CTCA

CALIFORNIA TUBERCULOSIS CONTROLLERS ASSOCIATION

Updates to CCLHO

Phuong Luu, MD, MHS, FACP
CTCA Executive Committee, RSHJ Member
October 15, 2025

CTCA
CALIFORNIA TUBERCULOSIS CONTROLLERS ASSOCIATION

working towards elimination by promoting excellence in tuberculosis treatment and prevention

CTCA is a professional association of local health department (LHD) tuberculosis (TB) program staff working with California Department of Public Health TB Control Branch (CDPH TBCB) staff to **advance TB care, prevention and elimination** in California. Find local and state TB staff in this **TB staff Directory**.

Guidance

Developed by representatives from the state and local health department TB control programs, CTCA member and CDPH-TBCB have endorsed these guidelines for use in California.

Events

CTCA hosts a variety of events, including educational conferences and planning meetings. Everyone is welcome to join and contribute to the fight against TB.

Awards

CTCA offers numerous awards to recognize individuals who have gone above and beyond in tuberculosis prevention, treatment, and advocacy.

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Emphasis on Health For All

CTCA is dedicated to **ensuring optimal health for all Californians.** We work to remove barriers to diagnosis, treatment, and prevention, focusing on communities disproportionately impacted by tuberculosis.

CTCA provides **resources** for **civil surgeons, patients, and providers,** including **joint guidance** in collaboration with CDPH TBCB.

Civil Surgeons

For Civil Surgeons who perform immigration medical examinations.

Patients

For individuals who have been diagnosed with tuberculosis.

Providers

For medical provideers and other professionals in the field.

Leadership

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Structure

The California Tuberculosis Controllers Association (CTCA) is led by a **volunteer-based** Executive Committee (EC), following the **Bylaws** (03/2025). The EC consists of officers who serve a four-year leadership cycle, and representatives from large, medium, small, and rural health jurisdictions.

At the start of each EC cycle, a **Work Plan** is developed to identify and prioritize the EC's goals for the upcoming year. Workgroups or committees are formed on an as-needed basis to support specific priorities outlined in the Work Plan.

The EC holds monthly meetings to review progress, discuss emerging priorities, and take action where appropriate. TB Controllers and their staff are invited to participate in these meetings through the TB Controllers email list.

To learn more about the EC meetings or get involved with any of CTCA's ongoing efforts, please click the **"Contact Us"** button below.

Executive Committee

- **President**
  Cameron Kaiser, MD, MPH, FAAFP
  Deputy Public Health Officer / EPIC Bureau Chief and TB Controller
  Solano Public Health Services

At-Large Members

- **Representative from the Highest Morbidity Jurisdiction**
  Julie Higashi, MD, PhD
  TB Controller
  Los Angeles County Public Health Tuberculosis Control Program

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- **President-Elect vacant**
- **Secretary-Treasurer**
  Sherilynn Cooke, MD
  TB Controller
  Los Angeles County Public Health Tuberculosis Control Program
- **Past President**
  Ankita Kadakia, MD
  Deputy Health Officer
  San Diego County Health and Human Services Agency
- **Ex-Officio Member**
  Jennifer Flood, MD, MPH
  Chief, TB Control Branch
  California Department of Public Health (CDPH)

- **TB Controller-at-Large**
  Sharon Wang, DO
  TB Controller
  San Bernardino County Public Health, Communicable Diseases, Emerging Diseases
- **Nurses and Allied Health Professionals (NAHP) Representative**
  Rocio Agraz-Lara, MSN, RN, PHN
  Nurse Manager
  San Francisco Department of Public Health, Population Health Division, Disease Prevention and Control, Tuberculosis Control
- **Rural and Small Health Jurisdictions (RSHJ) Representative**
  Phuong Luu, MD, MHS, FACP
  Health Officer and TB Controller
  Sutter County Health and Human Services, Public Health, Communicable Disease (CD); Yuba Health and Human Services
- **Additional Executive Committee Members**
  Amit Chitnis, MD, MPH
  Alameda County Public Health Department, Division of Communicable Disease Control and Prevention
  Angelito Bravo, MD
  Program Manager, Pulmonary Disease Services
  Orange County Healthcare Agency

For Medical Providers

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Introduce your TB patients to

we are TB, a national TB patient peer support and advocacy network, empowering those affected by TB through treatment and beyond.

we are TB flyer

Somos TB (Spanish flyer)

TB in Many Languages

(Thank you, Massachussets.)

