 Pre-Approval for Therapeutic Drug Monitoring Coverage

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 clinician 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 ministry's **Laboratories and Genetics Branch, Out of Country Program** 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 clinician completes and submits the application form electronically.

9 Immigration Screening for TB

9.1 Pre-entry Immigration Medical Exam (IME) Process

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:

- 1) Danger to public health;
- 2) Danger to public safety; and
- 3) Excessive demand on health and social services.¹⁰

Individuals applying for a Canadian visa, permanent residency, refugee status, or citizenship have an Immigration Medical Exam (IME) in part to rule out active pulmonary TB disease prior to arriving in Canada. If active pulmonary TB disease is ruled out but there is evidence of inactive pulmonary TB (see [Section 9.1.2 - 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 TB medical surveillance (TBMS) 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., individuals applying for student, worker, and visitor visas) 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 who have visited or lived in a country with a high TB incidence for more than 6 months during the 1 year immediately preceding the date application for residency is made.

9.1.1 IME Process - General

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

The IME must 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 includes any or all of the following:

- 1) Medical history;
- 2) Physical examination;
- 3) Mental examination;
- 4) Laboratory testing:
 - a) Urinalysis for applicants > 5 years of age; and
 - b) Syphilis and HIV serology for applicants ≥15 years of age.
- 2) Diagnostic testing:
 - a) Chest x-ray for applicants ≥11 years of age; and
- 3) Medical assessment of records respecting the applicant.

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 from the date it was assessed by the RMO; 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 9.4 – Common Issues in Immigration Medical Surveillance Follow-up](#)).

9.1.2 IME Process - TB Specific

All applicants ≥11 years of age must have a chest x-ray as part of the IME to detect active pulmonary TB; children <11 years of age may also be required to have a chest x-ray if they are in a defined **TB high-risk group**:

- 1) Close contact with an active TB case in the previous 5 years;
- 2) HIV-positive serology;
- 3) History of certain head and neck cancers within the previous 5 years;
- 4) Dialysis or advanced chronic kidney disease (eGFR <30 mL/min/1.73 m²);
and/or
- 5) Solid organ or bone marrow transplant and on immunosuppressant therapy.⁴

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 TBMS is required.⁴

Individuals in a defined [TB high-risk group](#) (see above) are at higher risk for TB reactivation and must also be screened for TBI with the following tests:

- 1) If ≥2 years of age: IGRA testing (or TST if IGRA unavailable)
- 2) If <2 years of age: TST.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;
- 3) Stable and/or improving chest x-rays.

Inactive pulmonary TB

Applicants identified as having inactive pulmonary TB are permitted to enter Canada, however, they have a 'condition of entry' placed on their visa requiring them to complete post-landing TBMS.

The criteria for a post-landing TBMS referral includes:

- 1) Previously treated TB
- 2) Inactive pulmonary TB on chest x-ray (after investigations to exclude active pulmonary TB)
- 3) Extrapulmonary tuberculosis
- 4) Household/close contacts of persons with active pulmonary TB within the previous five years
- 5) Individuals with a reactive pre-landing IGRA or TST who are at high risk for TB reactivation (e.g., chronic kidney disease, HIV, history of certain head and neck cancer in previous 5 years, solid organ or bone marrow transplant recipients who are on immunosuppressive therapy)

Referred persons must report to, or be contacted by, a public health authority within:

- 30 days of landing for inactive TB (non-urgent TBMS, S-code 2.02); or
- 7 days of landing for urgent cases of inactive TB or extra-pulmonary TB (complex/urgent TBMS, S-code 2.02U).

Additional information can be found in the [CTBS, 8th Edition; Chapter 13: Tuberculosis surveillance and tuberculosis infection testing and treatment in migrants](#).

9.2 TB Medical Surveillance Requirements for Pre-entry IME

9.2.1 Notification to Applicant of TBMS Requirements

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 TBMS as a 'condition of entry' on their visa.

A *Medical Surveillance Undertaking* form (i.e., the IMM0535B form) is given to the applicant, along with instructions.

- 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.

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.

Note: 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* upon their return. See [Section 9.2.5 - Compliance and the Medical Surveillance Reporting Form](#) for further instructions regarding compliance.

9.2.2 Notification to PHO of Persons referred for TBMS in Ontario

Staff within the Migration Health Branch of IRCC upload the *Medical Surveillance Undertaking* form and additional documents from the IME (e.g., chest x-ray, laboratory results, medical history etc.) as available to the Provincial/Territorial Public Health Authority web portal for those required to undergo post-landing TBMS in Ontario (i.e., those who provide an Ontario residential address as their intended location).

9.2.3 Notification to the Board of Health of Persons referred for TBMS in Ontario

PHO's TB program staff download the *Medical Surveillance Undertaking* form and available IME documents for each client from the web portal and create 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 available IME documents to the appropriate board of health via iPHIS referral.

9.2.4 Board of Health Initiates Post-Landing TBMS

The board of health shall attempt to initiate and continue TBMS until the person has been discharged (i.e., until the assessment for active TB has been completed). The board of health is responsible for facilitating TBMS with the primary goal of ensuring assessment and early diagnosis of active TB disease.

When the board of health receives a TBMS referral from PHO via iPHIS the board of health should implement the recommendations outlined in [Appendix 5: Conducting a Public Health Investigation for Immigration Medical Surveillance](#).

9.2.5 Compliance and the Medical Surveillance Reporting Form

In order to have the medical surveillance 'condition of entry' removed from the client's visa, IRCC must receive confirmation that the client is in compliance with their TBMS requirements. In Ontario, this is defined as:

Completing an assessment for active pulmonary TB by a physician/health care provider. This assessment includes at minimum:

- 1) A physical exam, including a TB symptom check, and a detailed health history (including assessment for previous TB diagnosis/treatment and relevant risk factors); and

- 2) Any diagnostic testing (i.e., chest x-ray, sputum smear microscopy and culture) deemed necessary by the physician/health care provider to effectively rule out active TB.

Additionally, assessment for TBI for individuals in a [TB high risk group](#) is strongly recommended. The health care provider may also assess for TBI in individuals who are not in a TB high risk group, considering testing in those who may benefit from treatment, as per the [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#) and [CTBS 8th Edition; Chapter 13: Tuberculosis surveillance and tuberculosis infection testing and treatment in migrants](#).⁴

The board of health shall update the client's Episode Status in iPHIS according to whether the client has met/not met IRCC's medical surveillance requirement, and a Medical Surveillance Reporting Form (MSRF) should be submitted to PHO via iPHIS. See [Appendix 5: Conducting a Public Health Investigation for Immigration Medical Surveillance](#) for instructions on how to submit the MSRF.

9.2.6 Notification of TBMS Compliance to IRCC

When PHO receives the MSRF from the board of health confirming the client's TBMS condition of entry has been/has not been met, PHO notifies IRCC directly in the web portal. If compliance is met, the condition of entry will be removed from the client's immigration file. If compliance is not met, the condition of entry will remain until compliance can be met.

9.2.7 Discharging the Client from TBMS

Once assessment for active pulmonary TB has been completed (utilizing information outlined in the [CTBS, 8th Edition; Chapter 3: Diagnosis of tuberculosis disease and drug-resistant tuberculosis](#)), the client can then be discharged from TBMS (i.e., they do not require further public health follow-up for the purposes of TBMS).⁴ The TBMS iPHIS episode can then be updated and closed accordingly. Any further clinical follow-up recommended by the assessing health care provider, including repeat radiology or TPT should be managed per usual board of health protocols for suspect/confirmed active TB or TBI and entered in the appropriate iPHIS episode as per the iPHIS User Guide.

