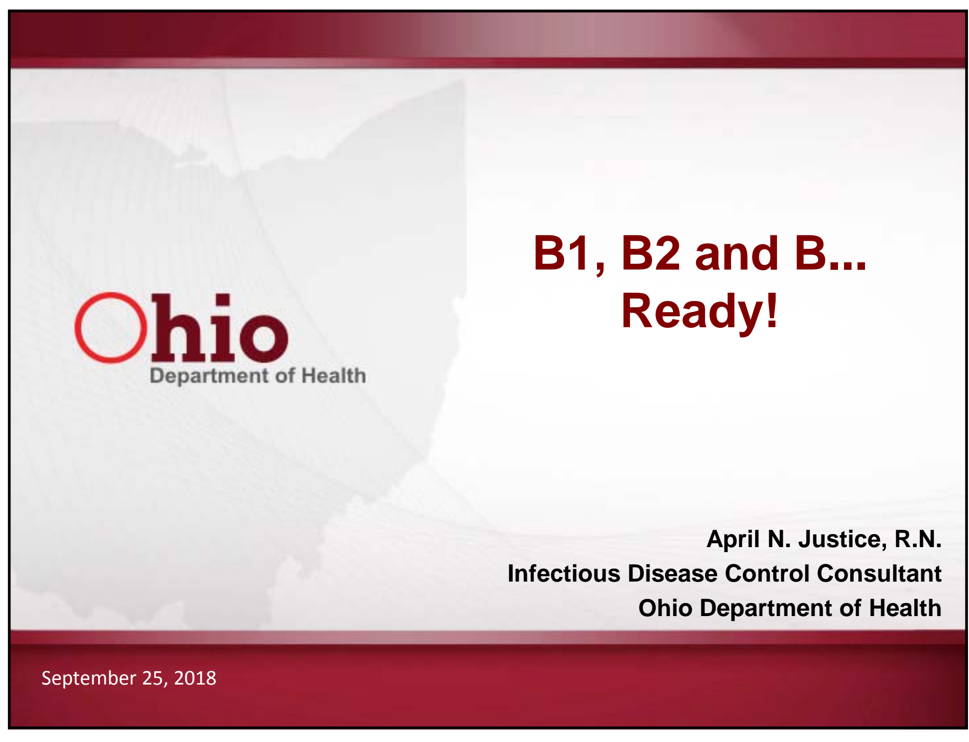

Contact Information

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Objectives

- Understanding the process of Immigration and Refugee Notifications
- Recognize TB classifications
- Discuss changes to the immigrant/refugee TB medical evaluation process
- Identify the TB high-burden countries

What are Immigrants and Refugees?

What is an Immigrant?

An immigrant visa (IV) is issued to a person wishing to live permanently in the U.S.

If person is in the U.S., they do **not** have to apply for an immigrant visa. Instead, they will apply for a Permanent Resident (Green) Card through an adjustment of status. The advantage of this is that the person won't have to return to their home country to complete visa processing.

If person is outside the U.S., they will apply for an immigrant visa through consular processing with a U.S. Department of State embassy or consulate abroad.

Immigration to the U.S.

https://www.uscis.gov/citizenship/

Ohio Department of Health

What is a Refugee?

Under United States law, a refugee is someone who:

- Is located outside of the United States
- Is of special humanitarian concern to the United States
- Demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group
- Is not firmly resettled in another country
- Is admissible to the United States

There is no fee to apply for refugee status. The information provided is not be shared with home country.

If approved as a refugee, person receives a medical exam, a cultural orientation, help with travel plans, and a loan for travel to the United States. After arrival, person is eligible for medical and cash assistance.