Created by Ilaur Aptukov from Noun Project

Reporting:

AB2132 Law Effective, 1-1-25:

Primary care providers in California are required to evaluate their adult patients for tuberculosis (TB). To help providers implement this initiative, CTCA adapted CDPH TB Free California guidance into this two page guide, PREVENTING TB DISEASE IN 4 STEPS. A guide for Preventing TB Disease in Children is also available.

CalMatters bill summary

CDPH **Medical Board Letter_AB2132** and **Board of Registered Nursing Letter_AB2132**

TB Information for Primary Care Providers from:
California Department of Public Health, TB Free California:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB_Provider_Resources.aspx

Centers for Disease Control and Prevention, Think Test Treat: **https://www.cdc.gov/think-test-treat-tb/site.html#hcp**

TB Risk Assessments:

The California Department of Public Health (CDPH) Tuberculosis Control Branch (TBCB), and the Curry International Tuberculosis Center (CITC) worked with CTCA volunteers to create the four risk assessments. The risk assessments identify those in California at risk for TB infection which can become TB disease. We aim to find and treat TB infection before TB disease develops.

AB2132 TB Screening Law for Adults Resource
PREVENTING TB DISEASE IN 4 STEPS
and a guide for **Preventing TB Disease in Children**

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Updated Guidance
Guidance for TB Screening, Testing, and Treatment of Health Care Personnel,
CTCA Title 22 Tuberculosis (TB) Testing Program Flexibility Checklist
Title 22 Program Flexibility Tuberculosis Checklist Frequently Asked Questions (FAQs)

Guidance revisions underway:

- Assessment of TB Patient Infectiousness and Placement into High and Lower Risk Settings – **at CDPH/TBCB for review**
- Responsibilities of Public Health Departments to Control Tuberculosis - **at CDPH/TBCB for review**
- Investigation of Contacts of Persons with Infectious Tuberculosis
- Interjurisdictional Continuity of Care Fact Sheet

Ongoing Survey: Impacts of TB Control Funding Uncertainty on TB Programs

CTCA/CDPH Joint Guideline: Aims of the 2025 Proposed Update

- Incorporate 2024 NTCA guidelines for respiratory isolation and restrictions (RIR) to reduce TB transmission in community settings
- Update RIR guidance to further delineate and incorporate appropriate treatment and clinical improvement in both high and low-risk settings
  - Move away from smear status as a binary indicator of infectiousness once patients are on appropriate treatment
- Provide structure for the application of newer molecular diagnostics to the 2005 CDC guidelines for RIR in healthcare settings

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	CTCA/CDPH 2017 guideline element	2025 proposed changes
Patient on appropriate treatment	Introduced NAAT-based early assessment (treatment interruptions not addressed)	Introduces tNGS, WGS (treatment interruptions not addressed)
Duration of appropriate treatment via DOT Clinical improvement recommended for all Molecular susceptibility results **required** for ALL high-risk settings & MDR	SETTING low-risk / high-risk Sm NEG: ≧1 d / ≧5 d Sm POS: ≧14 d + sm conv / ≧14d + sm conv MDR+/-: ≧14 d + sm conv / ≧14 d + cx conv	SETTING low/mod-risk / high-risk Sm NEG: ≧1 d / ≧5 d Sm POS: ≧5 d / ≧14 d MDR +/-: ≧14 d / ≧14 d smear and culture parameters utilized as part of "clinical improvement" assessment, but smear or culture conversion to negative not required
Mask use	Not addressed	Recommended use in moderate and high risk settings until cleared by public health
Healthcare settings	Same treatment as other high-risk settings	Carved out - CDC guidance (Table 2)
Additional tools		(1) RIR decision algorithm (2) Clinical Improvement checklist (3) Appropriate treatment checklist (4) Patient communication tool

