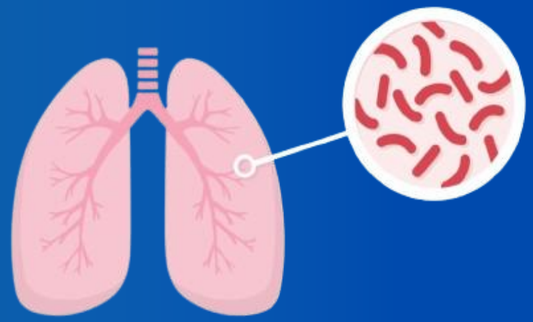
County of Los Angeles Public Health



SOUTHERN CALIFORNIA REGIONAL

COMMUNITY OF PRACTICE TO END TB

Wednesday, September 2nd, 2026

12:00PM - 1:30PM PST

Agenda

Community of Practice Member Updates

12:00 – 12:10	Welcome and introductions	**Melissa Zhang** TB Control Program Analyst Los Angeles County Department of Public Health	
12:10 – 12:25	Provider Portal and TB Reporting Update	**Ashley Randle** Senior Health Educator Los Angeles County Department of Public Health	**Parveen Kaur, MD** Clinical Lead Southern CA CoP to End TB
12:25 – 12:45	Strengthening Tuberculosis Prevention: A Pharmacist-Led Approach to LTBI Treatment	**Brian Buckley, MD MPH** Los Angeles County Department of Health Services	
12:45 – 1:05	TEA Mini-Grant Lessons Learned: Central City Community Health Center, Inc.	**Anna Melendez** Quality Improvement Lead Central City Community Health Center, Inc.	**Melissa Zhang** TB Control Program Analyst Los Angeles County Department of Public Health
1:05 – 1:15	Discussion session and meeting closure	**Melissa Zhang** TB Control Program Analyst Los Angeles County Department of Public Health	**Parveen Kaur, MD** Clinical Lead Southern CA CoP to End TB

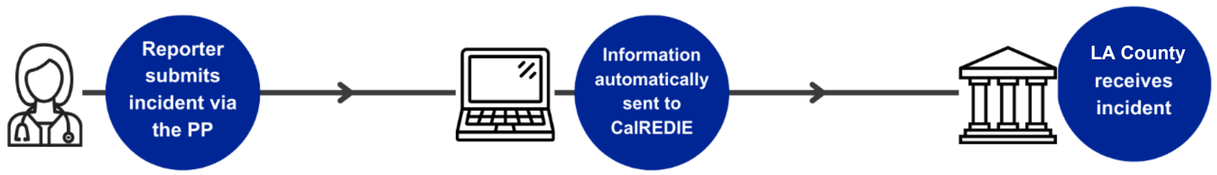
LA County is transitioning provider case reporting to CalREDIE's Provider Portal

Transition to Provider Portal effective on September 1st

- Online, state-wide interface for confidential morbidity report submissions
- No changes to case reporting requirements mandated by Title 17 Section 2500
  - Applies for all non urgent diseases and conditions (excluding HIV)
- Email LAC_PPSupport@ph.lacounty.gov with concerns or questions about the transition

Accounts required for individuals designated to submit case reports

- Register at https://redcap.link/CalREDIEProviderPortal
- Each user account must register all LA County facilities they submit reports for
  - Those with existing accounts should use the registration link to update it to register LA County facilities



Learn more at ph.lacounty.gov/hpreport

County of Los Angeles Public Health

TB Reporting
LA County TB Control Program

Parveen Kaur, MD

September 2, 2026

TB Reporting Requirements Effective September 1, 2026

- Beginning September 1, 2026, Public Health will receive reports of all suspected or confirmed tuberculosis (TB) cases in ambulatory healthcare settings through the CalREDIE Provider Portal.
- CalREDIE (California Reportable Disease Information Exchange)
- While reports of TB may still be submitted using the Confidential Morbidity Report (CMR) form by fax, there may be significant delays in processing referrals that are not submitted through the CalREDIE Provider Portal

Health and Safety Code (HSC) and Title 17 in CCR

- Reports of persons undergoing evaluation for TB disease and with confirmed TB are required under
- HSC Section 121362 and
- CCR (California Code of Regulations) Title 17, Section 2500

must be submitted within one working day of identification.

