

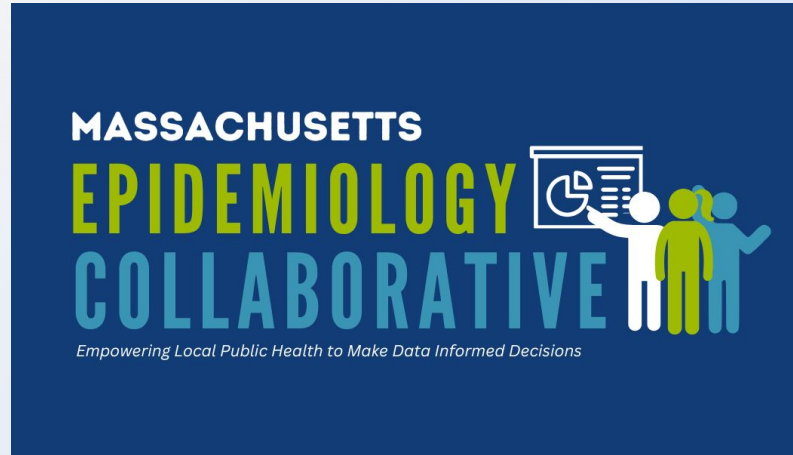
How Epidemiologists Can Assist Local Public Health Nurses (LPHNs) in TB Investigations

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MA Epidemiology
Collaborative

Agenda

1. Introductions
2. Background
3. Epidemiology
4. Legislation: 105 CMR 365.00
5. Case Study
6. Additional Resources



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What is Tuberculosis (TB)?

- TB is caused by a bacterium called *Mycobacterium tuberculosis*
- TB usually affects the lungs but *can* also affect other parts of the body, such as the brain, the kidneys, or the spine
 - TB can affect multiple parts of the body at the same time
- Not everyone infected with TB germs becomes sick. As a result, two TB-related conditions exist:
 - Latent TB infection (LTBI)
 - Active TB disease

Latent TB

VS

Active TB

No Symptoms



Not Contagious



Treated With Antibiotic
for 3–4 Months



Can Progress to
Active TB



May Have Cough, Chest
Pain, and Fatigue



Can Be Spread
to Others



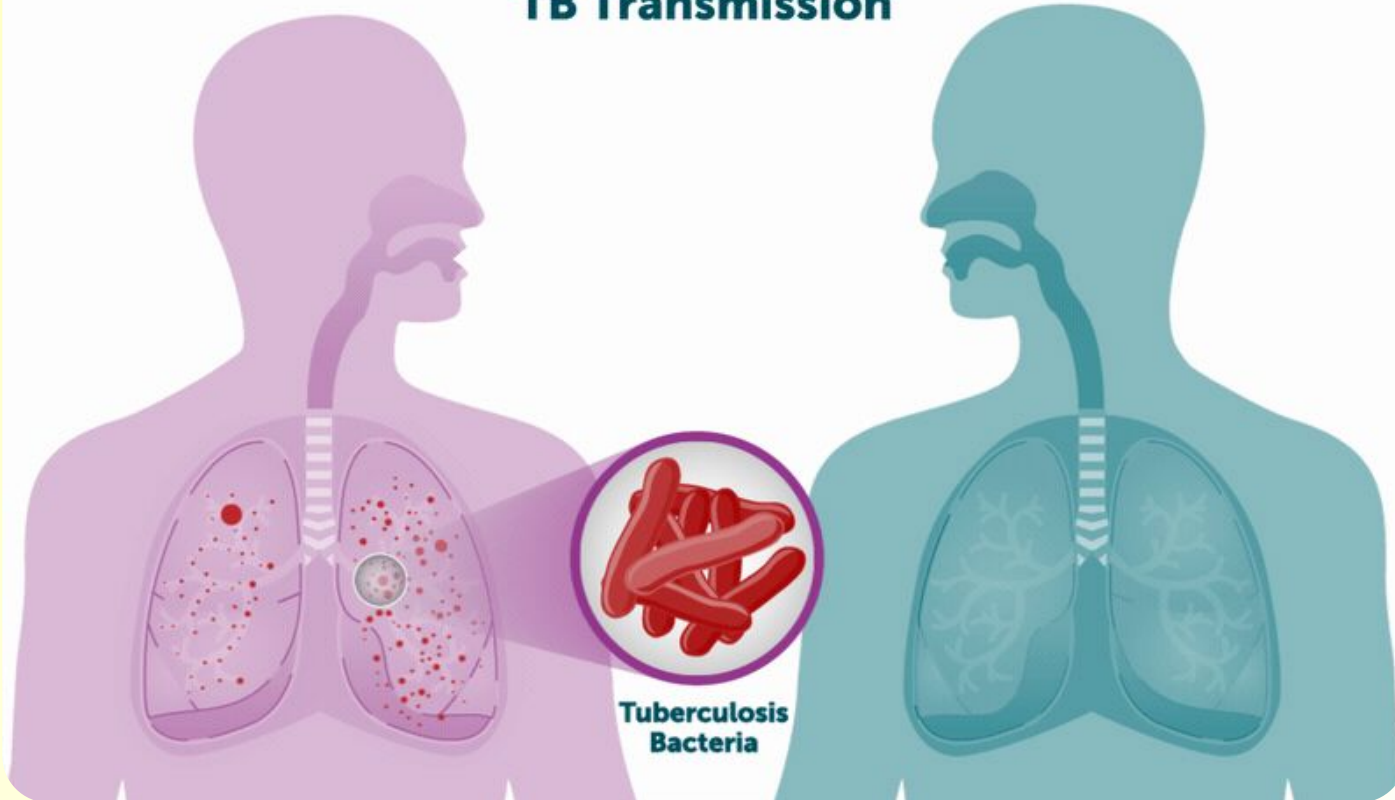
Treated With Antibiotic
Combo for 4–9 Months