9.3 Clients Diagnosed with Active Pulmonary TB on an in Canada IME

For individuals who complete their IME in Canada, the panel physician will complete the IME and assess the individual to rule out active pulmonary TB. Since these persons are being screened only after arrival in Canada active pulmonary TB may be detected. In these instances:

- 1) The panel physician will notify IRCC and must report to the board of health as per [Section 25\(1\)](#) of the HPPA;
- 2) IRCC will notify PHO by email that a client has been diagnosed with active pulmonary TB on their in Canada IME and upload the IMM0535B form (with 'S' code 2.01) and available IME documents via the web portal.
- 3) Upon receipt of the IMM0535B and IME documents, PHO will telephone the board of health involved to notify them of the person with active pulmonary TB disease in their jurisdiction and send these documents via a high priority iPHIS referral.

9.4 Common Issues in Immigration Medical Surveillance Follow-up

9.4.1 In Canada IME Referrals

Individuals who complete their IME in Canada have already been assessed for active TB within Canada. As such, it is at the board of health's discretion as to whether or not they will require the individual to undergo further assessment.

PHO continues to receive the IMM0535B form and available IME documents from IRCC for clients who had their IME in Canada; however, only the IMM0535B form and the eMED (Health Case Details) documents will be sent to the board of health via iPHIS referral. If necessary, the board of health can request additional IME documents (as available from IRCC) for these clients by sending an email to PHO's TB program (tb@oahpp.ca) and providing the client's unique client identifier (UCI).

9.4.2 Self-Referrals

In some instances, a client may self-report to a board of health prior to the board of health having received a referral from PHO. Possible reasons for this include:

- The client self-reports prior to PHO having received the referral from IRCC;
- The client has not provided IRCC with a valid Canadian address (i.e., the client requires TBMS, but IRCC does not know which province to send the referral);
- The client has not been assessed as requiring TBMS based on their IME.

When a client self-reports (regardless of whether the client has a completed IMM0535B form), the board of health should notify PHO by sending an email to the TB program (tb@oahpp.ca) with the client's unique client identifier (UCI). If the UCI is unknown, the board of health should provide the client's name and date of birth via iPHIS referral (i.e., do not send personal identifying information by email).

Upon notification of a client who has self-reported, PHO will contact IRCC to 1) confirm if TBMS is required for this client and 2) notify them that the client is in Ontario.

If IRCC confirms that TBMS is required, they will upload the client's IMM0535B and available IME documents to the web portal. PHO will then download the documents and send the referral to the board of health via iPHIS referral. Boards of health are strongly discouraged from creating the client's iPHIS record and initiating medical surveillance until they have received confirmation from PHO that TBMS is required.

9.4.3 Repeat Referrals

If a person is required to undergo another IME but was in compliance with a previous medical surveillance undertaking, IRCC will apply a new 'S' code of 2.06. Persons assessed with an S-code of 2.06 are not required to complete a new medical surveillance assessment and as such, IRCC will no longer submit their documents to the web portal.

If, however, a person is required to undergo another IME but was NOT in compliance with a previous medical surveillance undertaking, IRCC will continue to send the IMM0535B form and available IME documents to PHO via the web portal

which will then be sent to the board of health via iPHIS referral. The board of health shall initiate TBMS as per standard process to achieve compliance.

9.4.4 Person Moves Prior to Completing Medical Surveillance

If person changes jurisdictions within Ontario:

- 1) The board of health shall notify the receiving board of health by updating the client's contact information (i.e., address and telephone number) in iPHIS and sending them the IMM0535B and available IME documents via iPHIS referral.

If the person moves out of Ontario (including outside of Canada):

- 1) The board of health shall notify PHO by updating the client's contact information and Episode Status to 'Closed: Referred to MOHLTC' as per the iPHIS User Guide) and submitting an MSRF to PHO via iPHIS;
- 2) PHO will notify IRCC (do not submit an interjurisdictional notification [IJNI]).

Notes:

- IRCC will not accept a change of address information from anyone other than the client directly. Therefore, if a client moves within or outside of Ontario or Canada, boards of health should remind the client to contact [IRCC](#) to provide them with their updated address information.
- For clients that move outside of Ontario after completing their medical surveillance requirements, an IJN is only to be submitted to PHO if follow-up is required by the receiving jurisdiction (e.g., the client is on treatment for active TB or TBI, repeat chest x-rays or TST is required). Also, note that the IMM0535B and available IME documents received by the board of health via iPHIS referral from PHO are not to be shared with other jurisdictions as per the Data Sharing Agreement between IRCC and the ministry.
- If a client moves after completing their medical surveillance requirements (i.e., they are in compliance), the board of health should (if not already done) update the client's Episode Status to 'Open: Follow-up Complete' or 'Closed: Follow-up Complete' and submit the MSRF to PHO via iPHIS. There is no need to send any separate notifications to PHO/IRCC.

9.4.5 If Person is Pregnant:

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

9.4.6 If Person is Deceased:

As per the iPHIS User Guide, the board of health should:

- 1) Enter the date of death in the 'Date of Death' field in the Demographic Details;
- 2) Enter the date of death in the 'Date of Death' field in the TB Episode Details and select the appropriate option from the 'Cause of Death' dropdown list.
- 3) Update the Episode Status to 'Closed-Follow-up Complete' and submit the MSRF to PHO.

10 TB Health Promotion and Prevention

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

For more information related to health promotion principles, see [Appendix 6: TB Health Promotion and Prevention](#).

10.2 TB Prevention and Screening of High-Risk Settings and/or Populations

The [Tuberculosis Prevention and Control Protocol, 2018](#) (or as current) outlines the requirements that boards of health shall follow in relation to early identification of TB cases. Boards of health are encouraged to develop their own stakeholder engagement strategies to meet these objectives with support from evidence-based best practices.

10.2.1 Screening within Healthcare and Congregate Settings

Healthcare organizations and individual healthcare workers (HCWs) have a shared responsibility to apply effective TB infection prevention and care measures. All healthcare settings should have a TB management program supported at the highest administrative level. Boards of health can support healthcare organizations in considering local epidemiology when planning their screening activities.

Policies that consider application of the hierarchy of controls (i.e., 1) elimination; 2) substitution; 3) engineering controls; 4) administrative controls; and 5) personal protective equipment) are ideal for containing a hazard. Elimination of TB from a healthcare or congregate setting is not always possible, but effective treatment for respiratory TB is equivalent. Substitution is not a relevant approach to preventing transmission of TB.⁴

Administrative control policies for **health care worker** testing and treatment for TB infection should consider the recommendations and good practice statements outlined in the [CTBS, 8th Edition; Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#):

- Recommendations:

- We strongly recommend that all health care workers should have a baseline TB screening, including:
 - an individual risk assessment that identifies risks for TB (temporary or permanent residence in a high-incidence country, prior TB, current or planned immune suppression or close contact with someone who has had infectious TB since the last tuberculin skin test);
 - a symptom evaluation; and
 - a tuberculin skin test for those without documented prior TB disease or latent TB infection (good evidence).
 - We strongly recommend against routine periodic TB testing of all health care workers with negative baseline tuberculin skin test (good evidence).
- Good practice statements:
 - The tuberculin skin test is the preferred diagnostic test for pre-employment and periodic testing (if indicated) for TB infection among health care workers.
 - While **volunteers** should be screened for risk factors for latent TB infection, consideration could be given to performing a tuberculin skin test only in those who expect to volunteer at least one-half day/week or who have risk factors for latent TB infection.
 - A baseline 2-step tuberculin skin test should be done unless there is documentation of a prior negative 2-step test, in which case a single-step test should be done, and all results entered into the health care worker's health record.
 - All health care workers with a positive tuberculin skin test should be assessed for active TB disease, including a chest x-ray and a medical evaluation, including consideration for treatment of TB infection by a physician experienced in management of TB and latent TB infection; they should also be educated on the signs and symptoms of TB.
 - A tuberculin skin test should not be performed on a health care worker who was previously TST-positive or has prior documented TB disease.

