Introduction
The current model in place at many shelters and substance abuse (SA) rehabilitation facilities requires that residents are tested for tuberculosis (TB) with a PPD skin test prior to admission. Those who present with active TB are treated, while those with latent TB are given the option of treatment, though most either choose not to pursue treatment or begin treatment without following through. This poses a threat to residents at these facilities because latent cases have the potential to become active at the current lifetime risk of 5-15%. The Tulane TB Clinic Program oversees 5 clinics in New Orleans, which are either shelters or SA rehabilitation centers with both short-term and long-term programs. Testing occurs onsite at each of these facilities. Treatment is administered through the Wetmore Clinic, a local public TB clinic.

Methods
We have met with the clinical directors at each clinic to determine the needs and best course of action in regards to treatment of LTBI at the facilities. We have established a three-way communication between the TB clinic, the facility where the patient resides, and the Wetmore Clinic. Patients sign releases of treatment information, and they follow-up with the Wetmore Clinic throughout LTBI treatment.

All patients who present with active TB symptoms according to a screening questionnaire are considered “high risk” and are sent to the emergency department as exhibited in Figure 1.

Patients that are found to be free of active TB can be tested for LTBI with a TST. Those who are only staying short-term are not tested with the tuberculin skin test because they are unlikely to be present for reading 48-72 hours later and subsequent follow-up treatment at the Wetmore Clinic.

Patients staying long term (1-6 months) are administered a TST. Those who test positive for LTBI receive a secondary screen at the Wetmore Clinic as illustrated in Figure 1. They are educated and decide whether to pursue treatment for LTBI.

Follow-up and patient retention data is being gathered through the established three-way communication with the facilities.

Conclusions
The revised treatment model continues to screen for active TB, while also providing intervention for LTBI. By forgoing testing of those who are not going to follow-up, we reduce costs. We consider a test without follow-up to be a wasted test. These changes also continue to meet the goals of the facilities.

Future directions include using follow-up data to determine what improvements can be made to increase retention and accessibility of treatment. We are currently applying for grants to continue to provide supplies and we are looking into extending transportation options.

References