Can Be Deadly if
Not Treated



TB Transmission



<https://www.cdc.gov/tb/causes/index.html>

TB RISK FACTORS

As per the CDC, **ANYONE** can get TB.
People at higher risk for acquiring TB:



Travel to or were born in countries where TB is common (listed on following Epidemiology slides)

Recently spent time with or live with a person who has active disease



Live or used to live in large group settings where TB is more common, such as correctional facilities & congregate shelters



Work in places where TB is more likely to spread, such as certain healthcare settings, congregate shelters, nursing homes, and correctional facilities



Have a weaker immune system because of certain medications or health conditions, such as diabetes, cancer, and HIV



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TB Diagnosis

TB diagnosis can be complicated, as a licensed clinician must confirm the case. While TB tests can help determine whether a case is latent or active, they aren't definitive

Latent TB Infection (LTBI):

- **IGRA** (blood test, gold-standard) or **TST** (skin test)
- No symptoms: usually normal chest x-ray (CXR)

Active TB Disease:

- **Symptoms:** cough, fever, weight loss, night sweats
- **Chest x-ray:** lung abnormalities
- **Microbiology:** sputum smear, culture, or molecular tests confirm infection

TB Classifications: New Arrivals*

Class A: Active Disease

- Individuals with active disease who may not have completed adequate treatment or may be considered infectious
 - Not the focus of today's presentation

Class B: Latent Infection

- B0: recently treated TB disease
- B1: Significant findings, no signs of infectiousness
- B2: LTBI
- B3: TB contact

*Individuals are tested for TB during immigration if they are seeking permanent residence (i.e., immigrants, refugees). Temporary visa holders are typically not screened.

TB Classifications: New Arrivals

For additional questions on how TB cases appear in MAVEN, please see:

MAVEN Help Videos from MDPH:

1. Division of Global Populations Class A/B Update: Anna Hippchen, Michael Boyer, and Sergut Wolde-Yohannes (9/24/24)
<https://register.gotowebinar.com/recording/6520861958519460096>
2. Division of Global Populations Annual LBOH Webinar (4/9/2024): Falah Hashem, Anna Hippchen, Sergut Wolde-Yohannes, Kavita Gadani Seabe, Michael Boyer
<https://register.gotowebinar.com/recording/6019653977237722626>

TB Treatment

This is person-specific and depends on several factors. We won't go into detail about the different treatments, but here are a few points to provide context for future slides:

- The four most common first-line medications for TB treatment:
 - Rifampin (RIF)
 - Isoniazid (INH)
 - Pyrazinamide (PZA)
 - Ethambutol (EMB)
- DOT (**D**irect **O**bserved **T**herapy): A method for treating TB where a healthcare worker watches the patient swallow each dose of their prescribed medication. This ensures that the patient takes their full course of medicine, which is crucial for curing TB and preventing the spread of drug-resistant TB.

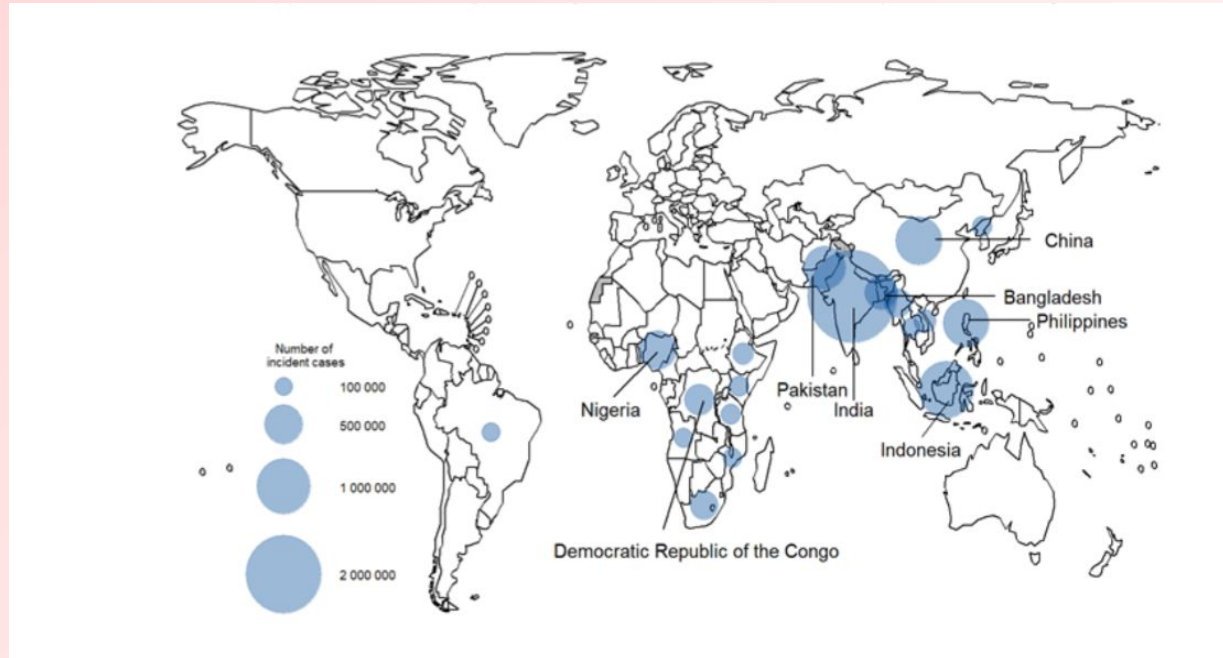
Epidemiology



Epidemiology of TB: Global TB Trends (Active Disease)