- Health care organizations can consider whether periodic screening for selected health care workers is warranted based on their organizational risk assessment.
- Symptom evaluation for all health care workers should be performed by Occupational Health Safety and Wellness when an exposure is recognized and referral for medical assessment be made as required.
- The health care worker with a baseline negative tuberculin skin test should have another such test 8 weeks after exposure.
- Treatment of health care workers with latent TB infection is encouraged in the absence of contraindications to the recommended medications.

The above recommendations and good practice statements can also inform infection prevention and care policies and procedures for staff and volunteers working in **congregate settings**.⁴ For additional details, refer to the [CTBS, 8th Edition: Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#).⁴

For staff, baseline screening and periodic screening (if indicated based on local epidemiology) is not covered with the publicly funded supply of TST. The publicly funded supply should only be used for screening of contact persons exposed to active TB. See [Section 8.2.1 - Eligibility for Publicly Funded TST](#) for additional information.

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

2. Long-Term Care Homes (LTCHs)

The legislative requirements for TB screening is found in Paragraphs 1 and 4 of subsection 102(12) under [Ontario regulation 246/22](#) of the [Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1](#).

- **NOTE:** The legislation **does not** stipulate what method should be used to screen clients/staff.

TB Screening Recommendations:

Staff and volunteers: See [Section 10.2.1 Screening within Healthcare and Congregate Settings](#).

Residents: The good practice statements are outlined in the [CTBS, 8th Edition; Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#) and include:

- An assessment of likelihood of respiratory TB should be done on or before admission to a long-term care home.
- A symptom screen to rule out active TB should be done, preferably prior to, and on admission to a long-term care home.
- A posteroanterior and lateral chest x-ray should be performed **only if** a resident is symptomatic and the resident should be referred for medical assessment if indicated.
- Routine tuberculin skin testing on (or prior to) admission and periodic tuberculin skin tests (such as annually) are not recommended for residents.
- If a resident has had exposure to respiratory TB, the need for testing should be individualized as part of contact tracing.

See also [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#).

3. Retirement Homes

The legislative requirements for TB screening are found in Paragraphs b through d of subsection 27(8) under [Ontario regulation 166/11](#) of the [Retirement Homes Act, 2010, S.O. 2010, c. 11 \(RHA\)](#).

- **NOTE:** The legislation does not stipulate what method should be used to screen clients/staff.

The principles and recommendations for preventing transmission of TB in healthcare settings described in the [CTBS, 8th Edition; Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#) can inform TB infection prevention and care policies and procedures for congregate settings, including retirement homes.

TB Screening Recommendations:

Staff and volunteers: See [Section 10.2.1 Screening within Healthcare and Congregate Settings](#).

Residents: See the good practice statements for residents under the LTCHs section above.

See also [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#).

4. Other Congregate Settings

In some congregate settings, such as shelters or drop-in centres for the homeless, correctional facilities, residential drug treatment centres, hospices, group homes, child care centres, home child care agency, etc., there may be a higher proportion of persons with risk factors that put them at greater risk for developing TB, with subsequent transmission to others.⁴ The principles and recommendations for preventing transmission of TB in healthcare settings, as outlined in the [CTBS, 8th Edition; Chapter 14: Prevention and control of tuberculosis transmission in healthcare settings](#), along with local epidemiology, can inform infection prevention and care policies and procedures for congregate settings.⁴

TB Screening Recommendations:

Staff and volunteers: See [Section 10.2.1 Screening within Healthcare and Congregate Settings](#).

- For **child care centres and home child care agencies**, section 57 in [O. Reg. 137/15: GENERAL](#) under [Child Care and Early Years Act, 2014, S.O. 2014, c. 11, Sched. 1](#) provides the legislative requirements for a health assessment and immunization as directed by the local medical officer of health.
- For **Children's Residence Licensees & Youth Justice Directly Operated and Transfer Payment Operated Custody/Detention Facilities**, section 100 in [O. Reg. 156/18: GENERAL MATTERS UNDER THE AUTHORITY OF THE MINISTER](#) under the [Child, Youth and Family Services Act, 2017](#) provides the legislative requirements for any immunization recommended by the local medical officer of health and a health assessment.

Residents: TB screening for residents is generally focused on the detection of persons with active TB disease (case-finding). All residents who show symptoms or signs of active pulmonary TB should be placed in airborne infection isolation (i.e., a single room with a closed door under additional precautions) and receive immediate medical assessment.

10.2.4 Screening of Other High-Risk Populations

For information on populations at higher risk of progression to TB disease, see "Table 2. Risk of TB disease and the incidence rate ratio of TB disease among different populations stratified by risk" in [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#). See [CTBS 8th Edition; Chapter 13: Tuberculosis surveillance and tuberculosis infection testing and treatment in migrants](#) for TB screening considerations in migrants.⁴

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Appendix 1: Roles and Responsibilities in TB Prevention and Care

1.1 The Ontario Ministry of Health (ministry)

To support boards of health in their efforts towards TB elimination, the ministry's Office of Chief Medical Officer of Health, Public Health (OCMOHPPH):

- 1) Establishes provincial standards for local TB Prevention and Care Programs and reviews and updates them, as required;
- 2) Designs and evaluates provincial TB prevention and care strategies;
- 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 Programs, in collaboration with Public Health Ontario (PHO) to:
 - a) Develop and recommend national policies; and
 - b) Facilitate the administration of TB Programs across boundaries.

This may include:

- 1) Consulting 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) Providing consultation to other divisions within the ministry (e.g., Long-Term Care Homes, Health Services) and other provincial ministries (e.g., Ministry of the Solicitor General, Ministry of Education, Ministry of Indigenous Affairs).

1.2 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 persons 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 manage infectious diseases;
- 7) Manages referrals for post-landing TBMS 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;
- 9) Provides and supports educational updates to groups and individuals involved in TB prevention and care, as needed; and
- 10) PHO Laboratory (PHOL) completes most of the mycobacteriology testing in the province.

1.3 Laboratories

Responsibilities of the laboratory/diagnostic facility in TB prevention and care:

- 1) Provide instructions to clinicians on the requirements for collection and submission of specimens for diagnostic testing;

- 2) Adhere to standards set by the [Institute for Quality Management in Health Care \(IQMH\) - Centre for Accreditation](#) in the collection, transportation, processing and retention of specimens;¹⁷
- 3) Report positive results promptly to the attending clinician who made the requisition and to the Medical Officer of Health (MOH) of the jurisdiction in which the person on which the test was performed resides;
- 4) Refer all client specimens suspected of *Mycobacterium tuberculosis* complex (MTBC) or positive acid-fast bacilli (AFB) cultures to the PHOL for identification and/or susceptibility testing;
- 5) When MTBC nucleic acid amplification (NAAT) is not available, refer all AFB smear positive specimens to PHOL for: (i) new, untreated patients and (ii) patients with no MTBC positive cultures for the past three years;
- 6) Interpret results for health professionals and board of health staff as required; and
- 7) Consult with and educate health care providers, as needed.

1.4 Federal Government

The Federal [Quarantine Act](#), revised in 2005, is a federal legislation that covers a schedule of 25 diseases, including active pulmonary tuberculosis. The purpose of the Act is "to protect public health by taking comprehensive measures to prevent the introduction and spread of communicable diseases."¹⁸ It applies to all international travellers and conveyances arriving or departing from any port entry/exit in Canada, providing Quarantine Officers with the ability to screen and assess international travellers. Further, Quarantine Officers can take various actions under the *Quarantine Act* in order to prevent the spread of communicable diseases, including:

- 1) Issuing a Report to Public Health Authority, when there is a suspicion of communicable disease (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.