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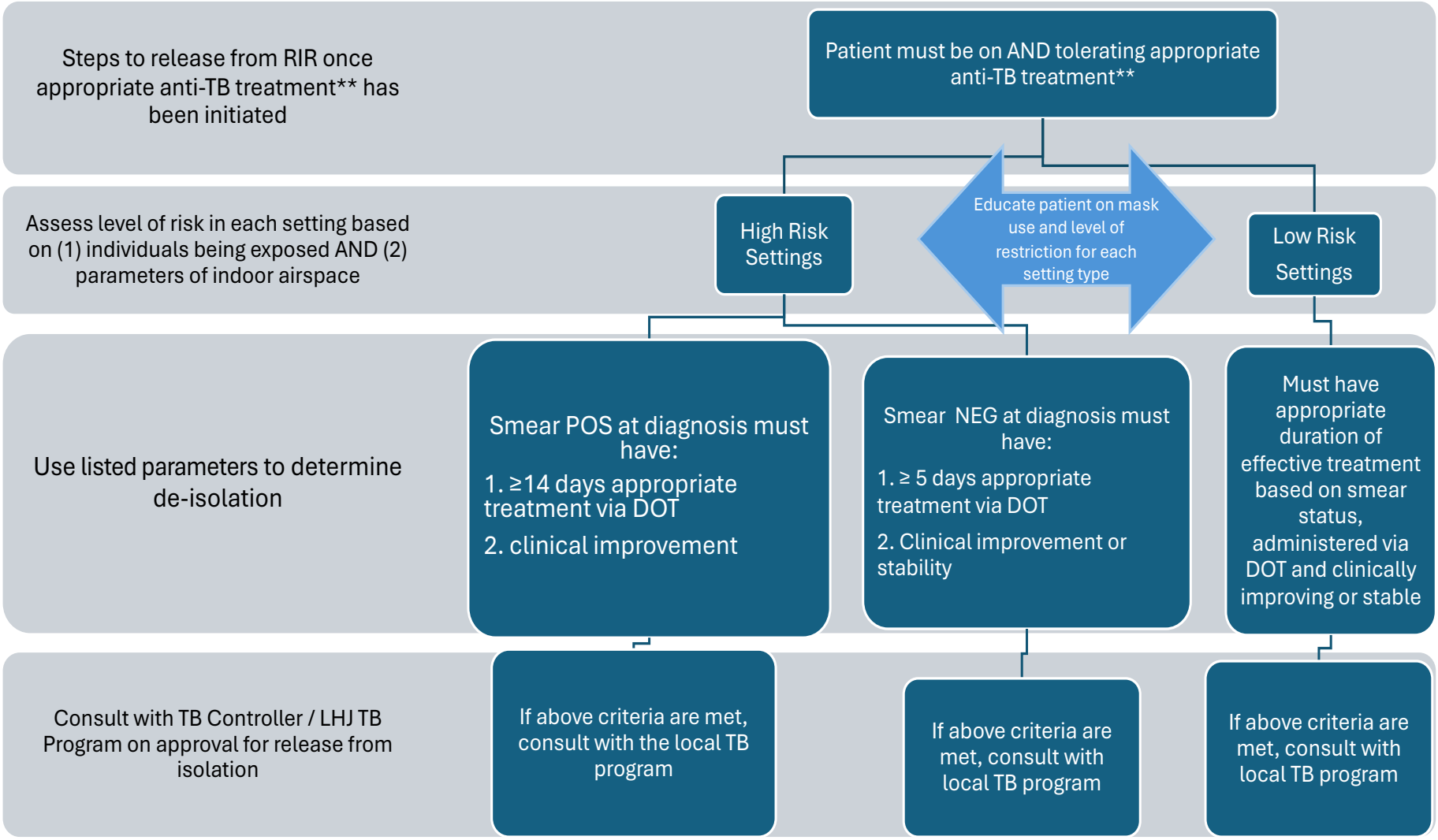


The bi-directional arrow acknowledges that patients might travel in and out of different risk settings and should be counseled on appropriate mask wearing when transitioning to a high-risk community setting such as for a medical appointment or in an indoor crowded space if they have not met de-isolation criteria for these settings.