Who Must Report?

- All health care providers (including administrators of health care facilities and clinics) who are attending a patient suspected or confirmed to have active tuberculosis must report within one working day from the time of identification.

- The director of any clinical laboratory, or their designee, must report laboratory evidence suggestive of TB to Public Health on the same day that the physician who submitted the specimen is notified (California Code of Regulations Section 2505)

When Do You Report?

When the following conditions are present:

- The patient has signs and symptoms of TB, and/or
- The patient has an abnormal chest x-ray consistent with TB, or
- The patient is placed on two or more anti-TB drugs for treatment of TB. (This does not include treatment for non-tuberculous mycobacteria [NTM].)
- When bacteriology smears or cultures are positive for acid-fast bacilli (AFB).
- When the patient has a nucleic acid amplification test, PCR, or culture that is positive for M. tuberculosis complex (i.e., M. tuberculosis, M. bovis, M. canettii, M. africanum, M. microti) or when phenotypic or molecular drug resistance is detected.
- When a pathology report is consistent with TB.
- When a patient age 2 years or younger has a positive tuberculin skin test (TST) or interferon gamma release assay (IGRA).

Why Report a Positive TB test under 2 yrs age?

- A positive Tuberculosis (TB) test in children under 2 years old is a critical public health event that requires immediate reporting primarily because it serves as a sentinel marker of active, ongoing TB transmission in the community.
- Because infants and toddlers are rarely contagious themselves, their infection means they were recently exposed to an infectious adult. Public health departments step in immediately to find the source and protect the child

Positive TB test under 2 yrs of Age

1. It signifies Recent Community Transmission

2. High Risk of Rapid Progression to Severe Disease

3. Danger of Extrapulmonary Complications

4. Ensuring Specialized Medical Monitoring

   guarantee that the child undergoes immediate

   - chest X-rays,
   - proper diagnostic staging, and
   - specialized pediatric treatment

Delay or Failure To Report

- Delay or failure to report communicable diseases results in continued disease transmission in the County.
- Under the California Code of Regulations, Title 16 (section 1364.10), failure to report a communicable disease is a violation of state regulations and may result in citations and monetary fines.
- The Medical Board of California determined that failure to report in a timely manner is a citable offense under California Business and Professions Code (Section 2234), "Unprofessional Conduct

How Do You Report?

- Submit through the CalREDIE Provider Portal, the preferred route for receiving reports.
- Alternatively, the CMR form may be submitted to the TB Control Program.
- Attach clinical notes, radiology reports, IGRA/TST results, microbiology (AFB sputum with smear and culture, Mtb PCR), pathology reports, and the insurance face sheet.

LTBI or TB Infection Reporting

- Routine reporting of latent tuberculosis (TB) infection in adults is not required in California, but it is mandatory in certain high-risk situations
- Children less than two years old.
- Persons with TST/IGRA conversion who live or work in a healthcare setting

Civil surgeons must report it via eMedical

How should LTBI be reported by Civil Surgeons?

- All civil surgeons in the United States are now **required** by the CDC to use an online system called eMedical to report persons adjusting their immigration status who are found to have latent TB infection.
- **We encourage you to stop using the CalREDIE Provider Portal, and to report LTBI using eMedical.**

What should be reported? and information on referring patients who need additional evaluation for TB.

https://ctca.org/civil-surgeons/reporting-instructions/

Questions?