1.5 First Nations and Inuit Health (FNIH) TB Prevention and Care in Ontario Region: Multi-jurisdictional Partnerships in Ending TB

Although healthcare is a provincial responsibility, Indigenous Services Canada (ISC) First Nations and Inuit Health Branch (FNIHB) – Ontario Region is responsible for funding or directly providing services to Indigenous communities that supplement the mandatory programs provided by boards of health under the Ontario Public Health Standards, including health protection. Response to a disease of public health significance in a First Nation community may be supported by FNIHB-Ontario Region and/or the local board of health.

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

Note: Under the [Health Protection and Promotion Act \(HPPA\)](#), a band council may enter into an agreement with a local board of health for the provision of health programs and services in community in exchange for the band council having representation on the local board of health. For more information, see [Relationship with Indigenous Communities Guideline, 2018](#) (or as current).

1.5.1 Communication between Local Board of Health and FNIHB-Ontario Region Health Protection Unit Staff and/or Community Health Nurses

Communication between the respective partners is essential to support the appropriate and complete follow up of active TB cases or TBI. Indigenous people who are diagnosed with either active TB or TBI may live both in and out of

community during their course of treatment and, as such, are at risk of being lost to follow up. This applies as well to a non-Indigenous individual living in community, e.g., teachers or nurses.

Therefore, communication between FNIHB-Ontario Region Health Protection Unit staff, Community Health Nurses[‡], applicable Indigenous health services agencies, the local board of health, and the treating clinician is essential for TB case and contact management. Participation in rounds or case consults may support communication and knowledge exchange between the partners, as well as support a person-centered approach. Communication and sharing of information may also support continuity of care for clients moving out of community to a different board of health jurisdiction. Further information can be obtained from [iPHIS bulletin #13 – Transfer Client Responsibility](#).⁷ If the local board of health would like to request a consult with a Public Health Physician at FNIHB-Ontario Region, they may fax their request to 1-807-343-5348.

The follow up of TB cases and TBI depends on the community and whether they work primarily with ISC or the local board of health for TB case and contact management. The local board of health collects TB case and contact person information and enters it into the provincial iPHIS data base, whereas FNIHB does not have access to iPHIS. As such, exchange of information occurs through verbal or written reports between the local board of health and the FNIHB-Ontario Region Health Protection Unit staff and/or the Community Health Nurse.

All individuals living in community and assessed in community as having TBI, as well as all probable/suspected and confirmed cases of active pulmonary and extra-pulmonary TB are to be reported by the FNIHB-Ontario Region Health Protection Unit staff and/or the Community Health Nurse to the respective local board of health as soon as possible.

[‡] Community Health Nurses may be employed by ISC, the community, or an Indigenous health services organization.

All individuals living in community and assessed out of community as having TBI, as well as probable/suspected and confirmed cases of active pulmonary and extrapulmonary TB are to be reported by the local board of health to the FNIHB-Ontario Region Health Protection Unit staff and/or the Community Health Nurse, if the local board of health is not conducting case and contact management. The local board of health should initiate case and contact management while the client is out of community and provide updates to the FNIHB-Ontario Region Health Protection Unit staff and/or the Community Health Nurse to support case and contact management in community.

Appendix 2: Additional Tools for Case Management

2.1 Case Management

2.1.1 Conducting an Initial Public Health Investigation

- 1) Within one business day of notification of the case, the board of health shall contact the clinician (or designate), PHOL or other laboratory that has completed the specimen testing, or review the client's file in Connecting Ontario Clinical Viewer, if possible, to obtain the following details (including whether or not the individual is already in airborne infection isolation, if necessary):
 - a) Confirmation if treating clinically or if bacteriological evidence;
 - b) Confirmation if the clinician who initially assessed the client will treat the client or if the client has been/will be referred to a TB specialist (respirologist or infectious disease physician);
 - c) Client 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) Treatment regimen (review for weight-based dosing);
 - h) Plans to acquire laboratory results:
 - i) Sputum smear microscopy for AFB;
 - ii) NAATs;
 - iii) Culture and/or pathology reports;
 - iv) Drug susceptibility testing;

- v) Initial liver function tests (LFTs); and
 - vi) Pathology.
 - i) Radiography results (within last three months);
 - j) Has patient been informed of diagnosis and isolation needs; and
 - k) Next appointment date.
- 2) The board of health shall contact the client as soon as possible to arrange a home visit⁵ to assess, educate, and counsel the client focusing on the items below:
- a) Explain the board of health role and collaboration with treating clinician and provide contact information
 - b) Assess the client's understanding of their diagnosis, treatment regimen, and isolation needs and answer any questions they have. Provide psychosocial support.
 - c) Assess the client's social supports and social determinants of health and any assistance they may require adhering to treatment (e.g., transportation to medical appointments)
 - d) Collect relevant demographic information, including eligibility for medical insurance
 - i) Refer to [Appendix 4: TB Diagnostic and Treatment Services for Uninsured Persons \(TB-UP\) Program](#) for information on services available for individuals not covered by provincial insurance or private health 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;

⁵ Whenever possible, the first visit with the person with TB should be conducted face-to-face in a well-ventilated area. As long as the person with TB remains infectious, a fit tested N95 respirator should always be worn by board of health staff.

- h) Assess the client's understanding and beliefs about TB;
- i) Advise about side effects of TB medication;
- j) Assess the client's ability to adhere with medication and medical follow-up;
- k) Assess need for DOT using available tools listed in [Appendix 2.2: Sample DOT Assessment Tool](#).
- l) If infectious, explain the need for isolation precautions and process for discontinuing isolation precautions;
- m) Where possible, educate the client and their family/social supports about:
 - i) The disease process, including communicability and transmission factors;
 - ii) The need for isolation in cases of suspected active TB;
 - iii) Treatment protocol and side effects;
 - iv) Necessity of adherence with treatment;
 - v) Necessity of adherence with medical follow-up appointments;
 - vi) Purpose of DOT if indicated;
 - vii) Necessity of continuing public health supervision; and
 - viii) The importance of identifying and screening high risk and close contacts.

For additional information on the diagnosis and treatment of active TB and/or latent TB infection, see [Section 5 - Diagnosis and Treatment](#).

2.1.2 Ongoing Follow-up

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

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.⁴

1) Contact the Client **

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

- a) At one month: Interview the client, 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.

2) Contact the Treating Clinician or their designate

It is strongly recommended that clients with active TB be assessed by their clinician at least monthly. As such, the board of health shall consider contacting the treating clinician or their designate monthly, or more frequently if collaborating on the management of issues (e.g., side effects), to obtain/discuss/review:

- a) Any changes in the treatment regimen;
- b) LFT results (if client is experiencing symptoms suggesting hepatotoxicity);
- c) Confirm the treatment regimen is consistent with recommendations of the CTBS 8th Edition and is based on results of sensitivity testing;
- d) Chest x-ray results;
- e) Eye examination results while on ethambutol;
- f) Attendance record at follow-up appointment;
- g) Smear and culture results;

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

- h) Provide any public health feedback on client status, including side effects and DOT adherence; and
- i) Confirm that the requirements of the section 22/35 order are being complied with if an order was issued.