Application of Draft CA Guidelines for Release from Respiratory Isolation and Restriction (RIR) in Community Settings

Susannah Graves, MD, MPH
Director, TB Branch
San Francisco Department of Public Health

Karissa LeClair Cortéz, MD, MPH
Deputy Health Officer
Santa Cruz County Public Health Division

Sep 8, 2025

Objective

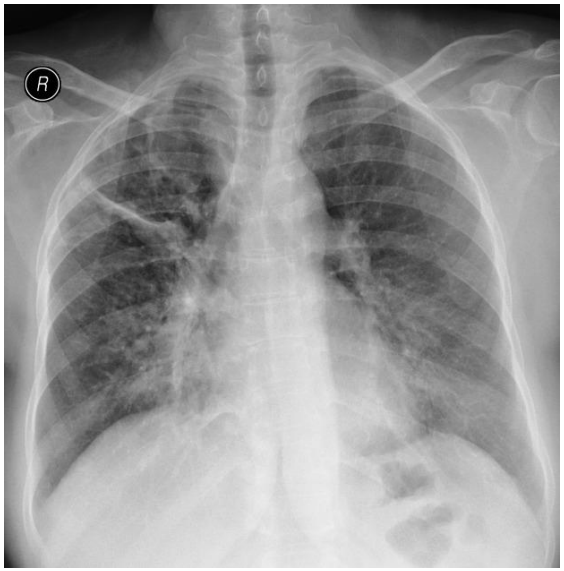
- Describe how to apply the draft updates to California's Guidelines for Release from Isolation to cases to support accurate assessment of patient infectiousness and appropriately tailor precautions in various community settings

Clinical Case: Initial Presentation

- **59 yo M** presents with 3 months of cough, ~30 lb weight loss
  - **PMH:**
    - T2DM
    - HTN
    - HLD
    - Smokes 1 PPD
    - EtOH use disorder?
  - **Social Hx:**
    - From Mexico (<6 mo ago)
    - Farmworker
    - Shares living space with someone treated for MDR TB within past year
- **Next steps?**

Clinical Case: Work-Up

- **Sputum:** 4+ smear, PCR+, Xpert+ with rpoB mutation, sent for DST and WGS
- **CT Chest:** reticulonodular densities in R lung and LUL. Cavitary lesions in RUL (2.2x5x1.8)
- Started on **BPaLM** in hospital for presumed MDR TB
  - Bedaquiline
  - Pretomanid
  - Linezolid
  - Moxifloxacin



[Similar image, not actual case CXR]

Category	Lab Criteria	Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
Low suspicion for TB **(TB5 low, alternate diagnosis more likely, no empiric treatment)** - **Smear neg x3, NAAT neg** - **Smear pos, NAAT neg x2 (ideally smear and NAAT from same specimen)**	AFB smear neg x 3 OR AFB smear pos and NAAT neg x2	No minimum days of TB treatment required	No minimum days of TB treatment required
TB known/suspected **(TB3 or TB5 high), without MDR risk-factors** - **Smear neg x3, NAAT neg** - **Smear neg x3, NAAT pos**	No rpoB mutation if NAAT pos	≥ 5 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement	≥1 dose of appropriate TB treatment taken by DOT and tolerated
TB known/suspected **(TB3 or TB5 high)** - **Smear pos, NAAT pos** **(NAAT or other molecular testing for rifampin susceptibility should be completed prior to RIR)**	No rpoB mutation	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement	≥ 5 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement
MDR TB suspected **(TB5 high)** - **Smear neg, NAAT neg, MDR risk factors**	1st and 2nd line DSTs requested on any culture growth with WGS DST	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement
MDR TB known (TB3) - **Smear neg, NAAT positive with rpoB mutation or high probability of rifampin resistance** - **Smear pos, NAAT positive with rpoB mutation or high probability of rifampin resistance**	Molecular resistance testing requested	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

Initial recommendation: **extensive (strict) isolation**

Categorize baseline infectiousness of pulmonary/laryngeal TB based on:

- TB known, high likelihood (TB5 high) or low likelihood (TB5 low)
- Smear and NAAT status
- Any known or suspected drug resistance

Category	Lab Criteria	Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
MDR TB known (TB3) - **Smear neg, NAAT positive with rpoB mutation or high probability of rifampin resistance** - **Smear pos, NAAT positive with rpoB mutation or high probability of rifampin resistance**	Molecular resistance testing requested	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

Clinical Case: Discharge Plan

- After 6 weeks in hospital…
  - Improved sx and weight gain, tolerating BPaLM (1.5 weeks)
- **Home Setting:** lived in garage with 6 other people, 2 high risk
  - 3 yo child
  - 54 yo F previously treated for MDR m. *bovis*
- **Discharged to:** hotel room
  - In-room kitchen
  - Food brought by Public Health staff