(WHO, 2022)

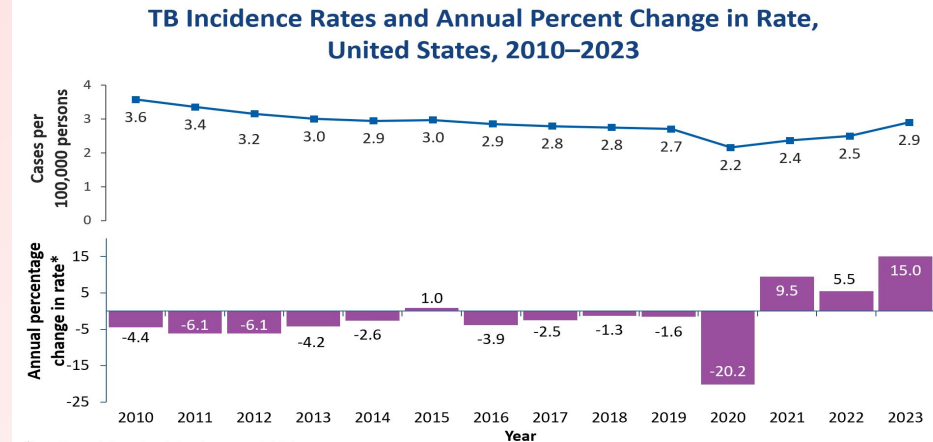
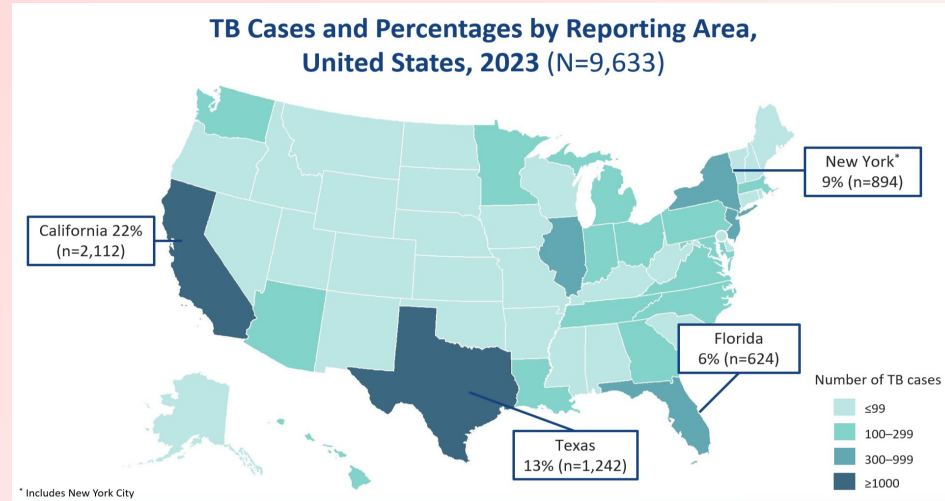
- **Total cases & incidence:** 10.6M people developed TB in 2022 (~133/100k); increase vs 2020–21
- **Regional distribution:** SE Asia (46%), Africa (23%), W. Pacific (18%), smaller in Americas & Europe
- **Top 8 countries:** India, Indonesia, China, Philippines, Pakistan, Nigeria, Bangladesh, DRC $\approx \frac{2}{3}$ of global cases
- **Trends & drivers:** COVID-19 disruptions → underdiagnosis (2020–21) → rebound in 2022
- **Drug resistance:** Multidrug Resistant TB (MDR/RR-TB) remains major challenge (see WHO report)



Epidemiology of TB: In the US

(CDC, 2023)

- **Cases & incidence:** 9,633 TB cases in 2023 (2.9/100,000); ~15% increase vs 2022, returning to 2013 levels
- **Geographic distribution:** 4 states (CA, TX, NY, FL) = ~50% of cases. MA incidence = 3.2/100,000
- **Drug resistance:** 588 isoniazid (INH) resistant, 100 MDR-TB cases; molecular testing included since 2023
- **Directly observed therapy (DOT):** A healthcare worker watches the patient take each TB dose to ensure the medicine is taken correctly and treatment stays on track
 - Widely used, 95% treatment completion goal
 - Standard practice in USA



Epidemiology of TB: In MA

- **Total cases & incidence:** 254 active TB cases; 3.6 per 100,000 population → 13% increase vs 2023 (national rate 3.0/100,000)
- **Demographics & risk groups:**
 - 90% non-U.S.-born; 10% U.S.-born
 - 90% cases in racial/ethnic minorities (Risk ratio[RR] vs white non-Hispanic: Asian 29.8×, Black 34.6×, Hispanic 11.6×)
 - Children <15 yrs: 5 cases (<1/100,000)
 - Unhoused individuals: 22 cases (9%)
 - HIV co-infection: 9 cases (4%)
 - Known contacts to previous TB cases: 15 (6%)
- **Clinical & diagnostic features:**
 - Pulmonary: 61%; Extrapulmonary: 11%; Both: 28%
 - Cavitory disease: 31%; Non-cavitory: 53%
- **Drug resistance (culture-confirmed, N=194):**
 - Any resistance: (27%); INH-resistance: (15%); MDR-TB: 3 cases: (2%)

Geographic TB Case distribution

Case Counts and Percent Distribution

TB Case Distribution – Key Insights

- 60% of TB cases are from Suffolk, Middlesex, and Essex counties
- Suffolk (Boston) reports the highest number of cases
- Dukes County has a high rate, but very few actual cases
- Case counts + percentages together give a clearer picture