2.2 Sample DOT Assessment Tool

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

ASSESSMENT FACTOR FOR DOT	NO	YES
Resistant to one or more TB drug		
Multidrug resistant (resistant to isoniazid and rifampin)		
Laboratory confirmed culture positive pulmonary TB		
Non-adherent with treatment		
Substance abuse (e.g., alcohol or drugs)		
Slow clinical improvement with treatment		
Other comorbidities (e.g., cancer, Chronic kidney disease on hemodialysis etc.)		
Transient/homeless/under-housed		
Persons who are too frail, elderly, impaired or forgetful to manage own care; no caregiver; mental health concerns		
Previous long term treatment failure. E.g., diabetes or hypertension medication non-adherence		
Prescription for intermittent therapy		
Flight risk		
Child/adolescent		
Person whose TB has reactivated		
Person who denies diagnosis of TB		
Person recently discharged from correctional facility		
Person who has difficulty swallowing pills		
Person who avoids government or authorities for fear of revealing immigration status		
Person under Section 22 Order or Section 35 Order under the HPPA		
Non-adherent with appointments		
Side effects with TB medications		
HIV positive		
Lack of trust of healthcare professionals		
No family clinician or consistent health care provider		
Immune compromised. E.g., diabetes or cancer		
Inadequate social supports; financial difficulties		
Language barriers		

2.3 Management of Persons with TB Who Travel

2.3.1 Management of Persons with Suspected or Confirmed Pulmonary TB Leaving Canada while still Infectious

For air travel, although the [Quarantine Act](#)¹⁵ may not prevent a person leaving Canada with TB, individual airlines may decide not to allow a person with infectious pulmonary TB to board the plane. Under the International Health Regulations (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.

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, and there is factual evidence to support this (i.e., travel plans are in place, such as a purchased airline ticket with confirmed travel dates), the board of health should educate the person on the risk of spread of TB and try to persuade them to change their travel plans until they are no longer infectious.^{††} If it is determined that the person may present a public health risk, the MOH may issue a [Section. 22](#) under the HPPA, R.S.O. 1990, c. H.7.

If a person with infectious pulmonary TB still plans 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 PHO healthprotection@oahpp.ca of a person with infectious pulmonary TB with intentions to travel internationally;

^{††} In most situations, the board of health can intervene with the airline to have booked tickets re-booked at no charge once the person is no longer infectious and safe to fly.

- 2) PHO will complete the Canadian Tuberculosis and Air Travel Reporting form available in the reporting forms section at [PHAC's For health professionals: Tuberculosis \(TB\)](#).¹⁹
- 3) PHAC 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).

2.3.2 Management of Persons 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, PHAC can take various measures (i.e., issue an IHR notification and/or place the person on a Canadian Border Services Agency [CBSA] Lookout List). The following steps should be taken to initiate this process:

- 1) The local board of health should consider notifying PHO at healthprotection@oahpp.ca of a person with infectious pulmonary TB with intentions to travel internationally;
- 2) PHO will complete the Canadian Tuberculosis and Air Travel Reporting form available in the reporting forms section at PHAC's [For health professionals: Tuberculosis \(TB\)](#).¹⁹
- 3) PHAC 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).

2.3.3 Transferring TB Case and Contact Person Information between Public Health Jurisdictions

People with active TB and contact persons of active TB cases will often travel, either temporarily or permanently, from one jurisdiction to another.

Transfers to Jurisdictions within Ontario

- 1) Information on cases and/or contact persons that live in Ontario but outside of the board of health should be sent via iPHIS to the appropriate responsible board of health (where the case/contact person resides).
- 2) The receiving board of health should notify the referring board of health if the person is lost to follow-up in the transfer process.
- 3) 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

Transfers to Jurisdictions Outside Ontario and Canada

- 1) Boards of health should complete an Interjurisdictional Notification ([IJN](#)) form (see form below) with the necessary information and send to PHO via iPHIS referral.
- 2) The PHO information clerks receive the referrals and forward the IJN 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.

Ontario Interjurisdictional Referral Form

Please use one form for each receiving health jurisdiction

Referring Public Health Unit:	
Sender Contact Information:	
Receiving Health Jurisdiction:	
Date Sent (DD-MMM-YYYY):	

Client Information:

Last name:		Given name(s):	
Gender:		Date of Birth: (DD-MMM-YYYY)	
Address:			
Phone number:			
Email address:			
Disease:		<input type="checkbox"/> Case	<input type="checkbox"/> Contact

Note: Please copy additional tables for multiple contacts, if needed.

Comments:

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The Ontario IJN referral form **is not** required for a confirmed case when **complete** client demographics are included on the laboratory report and no additional information is available.

2.3.4 Provision of TB Medications for Persons Leaving Ontario

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.

Boards of health should:

- 1) Provide a one month's supply of medication, or ensure the clinician provides a one month's supply of medication, and treatment details to a person with active TB who is leaving Ontario.
 - a) The person should confirm they will seek follow-up care in order to continue treatment.
 - b) If concerns about treatment adherence exist, boards of health, in consultation with the client's clinician, can provide more than one month's supply of medication.
- 2) Consult with PHO regarding a client intending to travel to ensure continuity of care:
 - a) Complete an [IJN](#) with all of the case's relevant information, including the client's contact information (e.g., cell phone number, email, Facebook, new address, etc.) and clinical details and send to PHO via iPHIS referral.
 - b) PHO will send the completed IJN to the appropriate public health authority in the province/territory the person is travelling to (if within Canada) or to PHAC if the person is travelling outside of Canada. PHAC will notify the national TB program in the country they are travelling.
 - c) Consider notifying PHO if the person indicates that they intend to return to Ontario but does not return when expected. PHO can notify the necessary public health authorities as deemed necessary.
 - The patient may have run out of medication and become infectious (or resistant to the existing treatment).

- The person may be denied re-entry into Canada until they provide documented proof of successful treatment completion and that they are not infectious.

Persons with TB Infection

While it is not necessary to hold to a stringent rule of “only one month’s supply of drugs” for TBI 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 consider:

- 1) Client adherence and individualizing the quantity of drug to supply;
- 2) Need for laboratory monitoring based on clinical status and co-morbidities;
- 3) Anticipated delay in linking with a clinician in a different jurisdiction; and
- 4) Likelihood of return to Canada.

2.4 West Park Healthcare Centre (WPHC)

2.4.1 Introduction

Toronto's West Park Healthcare Centre (WPHC) TB Service, located at: **82 Buttonwood Avenue, Toronto, M6M 2J4**, runs an outpatient TB clinic for management of uncomplicated and complex clients with active TB and TB infection.

WPHC is also the only provincially designated inpatient treatment centre for complex and/or difficult to treat TB. Collaboration between the local board of health, where the client primarily resides, and Toronto Public Health (TPH) ensures continuity of care while the client is an inpatient at WPHC. Board of health responsibility for the client, including whether the local board of health should transfer/refer the client to TPH via iPHIS referral, is determined between the local board of health and TPH on a client-by-client basis based on the client's needs, complexity, and anticipated length of admission. This may also include determining which board of health will provide incentives and enablers that support person-centred care while the client is an inpatient.

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. Clients that are usually seen at WPHC typically include those:

- 1) With drug-resistant, polyresistant, multidrug-resistant (MDR), extensively drug-resistant TB (XDR).
- 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).

2.4.2 West Park Healthcare Centre's Admission Policy for Patients Not Under Section 35 Orders

Outpatient TB Clinics

For referrals, please contact Unit Clerk, at (416) 243-3600, ext. 2180 or complete the [outpatient referral form](#) and fax to TB Outpatient Services at 416-243-3696.

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 Thursday mornings.

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 416-243-8397. Once received, the referral will be reviewed by the clinical team. At this time, admissions to WPHC occur Monday to Friday. Weekend admissions are reviewed on an urgent basis.

2.4.3 Discharge Planning for All Clients from WPHC

Discharge planning begins as soon as a person is admitted to WPHC. Discussions with WPHC and the health unit where the client is going to live after discharge should begin prior to admission to explore options and arrange person-centered care supports in the community, including DOT, to prevent treatment interruptions.

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

If clinical follow up is not arranged in the board of health jurisdiction where the client resides, clients will be followed by the WPHC Outpatient TB Clinic and return to clinic every four weeks after discharge until treatment is completed.

2.5 Issuing Orders under the HPPA

2.5.1 Section 22 Orders

The following situations illustrate when the board of health may consider issuing a Section 22 order:

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

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 to:
 - a. Confirm, alter, or rescind the decision of HSARB;
 - b. Exercise all of the powers of HSARB to confirm, alter, or rescind the order as the court considers proper; or
 - c. 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](#).