A Peek into the Medical Guidelines for Refugees

- Where they were born determines what type of medical screening and/or treatment is necessary before travel
- Rigorous medical testing is done on U.S. territory

Recommended for All Refugees	• Complete blood count with a white blood cell differential and platelets • Urinalysis (if old enough to provide a clean-catch urine specimen) • Infant metabolic screening in newborn infants, according to state guidelines
Recommended for Specific Populations	• Serum lipid profile • Cancer screening • Uric acid (for Hmong refugees)
Optional	• Serum chemistries and glucose

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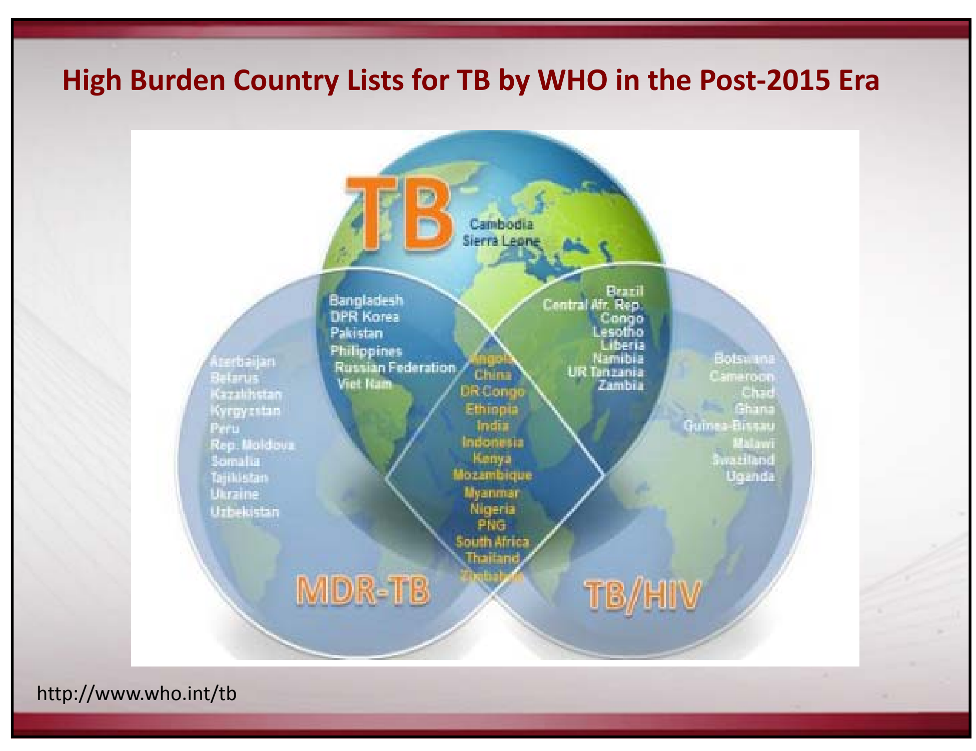
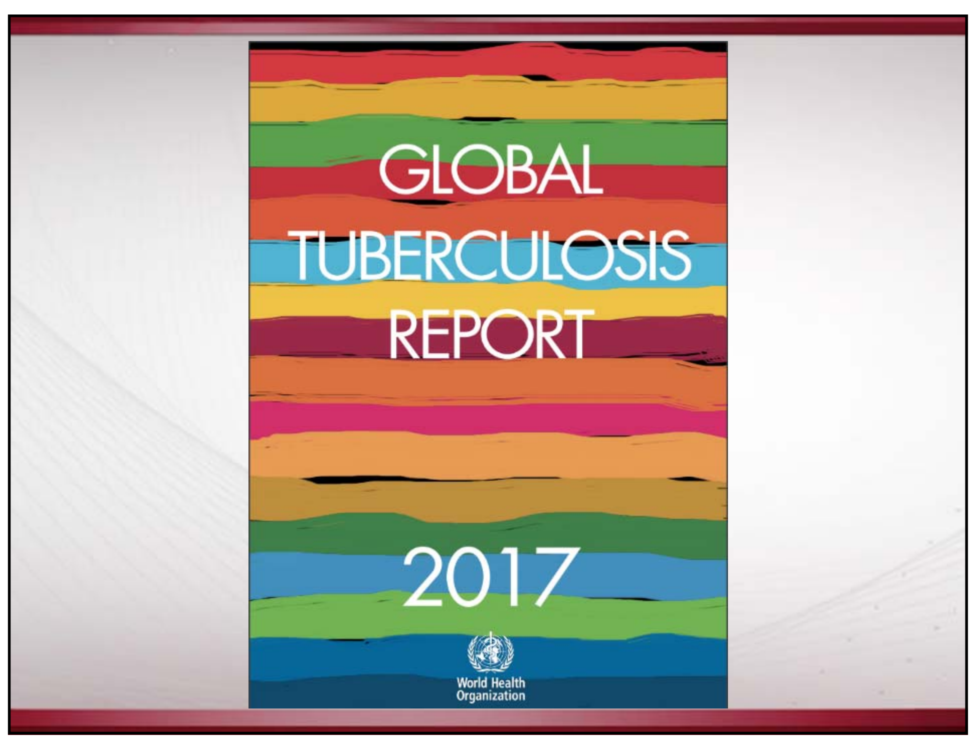
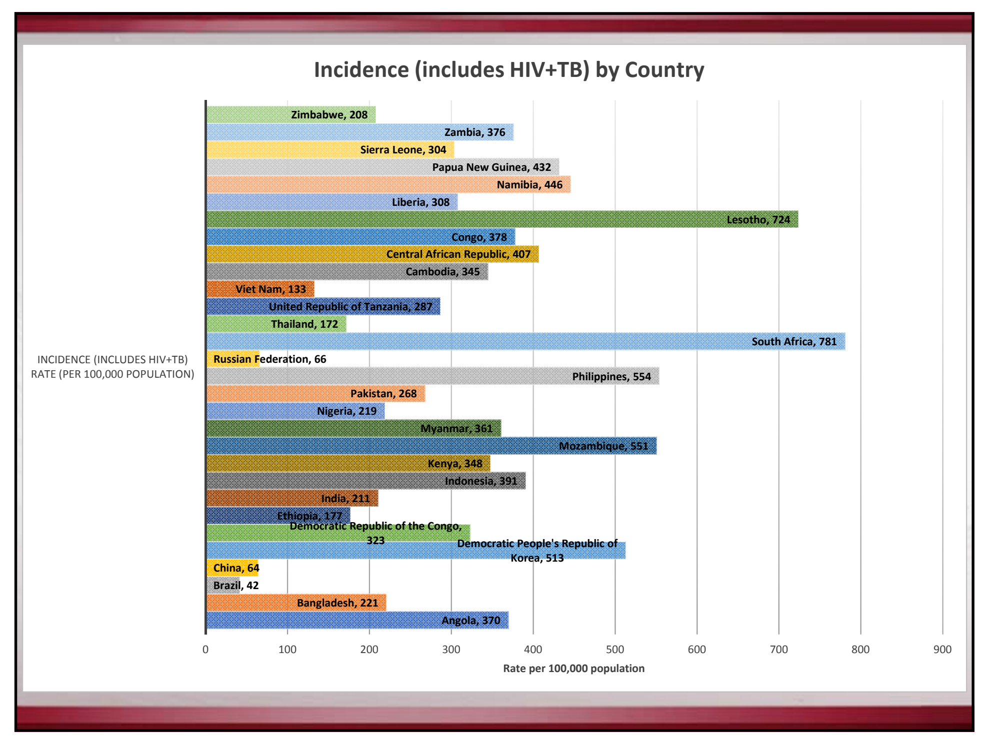

