

California Tuberculosis (TB) Risk Assessment

Frequently Asked Questions

Please refer to the fact sheet for specific instructions on how to complete the assessment.

1. Why was the California TB Risk Assessment for adults developed?

The California Tuberculosis Risk Assessment, a screening tool to aid healthcare providers in identifying adults for latent tuberculosis infection (LTBI) testing and to provide treatment, emphasizes testing of persons born outside the United States, those with current or planned immunosuppression, and close contacts to cases of infectious active TB. Routine testing of low risk populations is not recommended and may result in unnecessary evaluations and treatment because of false positive test results.

2. Who developed the California TB Risk Assessment?

The California Tuberculosis Risk Assessment is a product developed jointly by the Tuberculosis Control Branch at the California Department of Public Health (CDPH), the California Tuberculosis Controllers Association (CTCA), and the Curry International Tuberculosis Center (CITC). The tool is designed to help clinicians select adults for LTBI testing who are at high risk for TB exposure or progression to TB disease.

3. What evidence supports this change to using the California TB Risk Assessment?

Epidemiologic trends in California suggest that a large proportion of California's TB cases may be caused by progression of LTBI to active TB disease. In 2015, 81% of California's TB cases occurred in persons born in countries with elevated TB rates, up from 78% in 2014. From 2006 to 2015, the percentage of foreign-born TB patients who have resided in the United States for at least five years rose from 64% to nearly 80%, suggesting an increase in progression of remotely acquired LTBI to active TB disease.

Racial and ethnic disparities in TB remain evident in California. TB incidence rates among Asians and Pacific Islanders (19.5 per 100,000) were 21 times greater than among whites (0.9 per 100,000), while rates among blacks (4.0 per 100,000) and Hispanics (5.0 per 100,000) were four to five times as high. For the second year in a row, Asians and Pacific Islanders accounted for over half of California's TB cases (51% and 53% in 2014 and 2015, respectively).

In 2015, 37% of California's TB patients had at least one medical risk factor that increased their risk of progression from LTBI to active TB disease. The most common medical risk factor was diabetes mellitus, occurring in 28% of TB patients in 2015, up from 24% in 2014. Eighty-seven percent of TB patients were tested for HIV, and 2.9% of those tested positive. With the exception of HIV, medical risk factors were more prevalent among foreign-born TB patients than U.S.-born patients.

Very recently, the U.S. Preventive Services Task Force (USPSTF) has issued a draft statement recommending screening and treatment for LTBI in adults who are foreign-born from a country with an elevated TB rate. The USPSTF also recommended screening persons who live in, or have lived in, high-risk congregate settings (such as homeless shelters and correctional facilities). These recommendations received a “B” grade, meaning that this screening is required to be covered by insurance plans without cost sharing. The USPSTF is an independent panel of experts that systematically reviews evidence for the effectiveness of clinical preventive services.

4. *Who may use the California TB Risk Assessment?*

This simple assessment was designed with busy primary care providers in mind to focus testing and treatment on patients at highest risk. Persons that test positive for LTBI should generally be treated once active TB disease has been ruled out with a chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing. A decision to test is a decision to treat.

5. *Should the provider test an individual who was vaccinated with Bacillus Calmette–Guérin (BCG) and has been in the U.S. a long time?*

Yes, the individual should be tested at least once. Individuals vaccinated with BCG who have previously tested negative for LTBI and have no new risk factors would not need repeated testing.

6. *Should a provider use the California TB Risk Assessment for screening incarcerated or homeless persons or others who reside or work in congregate settings?*

The TB risk and epidemiology in these settings can vary substantially by geography and type of facility. In addition, regulatory and legal mandates may apply. Also, systematic screening programs may already exist in some communities (e.g., homeless shelter screening programs, jail screening programs).

Providers should contact their Local Health Officer for specific recommendations and requirements in their community. For more information, refer to the California Conference of Local Health Officers (CCLHO) page at: <http://www.cdph.ca.gov/programs/CCLHO/Pages/default.aspx>