2.5.2 Section 35 Orders

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.

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

Notification to Stakeholders of a Section 35 Order Application

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 (TPH) where WPHC is located, and the WPHC's TB Service Care Coordinator, and advise them of the pending order;
- 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 WPHC) that meets the following criteria:
 - a) Can provide the required medical care/expertise and treatment;
 - b) Has a secure bed where the person may be kept without the possibility of leaving; and
 - c) Can provide negative pressure ventilation;
 - **Note:** 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;
- 4) Both the local hospital and WPHC must be included in the (draft) section 35 order presented to the judge.

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

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

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

WPHC can only admit clients during the week during business hours, and ideally not on Fridays. If a client is apprehended under a section 35 order outside of these times, and/or cannot be moved to WPHC within these times, the board of health will have to make alternative arrangements to detain and isolate the client until WPHC is able to admit them.

To initiate the formal intake process, the referring MOH will arrange a teleconference to alert the TB unit of the ministry, TPH AMOH-TB, the clinician currently treating the person with TB, and the WPHC Care Coordinator and WPHC Clinician in charge of the impending admission. The referring board of health is advised of the information and documentation required by WPHC to assess whether the WPHC TB service is the most appropriate facility to detain and treat the patient at the current time given the client'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) Client's first language; their ability to communicate in English;
- 5) If the client 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 person'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) Client's housing status/if they are precariously housed, 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) Client's willingness to undergo TB assessment and to take TB medications as prescribed by the WPHC TB Clinician; and
 - i) Potential for discharge barriers (e.g., homelessness, financial problems).

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

- **Note:** If it is determined that the client has a psychiatric condition or behavioural concerns, a full psychiatric assessment is required prior to admission. If the psychiatric status of the patient cannot be managed safely at WPHC, the clinician at WPHC will discuss this with the referring MOH so alternative plans can be made.

Once the person 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 and then mailed to WPHC.

Role of Toronto Public Health and WPHC regarding Patients under a Section 35 Order

All clients at WPHC who are under a section 35 order become the responsibility of TPH as the hospital is within the health unit's jurisdiction. Therefore, if a client being detained under a section 35 order leaves hospital property without permission, WPHC should notify TPH. TPH will then attempt to locate the client. WPHC will also notify the police of the missing client.

In the event a TB client 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 (See Extending a Section 35 Order/Certificate of MOH below). TPH will review Section 35 orders that are nearing expiry and arrange extensions of the orders, if necessary, in consultation with clinician at WPHC and the originating board of health.

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 TPH and WPHC). An order may be extended if:

- 1) The court is satisfied that the person continues to be infected with an agent of a virulent disease; and
- 2) That discharging them from hospital would present a significant risk to the health of the public.

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 client from the hospital or other facility prior to the expiry of the order. An attending clinician does not have this authority.

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

1) The individual is no longer infected (i.e., treatment is completed);

OR

2) Release of an individual no longer presents a significant risk to the community.

Before discharging a client from hospital, notify the MOH of the health unit where the client will reside after discharge to support continuity of care and follow-up.

Appendix 3: Additional Tools for Contact Management

3.1 Extrapulmonary TB Cases (Non-Infectious)

3.1.1 In a child less than 5 years of age

When active TB (whether pulmonary or extrapulmonary) is diagnosed in any child under 5 years old, a source case investigation to search for an infectious case close to the child is recommended. For further details, refer to the [CTBS, 8th Edition; Chapter 9: Pediatric tuberculosis](#).⁴

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

Extrapulmonary TB is not infectious unless there is concurrent pulmonary 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 pulmonary TB as appropriate for the particular case.

Source case investigations should generally not be undertaken for children 5 years and older or adults as the yield is very low.

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

3.2 Long Distance Public Transportation

3.2.1 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, 8th Edition; Chapter 11: Tuberculosis contact investigation and outbreak management](#).⁴

Additional resources include the WHO's [Tuberculosis and Air Travel Guidelines for Prevention and Control, 3rd Edition](#), and the [Canadian Guidelines for Contact Investigation Following Exposure to Tuberculosis during Air Travel, October 2019](#).^{22,23}

3.2.2 Train or Bus Contacts

If during the course of the contact investigation the case reports having travelled by public conveyance (i.e., bus, train) between board of health jurisdictions while infectious, the board of health shall notify PHO by email at healthprotection@oahpp.ca.

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

3.3.1 What is OUT-TB Web?

OUT-TB Web is a secure, internet-based geographic information system (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 MTBC isolate from each new case as part of the OUT-TB program. This program assists local boards of health by providing information that bridges across board of health jurisdictions, identifying cases of TB caused by genotypically identical and related MTBC strains, and helping to confirm suspected transmission, epidemiological links, and identify unsuspected transmission events.

3.3.2 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.

3.3.3 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.

3.3.4 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.

Appendix 4: TB Diagnostic and Treatment Services for Uninsured Persons (TB-UP) Program

4.1 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 (1) 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 clinicians, laboratories, and radiology service providers, for treating uninsured individuals. 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.

4.1.1 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 person of an active TB case; or
- 3) any other person considered at high risk and very high risk of developing active TB (see “Table 2. Risk of TB disease and the incidence rate ratio of TB disease among different populations stratified by risk” in [CTBS, 8th Edition; Chapter 4: Diagnosis of tuberculosis infection](#)) and as determined by the TB Program staff of the board of health,

AND

Not be covered by any public/private medical health insurance for TB services.

This includes persons such as the following:

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

Note: 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.

4.1.2 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 medical clinical (clinician) services (provided by clinicians 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 TBI; and
- 2) Medical clinical services which are provided by a clinician who is a specialist paid on a fee-for-service basis (e.g., respirologist, infectious disease clinician, internist, pediatrician, general or thoracic surgeon etc.) for services related to the diagnosis or treatment of TB or TBI.

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 TBI; and
- 2) Services provided by clinicians 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.

Note: Although inpatient stay/services are not routinely covered by the TB-UP program, 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 may contact the ministry at IDPP@ontario.ca to discuss the possibility of coverage for such cases.

4.2 Registration into the TB-UP Program

4.2.1 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 clinician, the TB control program staff at the local board of health may assist them in finding one.

4.2.2 Obtaining Application and Consent for the TB-UP Program

Applying for TB-UP at the board of health:

The board of health shall review the criteria outlined on the TB-UP application and consent form with the client by phone or in person. The client must sign the TB-UP application and consent form to be registered in the TB-UP program. The client can sign the form either at the office of the board of health, attending clinician's office, home, or hospital if client is on isolation.

Additionally, the board of health shall verify the individual's personal identification before the client signs the TB-UP application and consent form for the TB-UP Program. Acceptable forms of personal identification include:

- 1) Passport;
- 2) Landed immigration papers/student visa/work permit; or
- 3) Confirmation/referral from service agency (e.g., homeless persons).

Note: If the patient is registering for TB-UP remotely (i.e., not in person), the board of health may conduct the personal identification process via video call to ensure that the individual matches the form of personal identification that was provided.

Applying for the TB-UP Program from the Service Provider's Office/Clinic:

In general, the eligible client should register for TB-UP at the board of health office during regular business hours. However, the uninsured person may be seen by the service provider in their office or clinic first (i.e., a person may present due to symptoms compatible with TB). In this situation:

- 1) The clinician will call the local board of health to notify of uninsured persons meeting the TB-UP eligibility criteria and request a TB-UP application and consent form.
- 2) The board of health can fax or email a blank TB-UP application and consent form to the attending clinician's office or hospital out-patient clinic.