High Burden Country Lists for TB by WHO in the Post-2015 Era
TB
Cambodia
Sierra Leone
Bangladesh
DPR Korea
Pakistan
Philippines
Russian Federation
Viet Nam
Brazil
Central Afr. Rep.
Congo
Lesotho
Liberia
Namibia
UR Tanzania
Zambia
Azerbaijan
Belarus
Kazakhstan
Kyrgyzstan
Peru
Rep. Moldova
Somalia
Tajikistan
Ukraine
Uzbekistan
China
DR Congo
Ethiopia
India
Indonesia
Kenya
Mozambique
Myanmar
Nigeria
PNG
South Africa
Thailand
Botswana
Cameroon
Chad
Ghana
Guinea-Bissau
Malawi
Swaziland
Uganda
MDR-TB
TB/HIV
http://www.who.int/tb


GLOBAL
TUBERCULOSIS
REPORT
2017
World Health
Organization



Incidence (includes HIV+TB) by Country
INCIDENCE (INCLUDES HIV+TB) RATE (PER 100,000 POPULATION)
Zimbabwe, 208
Zambia, 376
Sierra Leone, 304
Papua New Guinea, 432
Namibia, 446
Liberia, 308
Lesotho, 724
Congo, 378
Central African Republic, 407
Cambodia, 345
Viet Nam, 133
United Republic of Tanzania, 287
Thailand, 172
South Africa, 781
Russian Federation, 66
Philippines, 554
Pakistan, 268
Nigeria, 219
Myanmar, 361
Mozambique, 551
Kenya, 348
Indonesia, 391
India, 211
Ethiopia, 177
Democratic Republic of the Congo, 323
Democratic People's Republic of Korea, 513
China, 64
Brazil, 42
Bangladesh, 221
Angola, 370
0
100
200
300
400
500
600
700
800
900
Rate per 100,000 population

Immigrant and Refugee Notifications and Follow-Up
Ohio
Department of Health

Medical Screenings

A medical examination is mandatory for all refugees coming to the U.S. and all applicants outside the U.S. applying for an immigrant visa.

Panel Physicians: Outside the U.S., medical examinations are performed by approximately 600 physicians (panel physicians) selected by U.S. Department of State consular officials.

Civil Surgeons: In the U.S., medical examinations are performed by approximately 5,000 physicians (called civil surgeons) designated by district directors of the USCIS.

The CDC Division of Global Migration and Quarantine (DGMQ) is responsible for providing the Technical Instructions to civil surgeons and panel physicians.

Why do we need TB Classifications?

TB classifications give information on whether an individual has active disease, evidence of disease, suspected latent TB infection, or is a contact to a recent known case of TB.

Classifications of TB

Class B1

Pulmonary

- No treatment (have had an exam or CXR suggestive of pulmonary TB, but three negative sputum)
- Completed treatment with negative sputum three times

Extrapulmonary

- Evidence with anatomic site documented

Class B2

LTBI Evaluation

- Applicants have had a positive skin test or positive IGRA

Class B3

Recent Contact to Known TB Disease Case

- Treat like a contact to a domestic TB case
- Not very common

Patient Follow-Up

The paperwork may look like everything is complete on the evaluation, but **REMEMBER…**

ALL B1 and B2 arrivals need at least a new diagnostic evaluation for active disease, including a TST, IGRA and chest x-ray.

What Are the Differences Between B1 and B2 Evaluations?

B1	B2
A person in this class is considered a TB suspect until they have completed follow up	**A person in this class is considered to have latent TB infection**
• Give an IGRA unless a documented positive test is available. • Perform a chest x-ray (CXR), regardless of CXR performed overseas. • Evaluate for signs and symptoms. • Review TB treatment history with the patient. • Collect sputum for testing (smear and culture to determine TB diagnosis).	• Give an IGRA unless a documented positive test is available. • Perform a chest x-ray (CXR), regardless of CXR performed overseas. • Review TB treatment history with the patient

Steps for Follow-Up

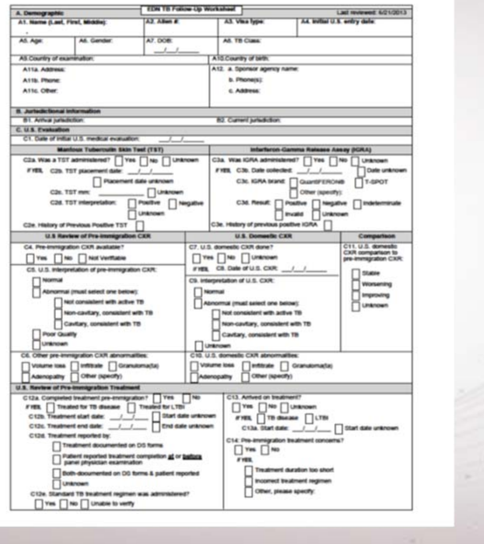
1. Check to see if the immigrant/refugee has already contacted the TB Control Unit.
2. If they have not, then make a telephone call to the home of the immigrant/refugee, sponsor or relative within five business days after receiving the notification. Arrange for the immigrant/refugee to come in during clinic hours at the health department and/or arrange for the patient to see a medical provider.