Strengthening Tuberculosis Prevention: A Pharmacist-Led Approach to LTBI Treatment

Brian Buckley MD MPH

September 2, 2026

Overview

- East Los Angeles Health Center Group Snapshot
- Clinical pharmacist-led LTBI clinic
  - Training
  - Workflow
  - Results

East Los Angeles Health Center Group

Ambulatory Care Network
HEALTH SERVICES • LOS ANGELES COUNTY
Quality • Compassion • Responsibility

East Los Angeles Health Center Group

- Part of LA County's Dept. of Health Services (DHS)
- Multispecialty care
  - Adult and pediatric primary care
  - OB/GYN
  - IM specialties (Cardiology, Complex DM clinic)
  - Medication-assisted treatment (MAT) clinic
  - **Clinical pharmacy service**
- On site laboratory, radiology and pharmacy

Patient Demographics

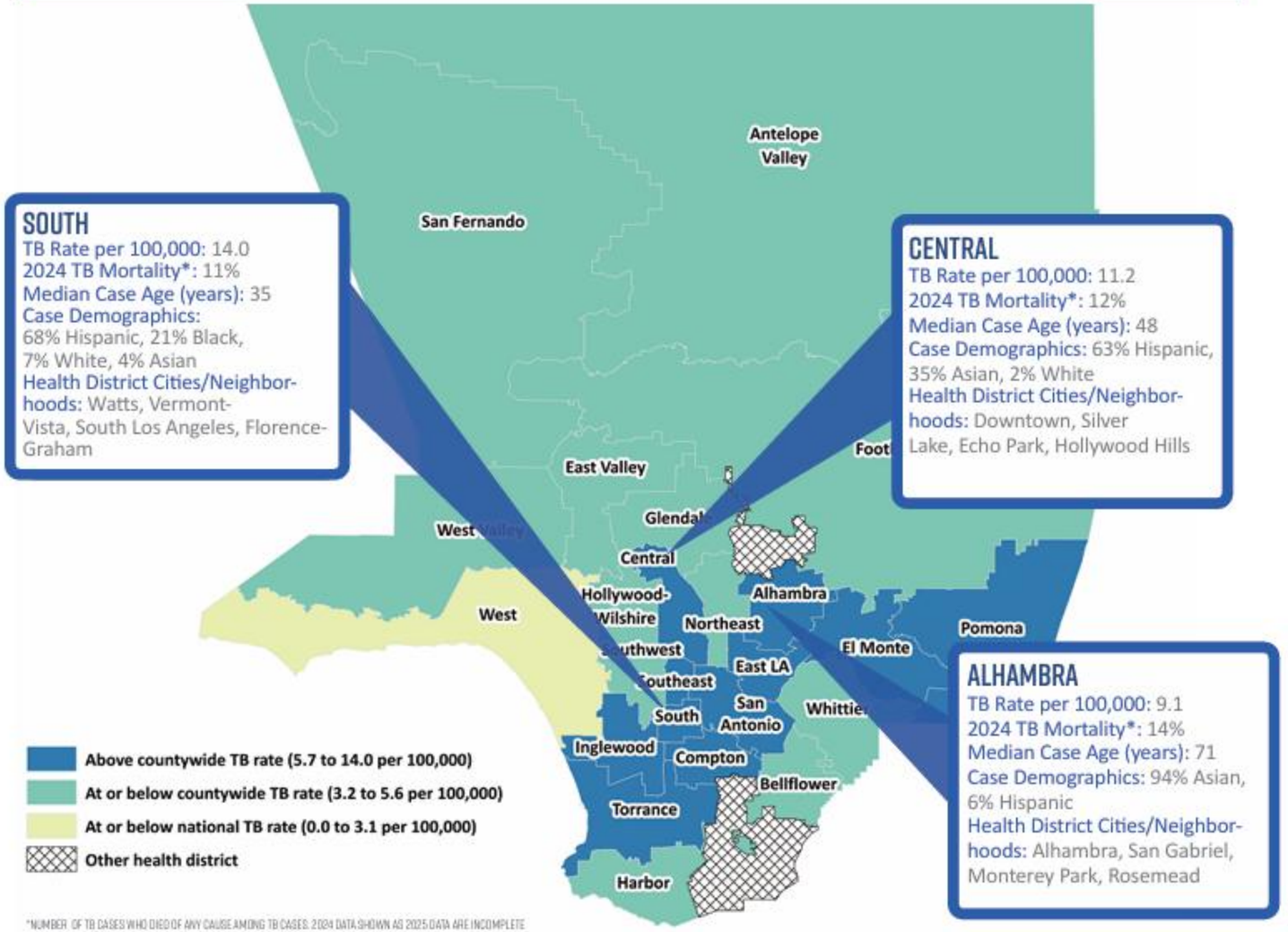
- Race/Ethnicity
  - Mexican = 67.9%
  - Central American = 13%
  - Non-Latinx =12%
    - Chinese = 2%
    - AA = 1%
- Language
  - Spanish = 63.8%
  - English = 33.9%
  - Cantonese = 0.7%
  - Mandarin = 0.627%