Why this matters:

- Helps target resources to high-activity areas
- Prevents misinterpretation in small counties (e.g., Dukes) due to small population sizes

Information obtained from: [MDPH, 2024](#)

County	No of Cases	% of State Total (=254 Cases)
Suffolk	66	26.0%
Middlesex	63	24.8%
Essex	29	11.4%
Norfolk	28	11.0%
Worcester	26	10.2%
Plymouth	25	9.8%
Bristol	8	3.1%
Hampden	4	1.6%
Dukes	<5	1.6%
Hampshire	2	0.8%
Franklin	2	0.8%
Barnstable	0	0%
Berkshire	0	0%
Nantucket	0	0%

Tuberculosis Legislation

105 CMR 365.00



105 CMR 365.00: TB Case Management Outside of Hospitals

Reference:

- “Case management for tuberculosis is the coordination of medical, nursing, outreach, adherence support, and social service systems to ensure appropriate therapy and completion of treatment for all persons with confirmed or suspected TB”

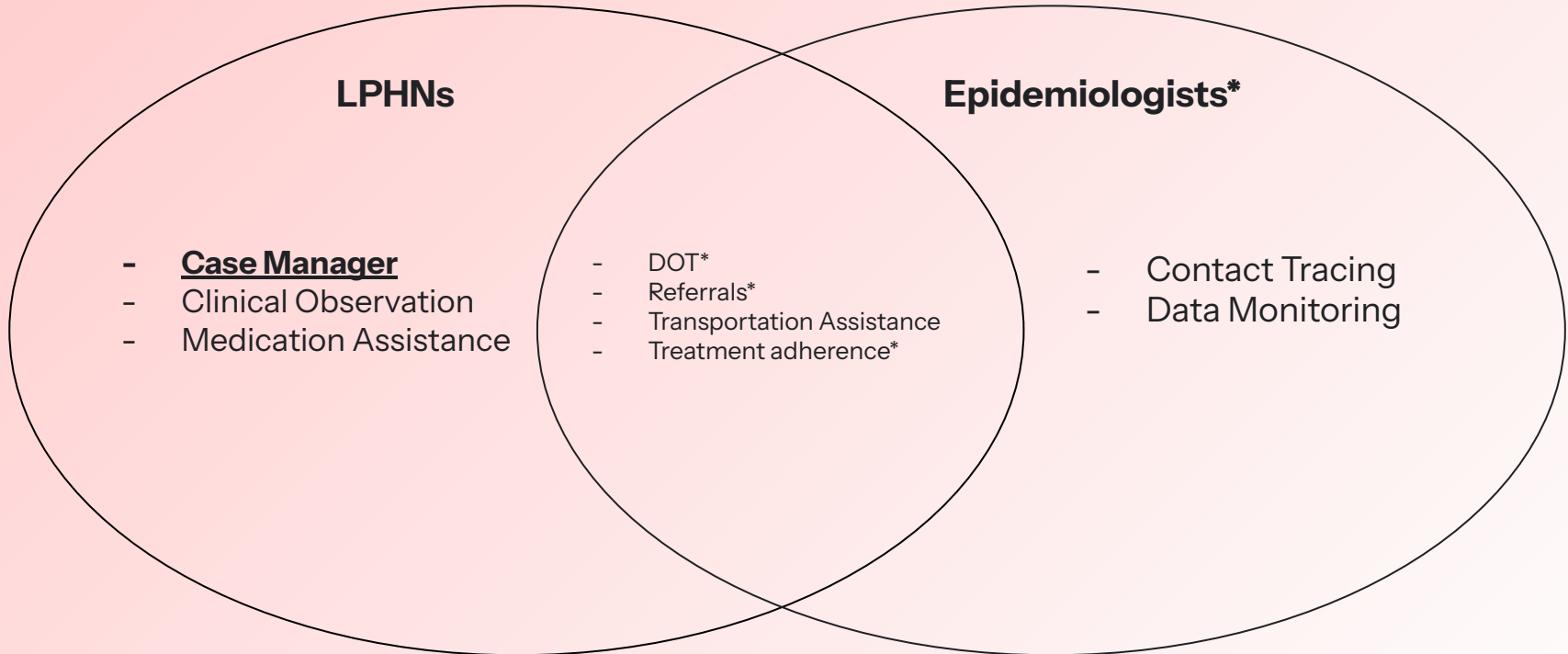
Key Points (per 105 CMR 365.200):

- **Every TB case must have a local nurse case manager designated by the local board of health**
- The nurse case manager leads case management and develops the care plan
- Local epis may provide referrals but cannot perform DOT or medication management without a Local Public Health Nurse (LPHN)
- Initial case assessment and contact investigation must begin within 3 business days of notification
- The LPHN remains responsible for overseeing DOT and may delegate specific tasks to epidemiologists or community health workers, as appropriate to their scope of practice

PHNs MUST Fulfill the Role of Case Management:

LPHNs may delegate other tasks to Community Health Workers (CHWs) and Epis on an as-needed basis

For example, in the context where an LBOH has an epidemiologist on staff:



*Epis can only do these case management activities under the management of a PHN and only work within their authorized scope of practice

NOTE: Community Health Workers may also assist with transportation assistance, education, and home visits

Case Study



Case #1: Pediatric LTBI

Scenario: Local Board of Health (LBOH) received notification of a positive IGRA in a Child <5 from local pediatrician's office. Child was US born, but lived overseas for 2+ years. Child was taken for IGRA testing upon return to the US as precaution by parents, even though it was not required. Child asymptomatic.