Follow-Up (cont.)

3. If the immigrant/refugee does not contact the TB Control Unit within 10 business days of the telephone call, send a letter to the home of the immigrant/refugee, sponsor or relative.
4. If the immigrant/refugee does not contact the TB Control Unit within 10 business days of the letter, make a visit to the home of the immigrant/refugee, sponsor or relative.

Follow-Up (cont.)

5. Complete all TB Follow-up Worksheet information. This form is essential for the state TB Program to conduct statewide surveillance, follow up on all B1 and B2 arrivals, and report results to the CDC.



EDN TB Follow-Up Worksheet

Last reviewed: 6/21/2013

A. Demographic

A1. Name (Last, First, Middle): | A2. Alien #: | A3. Visa type: | A4. Initial U.S. entry date:

A5. Age: | A6. Gender: | A7. DOB: __/__/____ | A8. TB Class:

A9. Country of examination: | A10. Country of birth:

A11a. Address:
A11b. Phone:
A11c. Other:

A12. a. Sponsor agency name:
b. Phone(s):
c. Address:

B. Jurisdictional information

B1. Arrival jurisdiction: | B2. Current jurisdiction:

C. U.S. Evaluation

C1. Date of initial U.S. medical evaluation: __/__/____

Mantoux Tuberculin Skin Test (TST)

C2a. Was a TST administered? ☐ Yes ☐ No ☐ Unknown
If YES, C2b. TST placement date: __/__/____ ☐ Placement date unknown
C2c. TST mm: ________ ☐ Unknown
C2d. TST interpretation: ☐ Positive ☐ Negative ☐ Unknown
C2e. History of Previous Positive TST ☐

Interferon-Gamma Release Assay (IGRA)

C3a. Was IGRA administered? ☐ Yes ☐ No ☐ Unknown
If YES, C3b. Date collected: __/__/____ ☐ Date unknown
C3c. IGRA brand: ☐ QuantiFERON® ☐ T-SPOT ☐ Other (specify):
C3d. Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ Unknown
C3e. History of previous positive IGRA ☐

U.S Review of Pre-immigration CXR

C4. Pre-immigration CXR available? ☐ Yes ☐ No ☐ Not Verifiable
C5. U.S. interpretation of pre-immigration CXR:
☐ Normal
☐ Abnormal (must select one below):
☐ Not consistent with active TB
☐ Non-cavitary, consistent with TB
☐ Cavitary, consistent with TB
☐ Poor Quality
☐ Unknown

U.S. Domestic CXR

C7. U.S. domestic CXR done? ☐ Yes ☐ No ☐ Unknown
If YES, C8. Date of U.S. CXR: __/__/____
C9. Interpretation of U.S. CXR:
☐ Normal
☐ Abnormal (must select one below):
☐ Not consistent with active TB
☐ Non-cavitary, consistent with TB
☐ Cavitary, consistent with TB
☐ Unknown

Comparison

C11. U.S. domestic CXR comparison to pre-immigration CXR:
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