Ho, Rizalina. Personal communication, September 13, 2023

TUBERCULOSIS
in Los Angeles County 2025

County of Los Angeles Public Health

TB CASE RATES BY HEALTH DISTRICT 2025 (TOP 3 DISTRICTS WITH HIGHEST RATES HIGHLIGHTED)



SOUTH
TB Rate per 100,000: 14.0
2024 TB Mortality*: 11%
Median Case Age (years): 35
Case Demographics: 68% Hispanic, 21% Black, 7% White, 4% Asian
Health District Cities/Neighborhoods: Watts, Vermont-Vista, South Los Angeles, Florence-Graham

CENTRAL
TB Rate per 100,000: 11.2
2024 TB Mortality*: 12%
Median Case Age (years): 48
Case Demographics: 63% Hispanic, 35% Asian, 2% White
Health District Cities/Neighborhoods: Downtown, Silver Lake, Echo Park, Hollywood Hills

ALHAMBRA
TB Rate per 100,000: 9.1
2024 TB Mortality*: 14%
Median Case Age (years): 71
Case Demographics: 94% Asian, 6% Hispanic
Health District Cities/Neighborhoods: Alhambra, San Gabriel, Monterey Park, Rosemead

*NUMBER OF TB CASES WHO DIED OF ANY CAUSE AMONG TB CASES. 2024 DATA SHOWN AS 2025 DATA ARE INCOMPLETE
**PASADENA & LONG BEACH EXCLUDED AS THEY HAVE THEIR OWN HEALTH DEPARTMENTS

Los Angeles County Department of Public Health. "Tuberculosis in Los Angeles County 2025." Retrieved from http://ph.lacounty.gov/tb/docs/2025TuberculosisFactSheet.pdf