Actions Required: Establish baseline understanding of TB workflows, identify and use available resources (MAVEN, providers, state/regional TB staff), collect and document demographic & risk history as available

Day 1-2

Initial Steps & Risk History

- Reviewed MAVEN lab report
- Contacted ordering provider to confirm results
- Confirmed date of chest x-ray (CXR)
- Collected demographics & risk history:
 - Household TB history
 - Prior TB treatment
 - Country of birth/origin
 - Recent travel

Week 1-2

Care Coordination

- Connected with treating providers and hospital infection preventionist (IP)
- Confirmed CXR results w/ ordering provider (OP)
- Confirmed treatment plan (e.g., rifampin [RIF] daily/4mos)
- No referral to the TB clinic needed

Pediatric LTBI

Scenario: Positive IGRA in child <5 y.o.

Actions Required: Establish baseline understanding of TB workflows, identify and use available resources (MAVEN, providers, state/regional TB staff), collect and document demographic & risk history as available

Week 2-3

Consultation with State TB Team

- Discussed case with State TB Nurse, State Direct Services Coordinator, and our Regional Nurse Consultant
- Determined this specific case **did not** require DOT due to:
- Results from CXR, complex past medical history, and their ongoing specialized/personalized care by multiple physicians (specialists & infectious disease doctors)
- Please note: You should always follow up with your State TB Nurse regarding pediatric cases that may need DOT, such as those under the age of 5. DOT may be determined on a case-by-case basis.

Ongoing

Monitoring & Documentation

- Monthly follow-up with treating provider/IP for adherence
- Enter updates into MAVEN question packages
- Continue collaboration with state/regional TB team as needed until end of treatment
- Work with the Local PHN to update event notes frequently
- Task monthly to remind self or Local PHN to follow up with ordering provider and/or infection prevention to conduct treatment adherence calls

Pediatric LTBI

Key Takeaways

- TB case management is nurse-led per 105 CMR 365.200
- Local epis play a vital support role in coordination, documentation, and communication
- Always consult the State TB Nurse for pediatric or complex cases before determining DOT needs
- Collaboration across local, regional, and state levels ensures timely, compliant, and patient-centered TB care

Local Epi Role

- Support the Local PHN and State TB Team through coordination and communication
- Collect and document key demographic and risk information in MAVEN
- Facilitate provider contact to confirm labs, CXR results, and treatment plan
- Assist with referrals and ongoing data entry
- Maintain case continuity by setting follow-up reminders and updating event notes

Case #2

B1 Arrival: Positive TB diagnosis with Family Hesitancy & Language Barriers

Scenario:

- Adult Female, arrived in the US as a B1 immigrant from a country with high TB prevalence
- Overseas screening: Abnormal chest X-ray; sputum smear negative
- Barriers: Language difficulties and family mistrust of outreach calls
- Support: Required interpreter and community health worker (CHW) involvement throughout the process

Timeline & Actions:

Initial Contact Phase:

- State TB team reviewed overseas records and notified local health department
- Local epi attempted multiple calls but the family declined to speak, believing the outreach might be a scam
- A community health worker fluent in the family's language was engaged to assist with communication

Trust-Building & Engagement Phase:

- CHW conducted a home visit, introduced the public health role, and explained confidentiality and purpose of the evaluation
- Family was encouraged to verify the health department's number before proceeding; they called and spoke with the local epi
- After reassurance and TB education, the family agreed to proceed with testing

B1 Arrival: Positive TB diagnosis with Family Hesitancy & Language Barriers

Diagnosis & Coordination Phase:

- IGRA testing was completed and returned positive.
- Local epi placed a referral to TB clinic for further evaluation.
- Repeat CXR and specimen collection were completed; sputum and culture confirmed TB disease.
- Epi and CHW jointly arranged interpreter services and transportation for clinic visits.

Treatment & follow-up Phase:

- The State TB Nurse initiated Directly Observed Therapy (DOT) at home, assisted by the local epi.
- CHW provided ongoing language and cultural support, helping the family understand the importance of treatment adherence.
- Epi documented all updates in MAVEN, coordinated with state staff, and monitored for any close contact evaluations and investigations for close family members.
- Treatment is ongoing; the case remains open until completion and confirmation of cure.

PHN & CHW Roles:

- PHN: Conducted DOT, symptom monitoring, and treatment adherence counseling.
- CHW: Provided language interpretation, trust-building, and ongoing family support.

B1 Arrival: Positive TB diagnosis with Family Hesitancy & Language Barriers

Local Epi Role:

- Coordinated interpreter services, transportation, and CHW support to overcome language and cultural barriers.
- Maintained comprehensive documentation in MAVEN and support PHNs with case tracking and follow-up.
- Engaged the family through trust building, education, and facilitating acceptance of testing and treatment.
- Collaborated with PHN, CHW, and state TB staff for DOT initiation, contact investigations and continuity of care.

Key Takeaways:

- Language barriers and mistrust can delay evaluation- trusted community partners are essential.
- CHW involvement can significantly improve engagement and adherence.
- Joint coordination among epi, PHN, CHW, and state staff ensures continuity and cultural sensitivity.
- Early verification and transparency build long-term trust with families and communities.

“What If” Scenario – Active TB

Patient arrives in Massachusetts classified as **B1**. Initial outreach is difficult. Later confirmed with **active TB** (could be MDR-TB). Lives with one roommate who will require screening.