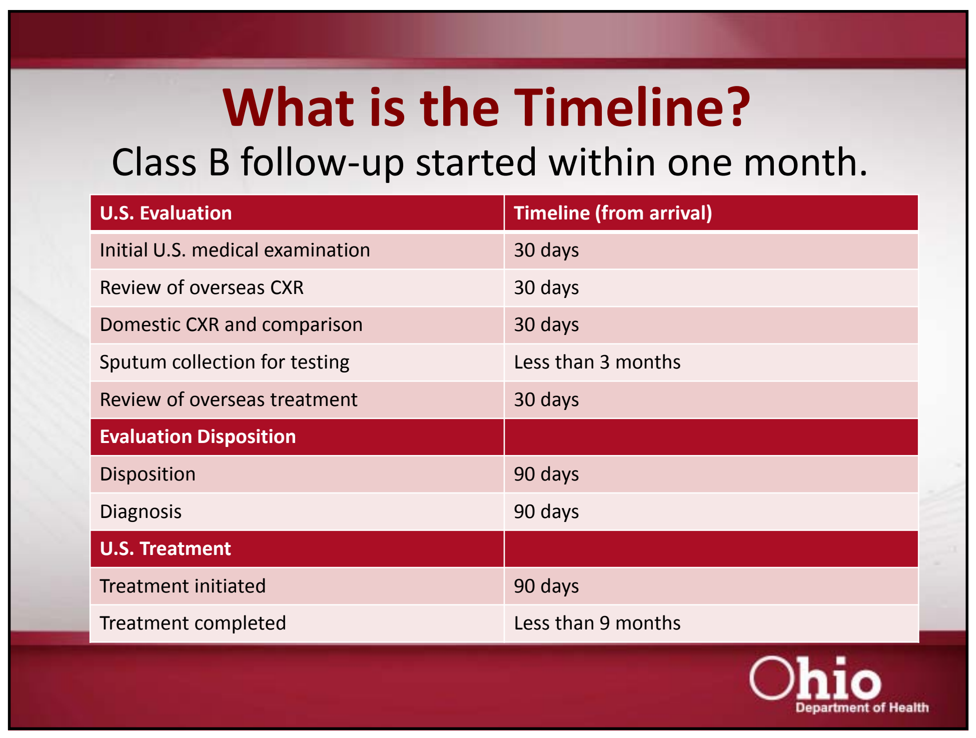
C6. Other pre-immigration CXR abnormalities: ☐ Volume loss ☐ Infiltrate ☐ Granuloma(s) ☐ Adenopathy ☐ Other (specify)

C10. U.S. domestic CXR abnormalities: ☐ Volume loss ☐ Infiltrate ☐ Granuloma(s) ☐ Adenopathy ☐ Other (specify)

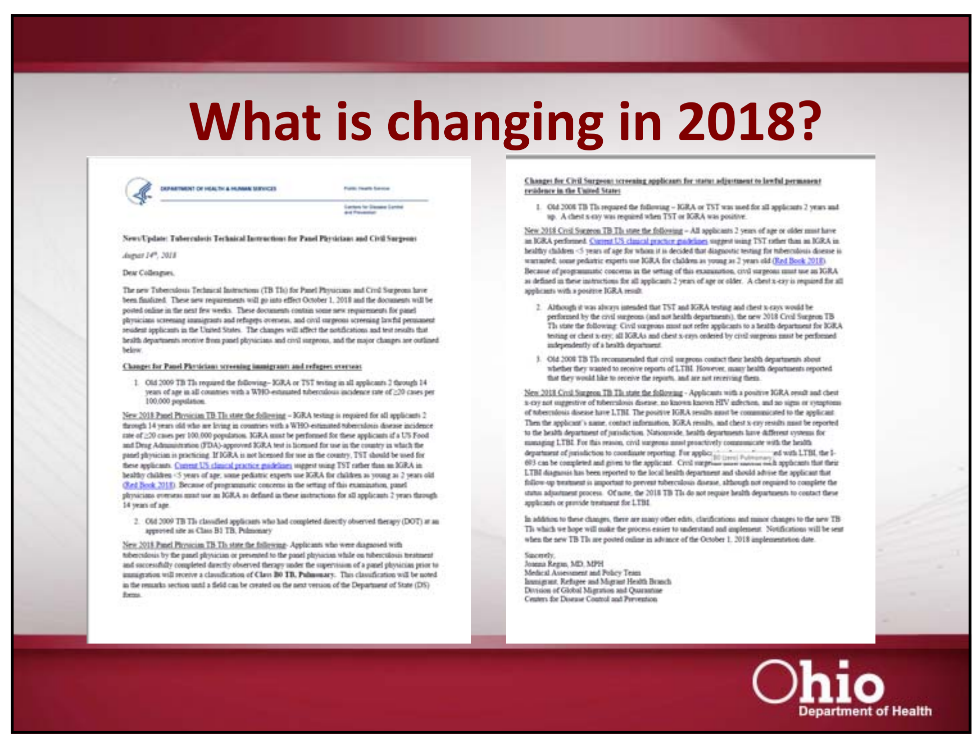
U.S. Review of Pre-immigration Treatment