Next: Assure Lab Criteria are met

Prior to release of respiratory isolation restrictions for a patient with **lab-confirmed** or **high likelihood** TB (TB3 / TB5 high):

Category	Lab Criteria	Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
MDR TB known (TB3) - **Smear neg, NAAT positive with rpoB mutation or high probability of rifampin resistance** - **Smear pos, NAAT positive with rpoB mutation or high probability of rifampin resistance**	Molecular resistance testing requested	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

Then: review considerations for progressive release of respiratory isolation restrictions (RIR)

Patient questions:

- When can I go back to work?
- When can I go grocery shopping?
- When can I return to my home?

RIR Public Health Interventions:

- Extensive (strict) RIR
- Moderate RIR
- No RIR

Category	Lab Criteria	Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
MDR TB known (TB3) - **Smear neg, NAAT positive with rpoB mutation or high probability of rifampin resistance** - **Smear pos, NAAT positive with rpoB mutation or high probability of rifampin resistance**	Molecular resistance testing requested	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

Review considerations for progressive release of respiratory isolation restrictions (RIR)

(1) *__At least__* 14 days appropriate TB

Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
≥ 14 days of appropriate TB treatment by DOT taken and tolerated	≥ 14 days of appropriate TB treatment by DOT taken and tolerated
AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	AND clinical improvement

What is considered "Appropriate TB treatment"?

Definition: A multi-drug regimen approved by the local health jurisdiction's (LHJ) TB Program to which the patient's TB isolate is expected to be susceptible based on epidemiology and molecular and/or phenotypic drug susceptibility tests (DSTs). For further detail, refer to the most recent CDC TB treatment guidelines for tuberculosis.

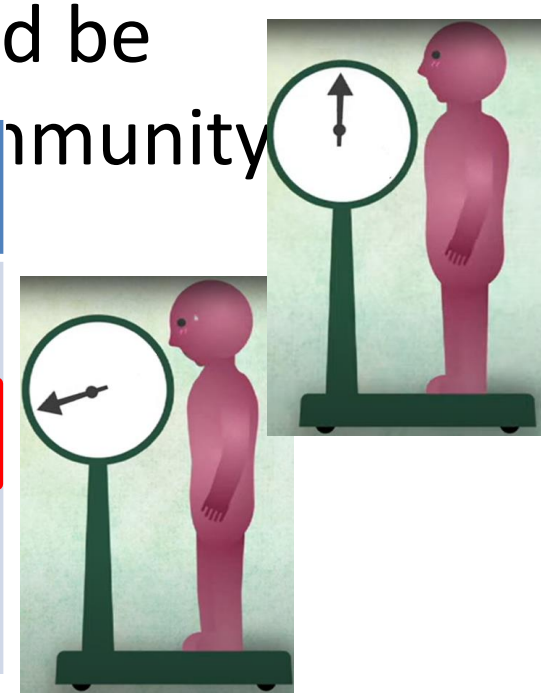
Checklist (Appendix 3 checklist):

- ✓ Multi-drug regimen (usually 4 drugs) approved by local TB program
- ✓ Patient is tolerating stable daily therapy
- ✓ If available, DST or molecular testing (WGS, tNGS) shows no evidence of resistance to medications in the regimen
- ✓ If performed, drug levels therapeutic

Review considerations for progressive release of respiratory isolation restrictions (RIR)

(2) Clinical improvement, cough should be

Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
≥ 14 days of appropriate TB treatment by DOT taken and tolerated	≥ 14 days of appropriate TB treatment by DOT taken and tolerated
AND clinical improvement, no cough	AND clinical improvement
AND Molecular or growth-based susceptibility results available	



Graphic adapted from: How the body reacts to TB (MSF)

What is considered "Clinical Improvement"?

Definition: observed improvement in clinical parameters (signs, symptoms, laboratory, radiographic or other findings).