Requires **immediate treatment, intensive monitoring, and contact investigation.**

Day 1-2

- **State PHN & State Direct Services Coordinator:** Reviews B1 report, alerts local team
- **Local PHN:** Attempts contact; delegates referral to Local Epi due to flu clinic workload
- **Local Epi:** Files clinic referral, sends welcome letter with appointment details, documents in MAVEN

Week 1-2

- **Local Epi:** Ensures risk factor documentation, flags a roommate for contact testing. Coordinates with State CHW (case & roommate are unresponsive)
- **Local PHN:** Coordinates clinic evaluation and sputum testing. Arranges interpreter or transport if needed. Conducts initial phone call with the case.
- **State CHW:** Assists outreach, locates patient, conducts home-visit, explains next steps
- **Clinic:** Confirms **active TB**; reports to MDPH
- **State PHN:** Reviews diagnosis & labs, initiates treatment planning

“What If” Scenario – Active TB

Patient arrives in Massachusetts classified as **B1**. Initial outreach is difficult. Later confirmed with **active TB** (could be MDR-TB). Lives with one roommate who will require screening.

Month 1-2

- **Local PHN:** Initiates DOT, monitors side effects, ensures documentation in MAVEN.
- **State PHN:** Reviews drug susceptibility testing (DST) results, consults on MDR-TB management. Communicates with LPHN to discuss treatment plan regularly. Creates MAVEN event for contact and tasks referral to LBOH.
- **Local Epi:** Maintains documentation and ensures ongoing coordination. Refers roommate to clinic & documents in MAVEN, ensures roommate is seen by clinic.
- **State CHW:** Supports adherence and connects patient to social supports.

Ongoing/Conclusion (Month 9-10)

- **Local PHN:** Continues managing video DOT (vDOT), patient is compliant, and completes final case review.
- **Local Epi:** Finalizes records in MAVEN, ensures contact complete testing, assists LPHN with vDOT, relays side effects to LPHN as needed.
- **State PHN:** Reviews DSTs, confirms documentation is accurate, and confirms cure and case closure.
- **State CHW:** Provides closure education and transition support.

“What If” Scenario – Active TB

Patient initially classified as **B1** now confirmed with **active TB** (or **MDR-TB**).
Requires **immediate treatment, intensive monitoring, and contact investigation.**

Weekly Coordination:

- Multidisciplinary case calls: **State PHN, Local PHN, Local Epi, State CHW**
- Review of clinical progress, contacts, and adherence barriers
- Shared updates documented in MAVEN

Communication & Access:

- Unified messaging to patient/family
- Language, transportation, and housing needs addressed collaboratively
- CHW supports continuity during isolation/treatment

Key Takeaways:

- Collaboration intensifies after disease confirmation
- Clear roles ensure fast, coordinated public health response
- LPHN delegates additional tasks as needed to local staff within their scope of practice
- Local logistics + State clinical oversight =
Successful case management

Referral Forms Examples

BMC TB clinic

BOSTON PUBLIC HEALTH COMMISSION Boston Public Health Commission, TB Clinic
BMC - Preston Family Building 5th Floor
732 Harrison Avenue, Boston MA 02118
Appointments: (617) 534-4967
Nurse Triage: (617) 534-4875
Fax: (617) 534-4976

PAGE 1

TB Clinic Referral Form

Referring Agency

NAME OF AGENCY: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

CONTACT NAME: _____ PHONE: () _____ FAX: () _____

Patient Information Please print clearly

PATIENT NAME, LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: () _____ 2ND PHONE: () _____ GENDER: MALE FEMALE

MARITAL STATUS: _____ SSN: - - DATE OF BIRTH: / /

COUNTRY OF BIRTH: _____ INTERPRETER NEEDED? YES NO IF YES, LANGUAGE: _____

PATIENT SEEN AT BMC BEFORE? ☐ YES ☐ NO IF YES, BMC RECORD # _____

DOES PATIENT HAVE HEALTH INSURANCE? ☐ YES ☐ NO

CARRIER: _____ POLICY #: _____ AUTHORIZATION # FOR VISIT: _____

TST Results & Medical History

TUBERCULIN SKIN TEST (TST): SIZE: (MM) _____ DATE READ: / /

IF YOU ARE REFERRING A PATIENT WITH A POSITIVE IGRA, WE REQUIRE A COPY OF THE LABORATORY REPORT.

PLEASE SUBMIT CURRENT PROBLEM LIST & ALL CURRENT MEDICATIONS ON SUPPLEMENTAL FORM OR IN ATTACHMENT:

☐ NO CURRENT MEDICATIONS ☐ NO SIGNIFICANT MEDICAL HISTORY

Appointment Scheduling Information

Please mark 1st, 2nd, and 3rd choice for appointment DAY. The appointment TIMES will be within the hours listed. The visit requires at least 2 hours to complete the process, including MD exam, chest x-ray, and laboratory work.

A PARENT MUST ACCOMPANY ALL PATIENTS UNDER 18 YEARS OF AGE.

____ MONDAY: 1:00—3:00 ____ WEDNESDAY: 1:00—3:00 ____ FRIDAY: 8:30—11:00
____ TUESDAY: 8:30—11:00 ____ THURSDAY: 8:30—11:00

To be completed by BPHC TB Clinic only:

The following patient has an appointment in the TB clinic. Please notify the patient. Thank you.

BMC MED REC#	APPT. DATE	DAY	TIME

Appointment not scheduled because of the following missing information: (check all that apply)

☐ TST (SIZE & DATE) ☐ DOB ☐ ADDRESS ☐ INTERPRETER ☐ OTHER: _____

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Clinical Information

____ (Patient Name) _____ (Date of Birth)

The BPHC TB Clinic has received a request for an appointment the patient referenced above.
To schedule an appointment, the following information is needed:

☐ **TUBERCULIN SKIN TEST (MANTOUX, PPD):**
The size of the TST is critical in determining appropriate treatment. The TB Clinic no longer accepts a patient's verbal report of a positive reaction. For all patients with an undocumented history of a "positive" TST, a repeat TST must be done or approval given by the TB clinic allowing for exclusion prior to receiving an appointment. Please contact the clinic triage office at (617) 534-4875 to discuss any patient or provider concerns.