- 3) The TB Program staff at the board of health should consider confirming that the clinician, or their support staff, verified the individual's personal identification (acceptable forms of personal identification are the same as indicated in previous section).
- 4) The attending clinician, or their support staff, will review the criteria outlined on the TB-UP application and consent form with the patient and request the client's signature.
- 5) Once the consent form is signed it can either be mailed or faxed to the board of health for retention in the client's file. A faxed TB-UP application and consent form with the client's signature will be adequate for the board of health to register the client in the TB-UP program and initiate first mailing of the health care provider claim forms.

Process if Client 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.

4.2.3 Assigning the TB-UP Registration Number

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

- 1) Search for and select the client in iPHIS TB module; and
- 2) 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.

4.3 Instructions for Health Care Provider Claim Forms

4.3.1 Access to Health Care Provider Claim Forms

Downloading the Health Care Provider Claim Forms

The electronic English and French forms can be downloaded from the following links:

- 1) [English Form](#)
- 2) [French Form](#)

Ordering TB-UP Application and Consent and Withdrawal Forms

The 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."
 - 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

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).

The TB-UP Application and Consent form may be requested by the Claims Service Branch (CSB) if the CSB determines the client's services can be billed through OHIP (see [Appendix 4.5.1 Claims Service Branch](#) for additional information). However, the TB-UP withdrawal form will not be tracked by the Ministry.

4.3.2 Completing the Health Care Provider Claim Forms

Instructions can be found directly on the new TB-UP electronic claim form. For all TB-UP clients registered in the TB-UP program (i.e., who have a TB-UP registration number and claim form), **the attending clinician 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 the health care provider claim forms. Incomplete health care provider claim forms will be returned to the service provider by the CSB.
- 2) Confirm the clinician'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 because of treatment for TB disease/TBI. The diagnosis and treatment of unrelated diseases are not covered for payment under the TB-UP program.

Note: Part B of the health care provider claim form only allows for one provider's information to be entered, therefore each clinician or service provider requires their own claim form. A single health care provider claim form with multiple clinicians or service providers listed will be rejected.

Tips on Using TB-UP Electronic Claim Form:

- 1) The forms must be opened with Adobe Acrobat Reader to be fillable and to be issued the unique invoice code required for submission.
- 2) The invoice number is a 14-digit unique auto-generated identifier and should not be altered by the board of health or service provider, unless indicated by the Ministry of Health. The TB-UP module in iPHIS has been changed to allow up to 14-digits to be entered in this field and to accommodate forms being directly downloaded from a health care provider's office (i.e., a new option of "Forms downloaded by physician" has been added the "Invoice given to" field). The invoice number is used for tracking and monitoring health care provider claims.
- 3) It is important to note that the 'print form' button needs to be hit after each invoice refresh to generate a unique invoice.

Note: The pink triplicate form that was originally mailed back to boards of health will no longer be sent. The new electronic health care provider claim form will be saved with the CSB and boards of health will no longer need to enter payment information into iPHIS. This information is already made available to OCMOHPH on a monthly basis, which also accounts for situations where a clinician completes and submits the health care provider claim form without the board of health's knowledge. OCMOHPH will work with CSB to produce a monthly TB-UP claims summary so that boards of health can see all the claims that were processed within their jurisdiction for that given month. Boards of Health may request records of these TB-UP claim summaries from OCMOHPH at IDPP@ontario.ca.

4.3.3 Distribution of Health Care Provider Claim Forms

Once the patient is registered in the TB-UP program (i.e., assigned a TB-UP registration number), the board of health shall consider preparing, printing, and distributing a package of Health Care Provider Claim Forms to the attending clinician and/or the client.

The board of health will complete Part A of the health care provider claim forms and record the invoice numbers and the person to whom they gave the claim forms to in

the TB Uninsured Person Claim Form Details screen in iPHIS. This data will be included in the regular iPHIS reporting to the ministry for the purpose of monitoring and evaluating the TB-UP program.

This initial claim form package will consist of 6 Health Care Provider Claim Forms to cover the following services:

- 1) Three health care provider claim forms for clinician services (two forms to cover first and second (follow-up) visit with the attending clinician and one form to cover radiologist services); and
- 2) Three health care provider claim forms for laboratory services (e.g., for blood work or repeat sputum specimens; three claim forms may be required if three sputum specimens are obtained and tested on different days).

The number of claim forms provided for subsequent clinician visits 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 clinician.

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.

4.3.4 Submitting and Processing of Claims for the TB-UP Program

The TB-UP Claims Form may be submitted using one of the three following methods:

- 1) **Mail:** Forms can be mailed to the address listed on the form.
- 2) **Fax:** Forms can be faxed to (613) 237-3246
- 3) **Email (encrypted/password protected):** Clinicians can send the new forms via email to: CSBOttawa@ontario.ca.

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.

- 1) 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.
- 2) 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.
- 3) 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 OCMOHPH.

Reasons for a Health Care Provider Claim Form to be Rejected by CSB

The CSB may reject a claim submitted by a service provider for reasons such as the following:

- 1) Client was not enrolled in the TB-UP program at the time the TB service was rendered;
- 2) Client 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 is stale dated, i.e., claim received more than 6 calendar months after date of service;
- 6) 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

7) Service provider is not listed in the Ministry provider database.⁵

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 clinician /facility and will provide the necessary information to correct the claim. The clinician /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 CSB directly at CSBOttawa@Ontario.ca.

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 TB related service(s) for the uninsured client. Service providers must be licensed within their province of practice to be eligible for payment under the TB-UP program.

If 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 OCMOHPH to discuss the specific issue.

4.3.5 Additional Fields for iPHIS Entry:

Status Review Date (SRD)

The status review date (SRD) is the date when the insurance status of the client 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 client 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 client file two weeks prior to the SRD to determine if the client is now covered by OHIP or any other health insurance. Once the client is covered for TB services under OHIP or another health insurance plan, they will no longer be eligible for coverage under the TB-UP program. The client will then be discharged from the TB-UP program (see [Appendix 4.4: Withdrawal of a Client from the TB-UP Program](#)).

The SRD can be extended at the discretion of the board of health (i.e., If the client 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.

4.4 Withdrawal of a Client from the TB-UP Program

4.4.1 Process for Discharging the Client from the TB-UP Program

The client should withdraw from the TB-UP program at the board of health. If the client withdraws at the service provider's office.

Client 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 client 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 client. The client should be informed that once they have signed the TB-UP withdrawal form, the client 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 client has signed the TB-UP withdrawal form, the board of health TB control program staff will discharge the client from the TB-UP program. The signed TB-UP withdrawal form will be retained by the board of health in the client's file. The board of health will update the iPHIS TB Uninsured Person Registration Details and the TB Uninsured Person Claim Form Details screen as per the data standards:

- The board of health shall contact the attending clinician 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.

The board of health should attempt to contact the attending clinician to inform them of TB-UP client's discharge from the TB-UP program.

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

The TB-UP client may request to withdraw from the TB-UP program while in the service provider's office. The attending clinician may direct the TB-UP client to the board of health for withdrawal. Alternatively, the attending clinician may contact the local board of health to inform of client'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 clinician's office. The attending clinician, or their support staff, will review the form with the client.

The signed TB-UP withdrawal form can be mailed or faxed to the board of health for retention in the client's file. A faxed withdrawal form with client's signature will be adequate to initiate discharge from the TB-UP program. The board of health will then update the iPHIS TB Uninsured Person Registration Details as per the data standards.

4.5 Roles of Responsibilities of the Ministry of Health:

4.5.1 Claims Services Branch (CSB):

The CSB 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. If so, CSB will request a copy of the TB-UP Application and Consent form from the board of health to disclose the patient's OHIP number to the service provider so the claim can be submitted through OHIP;
- 3) Verify claims 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.

