OPPORTUNITIES TO OPTIMIZE

1. Utilize patient intake survey or questionnaire to help flag risk factors early on. It is crucial to get patient contact information in case they need to be called back in for a chest X-ray (CXR).

2. Conduct review of the patient’s chart and medical history questions, led by patient triage provider. TB should be included with other immunizations needed for refugee health. A pre-populated EHR screening tool can standardize this process and automatically order the test if the patient meets the criteria, removing steps for the care team.

3. Contact local health department immediately if the patient is symptomatic. Active TB symptoms that are otherwise unexplained include a cough for more than 2-3 weeks, fevers, night sweats, weight loss and hemoptysis.

4. Utilize IGRA blood test which is recommended for asymptomatic testing, particularly for foreign born patients. The local health department should be contacted if there is trouble with interpretation of the test.

5. Outline clear delineation of care team role in delivering results. Locations where providers lack time can have medical assistants or patient navigators disclose results to patients over the phone.

Routine Screening: Test preformed and results communicated

1. Testing
2. Patient informed of results

FOLLOWING UP: Confirmatory testing and linkage to care, treatment and prevention

6. Recall patient to the clinic when informing them of a positive test
7. Leverage medical assistants to perform CXR in order to unburden provider.
8. Contact local health department right away if there is an abnormal film or the patient is symptomatic
9. Counsel and educate patient on what TB is and initiate 3HP treatment if active TB is ruled out by patient being asymptomatic and having a normal CXR.