SIZE: _____ (MM INDURATION) DATE READ: _____

☐ **MEDICAL PROBLEM LIST**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

☐ No significant medical history

☐ **CURRENT MEDICATIONS (DOSAGE AND FREQUENCY)**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

☐ No current medications

For persons with suspected TB disease, please provide information on any chest radiographs or CT scans performed since the time of symptom onset:

DATE: _____ TEST LOCATION: _____

RESULT: _____

PRIMARY CARE PROVIDER INFORMATION

NAME _____ PHONE # _____

PAGER # _____ FAX # _____

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- Referral processes differ by facility
- No standardized state form
- Forms may not be listed in MAVEN
- Encouraged to maintain direct communication with TB/pulmonary clinics

Additional Resources

Class AB Tracking Checklist

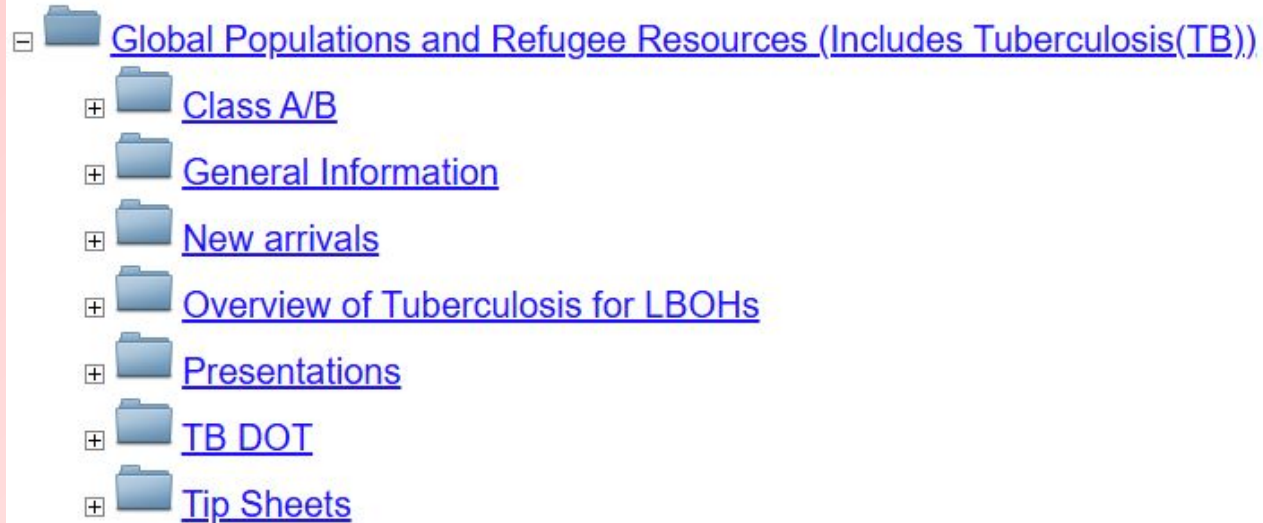
- Purpose: Helps track steps in TB case management and stay organized
- Usefulness: Especially helpful when managing multiple cases
- Note: Not a case management tool- more of a workflow/organizational aid

Massachusetts Class AB Tracking Checklist		
The Division of TB Prevention and Control appreciates all efforts made to locate and evaluate new arrivals with Class AB conditions within 30 days of your receiving the notification packet. Please use this checklist as a guide for follow-up. If a new arrival can not be located within 30 days please fax this checklist to the TB Division together with the completed TB Follow-up Worksheet. If you successfully make contact and schedule a clinic visit, please fill in the date and time of the appointment where indicated below and fax this checklist to the TB Division. CONFIDENTIAL FAX: 617-983-6540 OR 617-983-6590 ATTN: CLASS AB PROGRAM		
Arrival Name:	DOB:	MAVEN ID:
Packet Received – Date:		
Review contents of packet and specific instructions for this specific TB Classification		
Within 24 hours of receiving notification packet, attempt to initiate contact with new arrival. Use the guide below to help you.		
If a phone number is included in the packet		
Call 1 – Date:		Time:
Contact made	Set date for skin test and/or clinic appt	
Message	If no callback – proceed to Call 2 within 7 days	
No Answer	Proceed to Call 2 within 7 days	
Incorrect #	Send Letter (below)	
Call 2 – Date:		Time:
Contact made	Set date for skin test and/or clinic appt	
Message	If no callback – proceed to Call 3 within 7 days	
No Answer	Proceed to Call 3 within 7 days	
Incorrect #	Send Letter (below)	
Call 3 – Date:		Time:
Contact made	Set date for skin test and/or clinic appt	
Message	Send Letter (below)	
No Answer	Send Letter (below)	
Incorrect #	Send Letter (below)	
If no working phone number, or the new arrival does not respond after three attempts by phone		
Send letter of introduction including Nurse's name, phone number and brief explanation of process.		
Date sent:		
Contact made	Set date for skin test and/or clinic appt	
No response	If resources allow proceed to home visit within 14 days. If not, fax checklist and completed TB Follow-up Worksheet to TB Division within 24 hours	
If resources allow and no response by any other method, visit new arrival's home in person		
Visited new arrival at address provided in Class AB packet.		
Date:		
Contact made	Set date for skin test and/or clinic appt	
No one home	Repeat if resources permit, otherwise fax checklist and completed TB Follow-up Worksheet to TB Division within 24 hours	
Incorrect address	Fax checklist and TB Follow-up Worksheet to TB Division within 24 hours	
If contact is made with the new arrival during any of the above steps		
TST or IGRA Planted/Read (if required)	Date Read:	Result: Positive / Negative
Clinic appointment Scheduled	Write Appointment date, time and clinic in box on right. Fax a copy of this checklist to the TB Division	Appointment Date: Clinic:
New arrival refused care	Fax a copy of this checklist and the completed TB Follow-up Worksheet to the TB Division within 24 hours	
If the new arrival agrees to go to clinic		
Client does not show up to appointment	Reschedule appointment. If client continues non-compliance, fill out the TB Follow-up Worksheet and fax to the TB Division within 24 hours	
Client does not accept treatment for TB infection	Within 24 hours of receiving the TB clinic form from the clinic fill out and fax the TB Follow-up Worksheet to the TB Division	
Client starts treatment	Monitor adherence for duration of therapy	
Client completes treatment	Within 24 hours of notification from the clinic that the new arrival has completed therapy, fill out and fax the TB Follow-up Worksheet to the TB Division	
Client begins but does not complete treatment	Within 24 hours of learning that the patient stops treatment and refuses to restart, fill out and fax the TB Follow-up Worksheet to the TB Division	