4.5.2 Office of Chief Medical Officer of Health (OCMOHPH)

The OCMOHPH will:

- 1) Establish provincial standards (i.e., TB-UP policies and procedures) for the TB-UP program, and review and update as required;
- 2) Share the following forms with the board of health:
 - a) TB-UP Application and Consent form;
 - b) TB-UP Healthcare Provider Claim 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 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 prevention and care .

4.6 Roles and Responsibilities of Public Health

Ontario:

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 client information on the submitted claim form corresponds to the client's 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.

Appendix 5: Conducting a Public Health Investigation for Immigration Medical Surveillance

When the board of health receives a TBMS referral from PHO via iPHIS the board of health shall consider:

- 1) Contacting the person by letter, telephone, e-mail or in person
 - a) Confirming TBMS requirement (i.e., S-code of 2.02 or 2.02U) on IMM0535B form.
 - b) Confirming client's demographics and contact information, including verification that the client is reporting to correct board of health.
 - i) If inconsistencies on the IMM0535B form are identified PHO does not need to be notified as long as the board of health updates the client's demographics in iPHIS accordingly.
 - c) Determining a suitable mechanism to provide the client with the required medical assessment form.
 - d) 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 (see '[How to submit a MSRF to PHO via iPHIS](#)' below).
- 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 TBI

- 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 pulmonary TB and that a client 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) Once the client has completed their medical surveillance requirement (i.e., they have been adequately assessed for active pulmonary TB), 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 TBI is not considered part of the IRCC TBMS requirement so reporting of compliance should not be delayed or postponed until this latter follow-up is completed.
 - ci) Determine current immigration status, if not previously included in iPHIS referral (i.e., permanent resident, visitor, student, temporary worker);
 - cii) 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 [9.4 – Common Issues in Immigration Medical Surveillance Follow-up](#))
 - ciii) If the person has no health insurance coverage and there is an indication of active pulmonary TB or that the person is a recent contact of a case of TB, the board of health shall consider referring the person for active case management/contact persons management as per the [Tuberculosis Prevention and Control Protocol, 2018](#) (or as current) and the [CTBS, 8th Edition](#). This includes:

- i) Referring them to TB Diagnostic and Treatment Services for Uninsured Persons Program (“TB-UP”) for immediate medical assessment (see [Appendix 4: 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 TBMS 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 (e.g., a history of BCG vaccination, previous exposures to TB, preventive or active TB treatment, positive TB skin tests or IGRA results);
 - c) Dates and results of chest x-ray and other appropriate radiological investigation, if clinically indicated;
 - d) Sputum collection for smear and culture for mycobacterium tuberculosis 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 IME;
 - g) Reporting requirements under the HPPA if active pulmonary TB disease or TBI are diagnosed;
 - h) Written recommendations regarding treatment/follow-up for TBI^{##}; and
 - i) Current recommendations if TBI treatment is refused or is medically contraindicated.

^{##} **NOTE:** For health care providers, this is a clinical opportunity (rather than an IRCC/TBMS requirement) to consider TBI testing and treatment, as appropriate and as per the Canadian TB Standards 8th Edition.

- 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 pulmonary 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 TBI, monitoring as per guidelines;
 - (V) If person is not on treatment for either active disease or TBI, 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 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) Remind the client to notify IRCC of their change in address;

- (II) Update the client's address in iPHIS as per iPHIS User Guide; and
 - (III) Change Episode Status to 'Closed: Referred to MOHLTC' 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 need to submit MSRFs (and/or referrals) to PHO via iPHIS. Notification to PHO is **not required** when:
- (I) TBMS episode has been created for client in iPHIS (i.e., episode status 'OPEN');
 - (II) The client leaves Ontario (either temporarily or permanently) **after** completing medical surveillance (i.e., compliance status has already been reported to PHO/IRCC);
 - (III) The client is diagnosed with TBI or active TB disease;
 - (IV) The client is hospitalized and/or dies; or
 - (V) 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 TBI. This does not need to be reported to PHO.

How to Submit a MSRF to PHO via iPHIS

- 1) Open the client's TB Medical Surveillance episode.
- 2) Ensure that the client's Episode Status has been updated to the appropriate selection from the following:
 - a) Open: Follow-up Complete
 - b) Closed: Follow-up Complete

- c) Closed: Untraceable
 - d) Closed: Follow-up Incomplete
 - e) Closed: Referred to MOHLTC
 - i) NOTE: 'Open' is the default Episode Status that is populated when the Medical Surveillance episode is created. It must be changed to the appropriate Episode Status prior to submitting the MSRF (i.e., do not submit a MSRF with an Episode Status of 'Open').
- 3) Select 'Medical Surveillance Reporting' from the dropdown list under the 'Episode' tab (in between the Client and Encounter tabs).
 - 4) Select 'New', ensure that all of the episode details are correct, and then click 'Submit'.

Appendix 6: TB Health Promotion and Prevention

6.1 TB Health Promotion

6.1.1 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 Program has adequate and current knowledge and skills related to TB including, but not limited to:
 - a) Diagnosis;
 - b) Treatment of active TB and TBI;
 - 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 working towards TB elimination;
 - 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;
 - p) Community clinics that support TB prevention and care services; and
 - q) 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 awareness and 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, with culturally relevant and appropriate messaging to the target population, including use of technology when feasible.

6.1.2 Community Systems Strengthening

Community development is a process by which the community:

- 1) Defines its own health needs;
- 2) Considers how those needs can be met; and,
- 3) Decides collectively on priorities for actions.

It is a commitment to:

- 1) Equality;
- 2) Community participation;
- 3) Valuing of lay knowledge;
- 4) Viewing problems as shared and empowerment of individuals/communities through education;
- 5) Skills development; and,
- 6) Joint action.¹⁸

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.

6.1.3 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) Championing TB Elimination efforts through participation in and/or leading activities, initiatives, and events that raise awareness about TB and foster collaboration and information sharing among stakeholders (e.g., World TB Day events);
- 3) Supporting and promoting public policy aimed at addressing SDOH that contribute to the prevalence of TB; and
- 4) Helping people with TB access appropriate and equitable health care services for follow-up, regardless of their insurance status or ability to pay for these services.

6.1.4 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.

6.1.5 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.

Document History

Revision Date	Document Section	Description of Revisions
August 2023	Entire document	Reorganized sections throughout. Updated hyperlinks.
August 2023	4 - TB: Ontario Context	Added information on the epidemiological context of TB in Ontario and considerations for serving Indigenous peoples.
August 2023	5.3.2 – Indications for Hospitalization	Added as per the CTBS 8 th Edition.
August 2023	6.2.2 - Directly Observed Preventive Therapy (DOPT)	New section describing the recommendations for the use of DOPT.
August 2023	8.3 - Rifapentine for 3HP TB Preventive Treatment (TPT)	New section describing rifapentine and the process for boards of health to order the drug.

Revision Date	Document Section	Description of Revisions
August 2023	8.6 - Availability of Second-line TB Drugs, and 8.7 - Availability of Adjunct Therapies	Removed the pre-approval process for requesting coverage.
August 2023	9.1.2 – IME Process - TB Specific	Updated information: TB high risk group.
August 2023	9.2 - TB Medical Surveillance Requirements for Pre-entry IME	Streamlined the section to organize the TBMS requirements based on the process and order in which interventions occur.
August 2023	10 - TB Health Promotion and Prevention	Added the good practice statements and recommendations from the CTBS 8 th Edition for TB screening.
August 2023	Appendix 1.5 – First Nations and Inuit Health (FNIH) TB Prevention and Care in Ontario Region: Multi-jurisdictional Partnerships in Ending TB	Updated information and processes.

Revision Date	Document Section	Description of Revisions
August 2023	Appendix 2.3.3 – Ontario Interjurisdictional Referral Form	Added
August 2023	Appendix 4 - TB-UP	Reflects the new process for using the online TB-UP Health Care Provider Claim Form and the TB-UP FAQ document.