C12a. Completed treatment pre-immigration? ☐ Yes ☐ No
If YES, ☐ Treated for TB disease ☐ Treated for LTBI
C12b. Treatment start date: __/__/____ ☐ Start date unknown
C12c. Treatment end date: __/__/____ ☐ End date unknown
C12d. Treatment reported by:
☐ Treatment documented on DS forms
☐ Patient reported treatment completion at or before panel physician examination
☐ Both-documented on DS forms & patient reported
☐ Unknown
C12e. Standard TB treatment regimen was administered? ☐ Yes ☐ No ☐ Unable to verify

C13. Arrived on treatment? ☐ Yes ☐ No ☐ Unknown
If YES, ☐ TB disease ☐ LTBI
C13a. Start date: __/__/____ ☐ Start date unknown
C14. Pre-immigration treatment concerns? ☐ Yes ☐ No
If YES,
☐ Treatment duration too short
☐ Incorrect treatment regimen
☐ Other, please specify:



U.S. Evaluation	Timeline (from arrival)
Initial U.S. medical examination	30 days
Review of overseas CXR	30 days
Domestic CXR and comparison	30 days
Sputum collection for testing	Less than 3 months
Review of overseas treatment	30 days
Evaluation Disposition	
Disposition	90 days
Diagnosis	90 days
U.S. Treatment	
Treatment initiated	90 days
Treatment completed	Less than 9 months



What is changing in 2018?

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service — Centers for Disease Control and Prevention

News/Update: Tuberculosis Technical Instructions for Panel Physicians and Civil Surgeons

August 14th, 2018

Dear Colleagues,

The new Tuberculosis Technical Instructions (TB TIs) for Panel Physicians and Civil Surgeons have been finalized. These new requirements will go into effect October 1, 2018 and the documents will be posted online in the next few weeks. These documents contain some new requirements for panel physicians screening immigrants and refugees overseas, and civil surgeons screening lawful permanent resident applicants in the United States. The changes will affect the notifications and test results that health departments receive from panel physicians and civil surgeons, and the major changes are outlined below.

Changes for Panel Physicians screening immigrants and refugees overseas

1. Old 2009 TB TIs required the following– IGRA or TST testing in all applicants 2 through 14 years of age in all countries with a WHO-estimated tuberculosis incidence rate of ≥20 cases per 100,000 population.

New 2018 Panel Physician TB TIs state the following – IGRA testing is required for all applicants 2 through 14 years old who are living in countries with a WHO-estimated tuberculosis disease incidence rate of ≥20 cases per 100,000 population. IGRA must be performed for these applicants if a US Food and Drug Administration (FDA)-approved IGRA test is licensed for use in the country in which the panel physician is practicing. If IGRA is not licensed for use in the country, TST should be used for these applicants. Current US clinical practice guidelines suggest using TST rather than an IGRA in healthy children <5 years of age; some pediatric experts use IGRA for children as young as 2 years old (Red Book 2018). Because of programmatic concerns in the setting of this examination, panel physicians overseas must use an IGRA as defined in these instructions for all applicants 2 years through 14 years of age.

2. Old 2009 TB TIs classified applicants who had completed directly observed therapy (DOT) at an approved site as Class B1 TB, Pulmonary

New 2018 Panel Physician TB TIs state the following- Applicants who were diagnosed with tuberculosis by the panel physician or presented to the panel physician while on tuberculosis treatment and successfully completed directly observed therapy under the supervision of a panel physician prior to immigration will receive a classification of **Class B0 TB, Pulmonary**. This classification will be noted in the remarks section until a field can be created on the next version of the Department of State (DS) forms.