Additional Resources

MAVEN Help

Can be found at: <https://www.maven-help.maventrainingsite.com/>



Additional Resources

TB Outpatient Clinics

Can be found at: <https://www.mass.gov/info-details/massachusetts-tb-outpatient-services>

☰

Massachusetts TB Outpat...

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31,498 views

Published on July 21

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SHARE

☑

TB Outpatient Services Locations

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📍 All items

Cape Cod Hospital-Hyannis

Cape Cod Hospital-Falmouth

Lowell General Hospital (Accepting Limit...

Lahey Clinic, Inc.

Baystate Medical Center

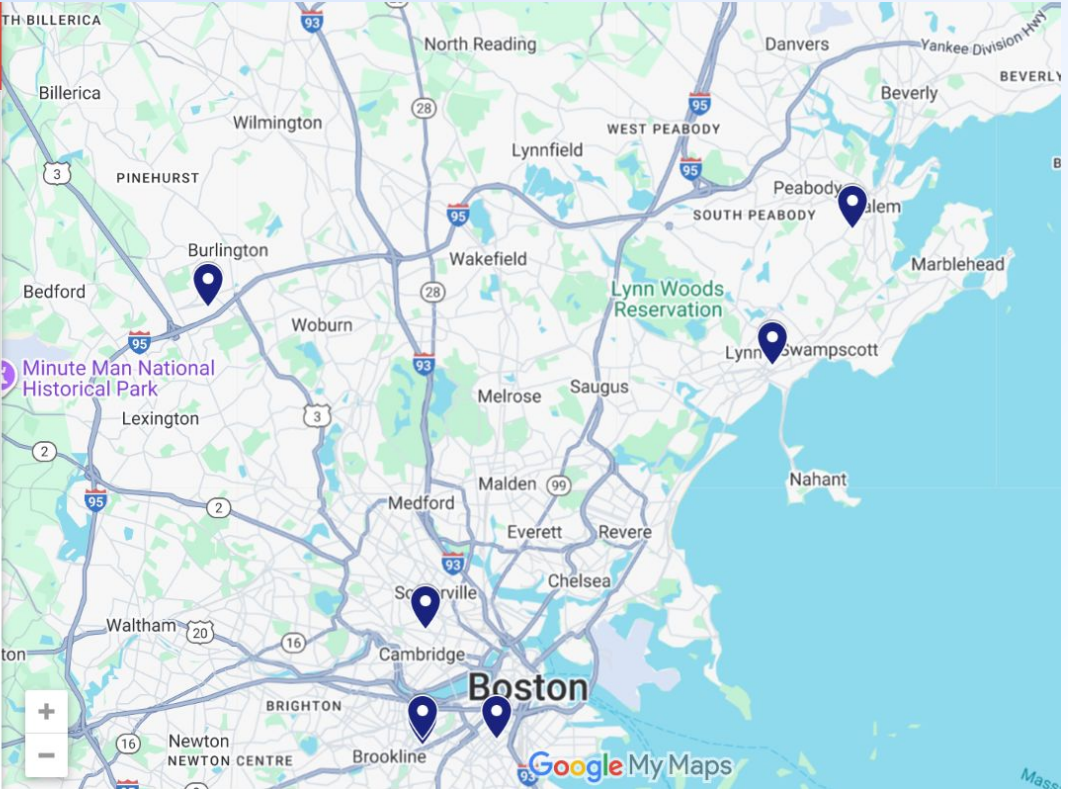
Boston Medical Center TB Clinic

UMass Memorial Medical Center

Brigham and Women's Hospital

Boston Children's Hospital

Cambridge Hospital



Questions?

Contact us!

Gruha Patel, MPH: GPatel@CityofMelrose.org

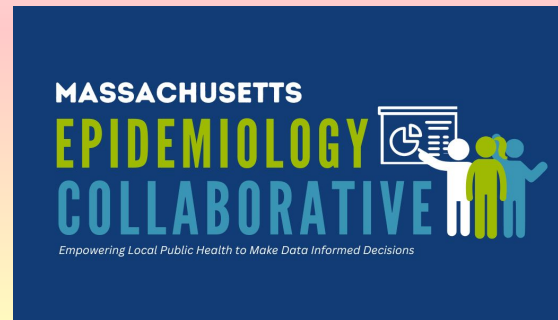
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North Shore Public Health Collaborative



Resources



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