Clinical Pharmacist Service

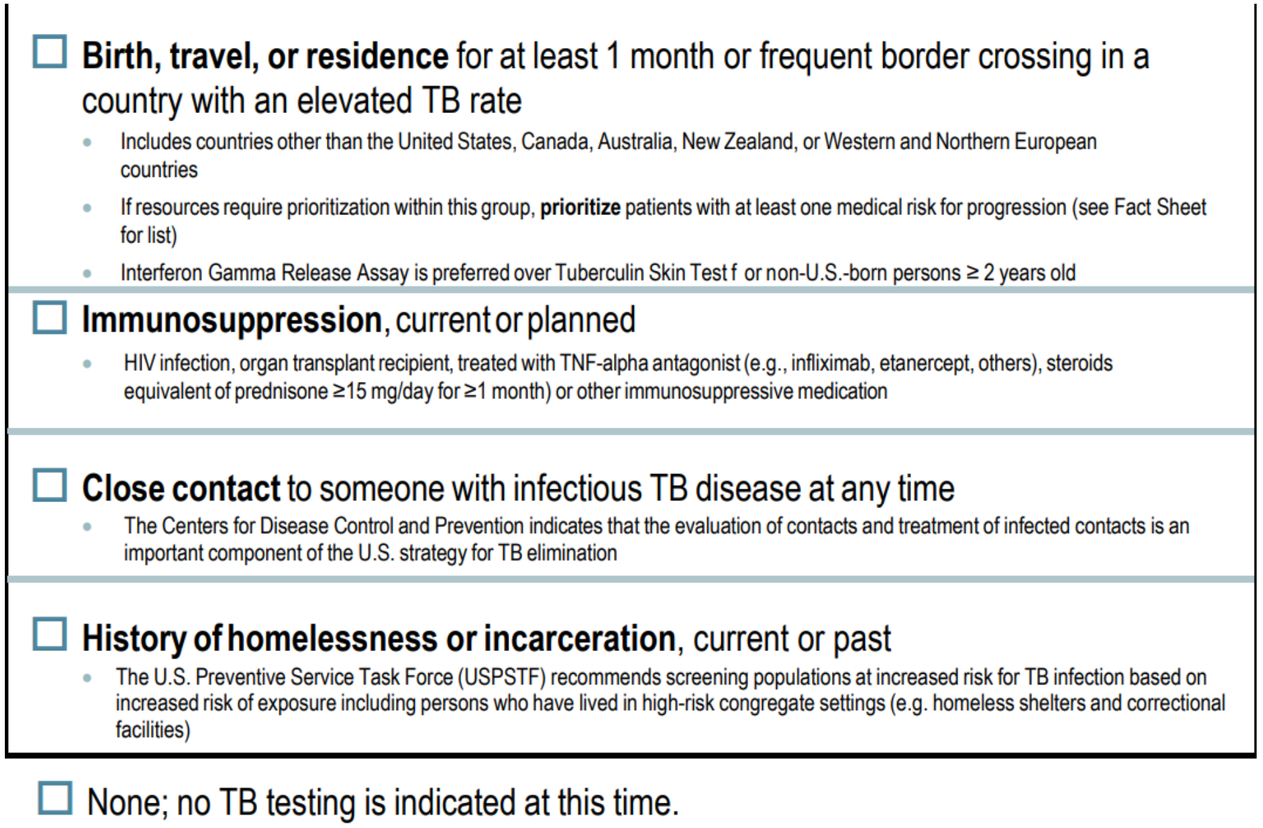
- Created by ELA Medical Leadership yrs ago
  - Converted open mid-level provider budget item to clinical pharmacist item
- Staffed by PharmD's
- Existing referral and titration practice for:
  - Anticoagulation
  - DM rx titration
  - BP rx titration
  - *H. pylori* tx
- Aug 2023
  - ELA leadership approves clinical pharmacy service to manage LTBI tx
  - MD-clinical pharmacist LTBI training
- Sept 2023
  - First referral to pharmacist-led LTBI Clinic

Clinical Pharmacist Training

- DHS Expected Practice for LTBI Treatment
  - Rifamycins preferred per 2020 NTCA/CDC Tx of LTBI guideline
  - Monitoring visits and labs (similar to 2000 ATS/CDC Statement on LTBI Tx)
    - At least monthly visits
    - Baseline LFT's
    - Repeat LFT per baseline results/risk factors
- Navigating DDI's
  - Rifamycin Drug-Drug Interactions – A Guide for Primary Care Providers Treating LTBI
- Managing Side Effects
  - Curry Nursing Guide for Managing Side Effects to Drug-resistant TB Treatment
  - 2016 ATS/CDC/IDSA Treatment of Drug Susceptible TB
- Closure documentation in EHR
  - Use LAC DPH form

LTBI Clinic Referral Procedure

- MD evaluates patient
  - TB Risk Assessment
  - TB disease sx screen
  - CXR
  - IGRA
- If c/f TB dz, MD starts eval
- If c/w LTBI, MD discusses r/b tx with patient
- If pt agrees to tx → MD refers to LTBI Pharmacy Clinic
  - Approx 1-3 wks until visit



☐ **Birth, travel, or residence** for at least 1 month or frequent border crossing in a country with an elevated TB rate

- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and Northern European countries
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see Fact Sheet for list)
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test f or non-U.S.-born persons ≥ 2 years old

☐ **Immunosuppression**, current or planned

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease at any time

- The Centers for Disease Control and Prevention indicates that the evaluation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination

☐ **History of homelessness or incarceration**, current or past

- The U.S. Preventive Service Task Force (USPSTF) recommends screening populations at increased risk for TB infection based on increased risk of exposure including persons who have lived in high-risk congregate settings (e.g. homeless shelters and correctional facilities)