Changes for Civil Surgeons screening applicants for status adjustment to lawful permanent residence in the United States

1. Old 2008 TB TIs required the following – IGRA or TST was used for all applicants 2 years and up. A chest x-ray was required when TST or IGRA was positive.

New 2018 Civil Surgeon TB TIs state the following – All applicants 2 years of age or older must have an IGRA performed. Current US clinical practice guidelines suggest using TST rather than an IGRA in healthy children <5 years of age for whom it is decided that diagnostic testing for tuberculosis disease is warranted; some pediatric experts use IGRA for children as young as 2 years old (Red Book 2018). Because of programmatic concerns in the setting of this examination, civil surgeons must use an IGRA as defined in these instructions for all applicants 2 years of age or older. A chest x-ray is required for all applicants with a positive IGRA result.

2. Although it was always intended that TST and IGRA testing and chest x-rays would be performed by the civil surgeons (and not health departments), the new 2018 Civil Surgeon TB TIs state the following: Civil surgeons must not refer applicants to a health department for IGRA testing or chest x-ray; all IGRAs and chest x-rays ordered by civil surgeons must be performed independently of a health department.
3. Old 2008 TB TIs recommended that civil surgeons contact their health departments about whether they wanted to receive reports of LTBI. However, many health departments reported that they would like to receive the reports, and are not receiving them.

New 2018 Civil Surgeon TB TIs state the following - Applicants with a positive IGRA result and chest x-ray not suggestive of tuberculosis disease, no known known HIV infection, and no signs or symptoms of tuberculosis disease have LTBI. The positive IGRA results must be communicated to the applicant. Then the applicant's name, contact information, IGRA results, and chest x-ray results must be reported to the health department of jurisdiction. Nationwide, health departments have different systems for managing LTBI. For this reason, civil surgeons must proactively communicate with the health department of jurisdiction to coordinate reporting. For applic[illegible]ed with LTBI, the I-693 can be completed and given to the applicant. Civil surg[illegible] applicants that their LTBI diagnosis has been reported to the local health department and should advise the applicant that follow-up treatment is important to prevent tuberculosis disease, although not required to complete the status adjustment process. Of note, the 2018 TB TIs do not require health departments to contact these applicants or provide treatment for LTBI.

In addition to these changes, there are many other edits, clarifications and minor changes to the new TB TIs which we hope will make the process easier to understand and implement. Notifications will be sent when the new TB TIs are posted online in advance of the October 1, 2018 implementation date.

Sincerely,
Joanna Regan, MD, MPH
Medical Assessment and Policy Team
Immigrant, Refugee and Migrant Health Branch
Division of Global Migration and Quarantine
Centers for Disease Control and Prevention

B0 (zero) Pulmonary

Applicants who were diagnosed with TB overseas and successfully completed treatment with DOT prior to immigration

Changes for Panel Physicians Screening

- New 2018 guidelines require use of U.S. Food and Drug Administration approved IGRAs
- If the IGRA is not licensed for use in the country where the Panel Physician is practicing then use a TST

Changes for Civil Surgeons Screenings

Previous TB requirements

- IGRA or TST was used for all applicants 2 years and over. A chest x–ray was required when an IGRA or TST was positive.
- 2008 recommendations- civil surgeon to contact the health department about receiving LTBI reports

NEW 2018 guidelines

- **All** applicants 2 years or older **MUST** have an IGRA performed
- **All** positive IGRAs still must have a chest x-ray
- Civil Surgeons must pro-actively communicate with the local health department

News/Update: Tuberculosis Technical Instructions for Panel Physicians and Civil Surgeons
August 14th, 2018

References

- http://www.who.int/tb/data/en/
- https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html
- TB Notifications – Ohio Department of Health, https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/bid/tuberculosis-control/tbnotifications.pdf?la=en
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