Checklist (Appendix 3 checklist):

- ✓ Decreased cough
- ✓ Weight gain
- ✓ If available, repeat radiographic imaging is stable or ideally improved
- ✓ If smear positive: AFB smears are improving/decreasing in positivity
- ✓ If culture positive: time to culture positivity is lengthening
- ✓ Other reported improvements

Review considerations for progressive release of respiratory isolation restrictions (RIR)

(3) For release into high risk community settings, molecular or growth-based susceptibility results appropriate

Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

Clinical Case: Questions

Progress: 2 weeks of BPaLM, no treatment holds, adhering to DOT, smear decreased from 4+ to 2+, continued weight gain, cough resolving. *Does not yet have WGS or DST results.*

- **Can I go back to work?**
  - Setting: outdoor farm work, portable toilets, open-walled shelter for breaks, commutes there alone in his private vehicle – **LOW RISK**

- **Can I go grocery shopping?**
  - Setting: includes persons not previously exposed to TB, but exposure is brief – **MODERATE RISK**

- **Can I return to my home?**
  - Setting: single room residence which includes high-risk contacts (and unable to get 3 yo to take WPP), frequent turnover of residents/quasi-congregate – **HIGH RISK**

Define the setting

Moderate risk settings:

- Non-high-risk settings that include persons not previously exposed to TB and where exposure is brief:
  - Indoor, public, non-high-risk settings (e.g. grocery store, library, pharmacy, local public transportation)
  - Outdoor, crowded events (e.g. wedding, concert, sporting event, rally)
  - Outpatient medical settings may be considered to be moderate risk, if they have appropriate administrative and environmental controls in place to be able to accommodate a patient with low infectious potential. Consult local TB Program with questions.

In these settings, recommend use of well-fitted, good quality mask, ideally provided by the TB program, until cleared by public health.

Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement, no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

✘ **Quasi-congregate home** – **HIGH RISK SETTING**

✓ **Outdoor work** – **LOW RISK SETTING**

Grocery shopping – **MODERATE RISK SETTING —> use mask**

Moderate RIR may be feasible

Definition: restrictions that may limit employment, congregate housing or social/community activities occurring in crowded and/or poorly ventilated indoor spaces, as well as new exposures to vulnerable populations. Well-fitted, high-quality mask use recommended for brief entry into moderate and low-risk settings, most outdoor activities are permitted.

- What is the impact on this individual from remaining in isolation?
- How well does he understand airborne transmission of TB?
- How well does he understand the instructions for different types of settings?
- Will masking in moderate or higher-risk settings that he enters be acceptable and feasible to him and those around them?

Clinical Case: Questions

Progress:

- **6 weeks of BPaLM, no treatment holds, adhering to DOT**
- **Smears this week are 0 and 1+, cultures from 5 weeks ago just started growing and cultures from 4 weeks prior are still NGTD**
- **Continued weight gain, cough resolved**
- **WGS shows *m. bovis* (constitutively PZA-resistant), and confirms rifampin resistance mutation in *rpoB.* No other high-prob resistance mutations detected.**
- **Phenotypic DST confirmed susceptibility FQN, LZD, BDQ, and (with a waiver) Pretomanid**

Patient questions:

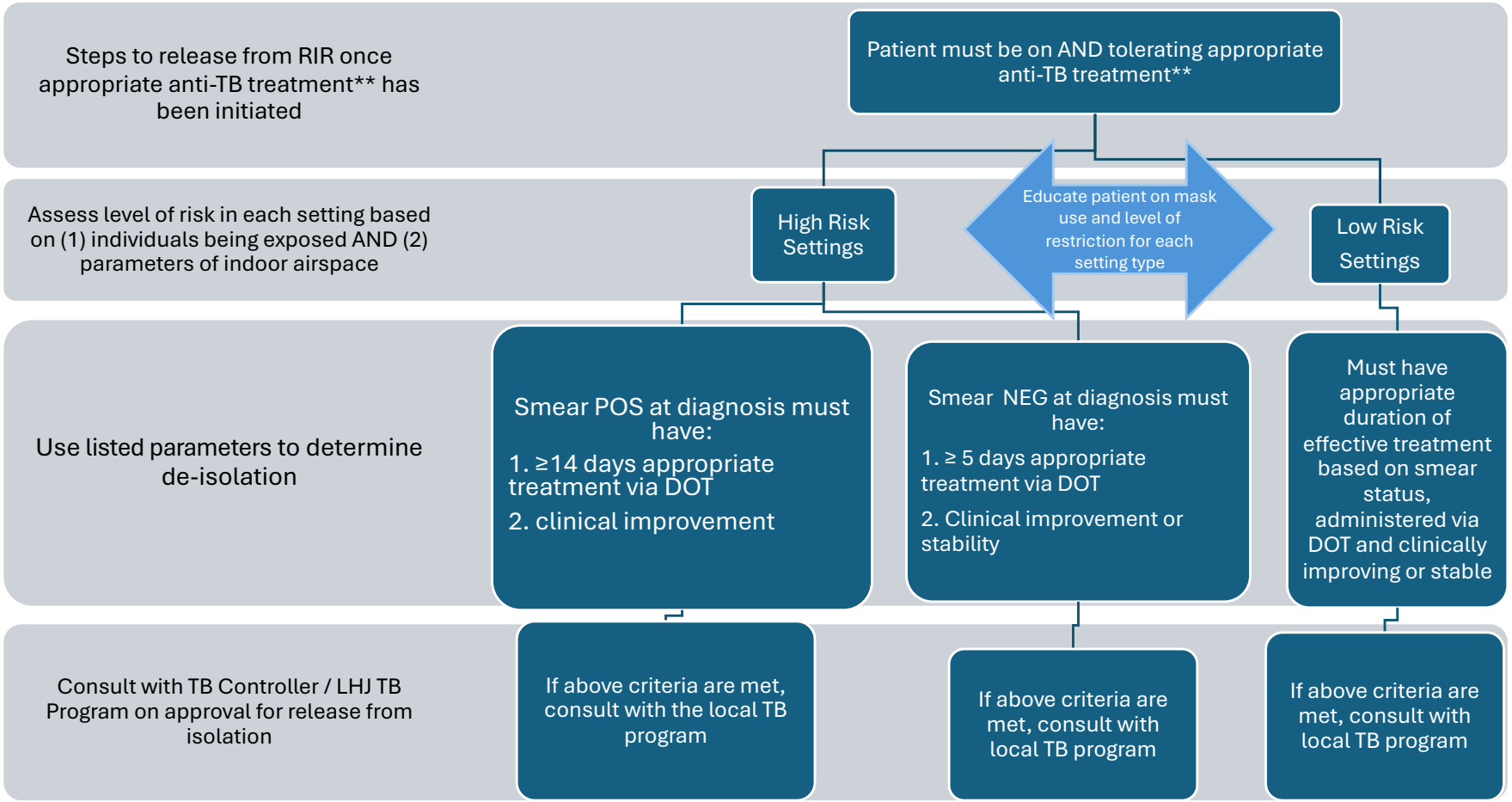
- **Can I go grocery shopping without a mask? — MODERATE RISK SETTING**
- **Can I return to my home now? Should I use a mask? – HIGH RISK SETTING**
- **Can I go to my granddaughter's baptism? Should I mask? – HIGH RISK SETTING**

Treatment Criteria for release from RIR into High Risk Community Settings	Treatment Criteria for release from RIR in Low/Moderate Risk Community Settings
≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement no cough AND Molecular or growth-based susceptibility results available	≥ 14 days of appropriate TB treatment by DOT taken and tolerated AND clinical improvement

× **Quasi-congregate home** – **HIGH RISK SETTING**

Baptism – **HIGH RISK SETTING —> use mask**

Grocery shopping – **MODERATE RISK SETTING —> use mask**



The bi-directional arrow acknowledges that patients might travel in and out of different risk settings and should be counseled on appropriate mask wearing when transitioning to a high-risk community setting such as for a medical appointment or in an indoor crowded space if they have not met de-isolation criteria for these settings.

Thank You

Appendix

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Survey: Impacts of TB Control Funding Uncertainty on TB Programs

CTCA seeks to stay informed about changes in TB control capacity across the state by periodically asking TB programs these questions. The only identifying question is about TB burden.

1. What gaps existed in your TB services prior to these new cuts that you felt your program should be providing? Please explain:

2. What is your active TB case burden? (cases/year)

- ◯ Low (<15)
- ◯ Medium (15-54)
- ◯ High (55-99)
- ◯ Very High (>100)

3. Are you seeing reductions in the LHJ's proportion of realignment dedicated directly to TB? If so, by how much?

- ◯ <25%
- ◯ 25-50%
- ◯ Other (please specify)