☐ None; no TB testing is indicated at this time.

http://publichealth.lacounty.gov/tb/docs/AdultTB-RiskAssessment.pdf

LTBI Pharmacist Clinic Operations

- Pre-referral expectations
  - IGRA done
  - Sx screen done and neg
  - CXR done and normal
  - Baseline LFT’s and CBC done
- PharmD reviews tx options
  - 4R and 3HP favored
- Prescribes tx independently
- Monitors labs
- Monitors for side effects
  - Hepatoxicity especially
- Confirms adherence
  - Pill counts
  - Calls pharmacy to confirm picked up rx
- Documents completion in EHR

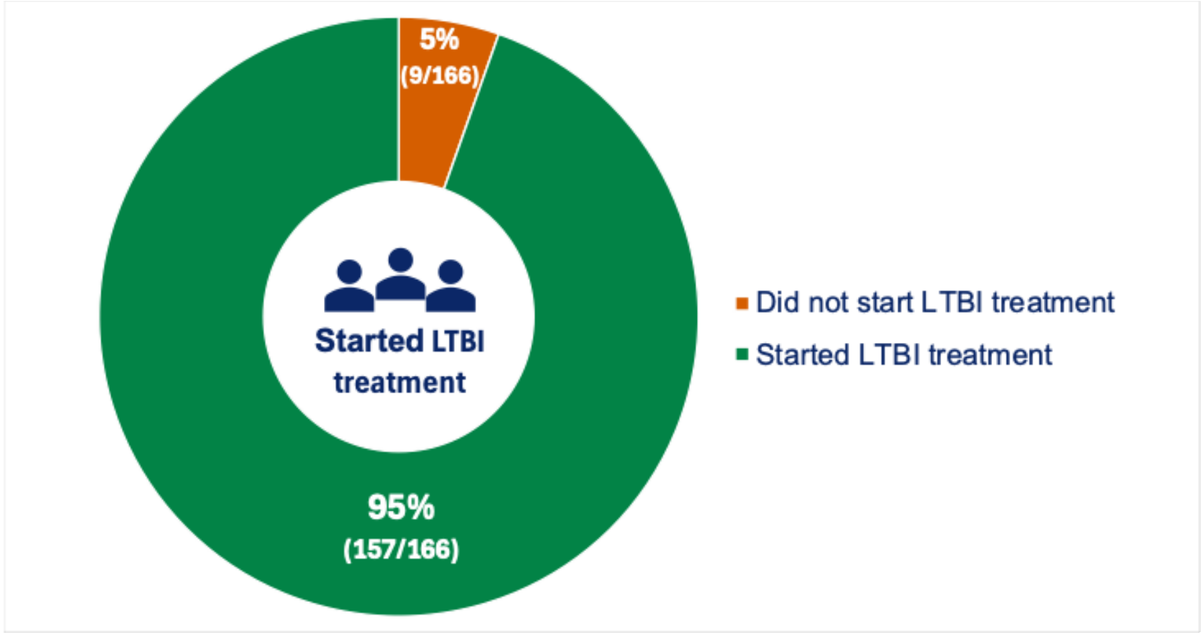
LTBI Pharmacist Clinic Operations

- MD Consultation available as needed
  - Local physician champion
  - LAC DPH TB Control Program
- Common reasons for consultation
  - Drug-Drug Interactions
  - Side effects/Regimen Intolerance
  - Coordination of care for complex patients (ie. Active cancer, immunocompromised, cirrhosis, etc.)
  - Treatment completion determination if used multiple regimens

LTBI Clinic Data Analysis

- All persons referred from adult primary/urgent care to the pharmacist-led LTBI clinic between September 1, 2023 and April 15, 2026
- Persons were eligible for referral if:
  - Positive QuantiFERON-TB test **AND**
  - Active TB ruled out through chest X-ray and symptom screening
- Persons excluded from analysis if they were still on LTBI treatment on April 15, 2026

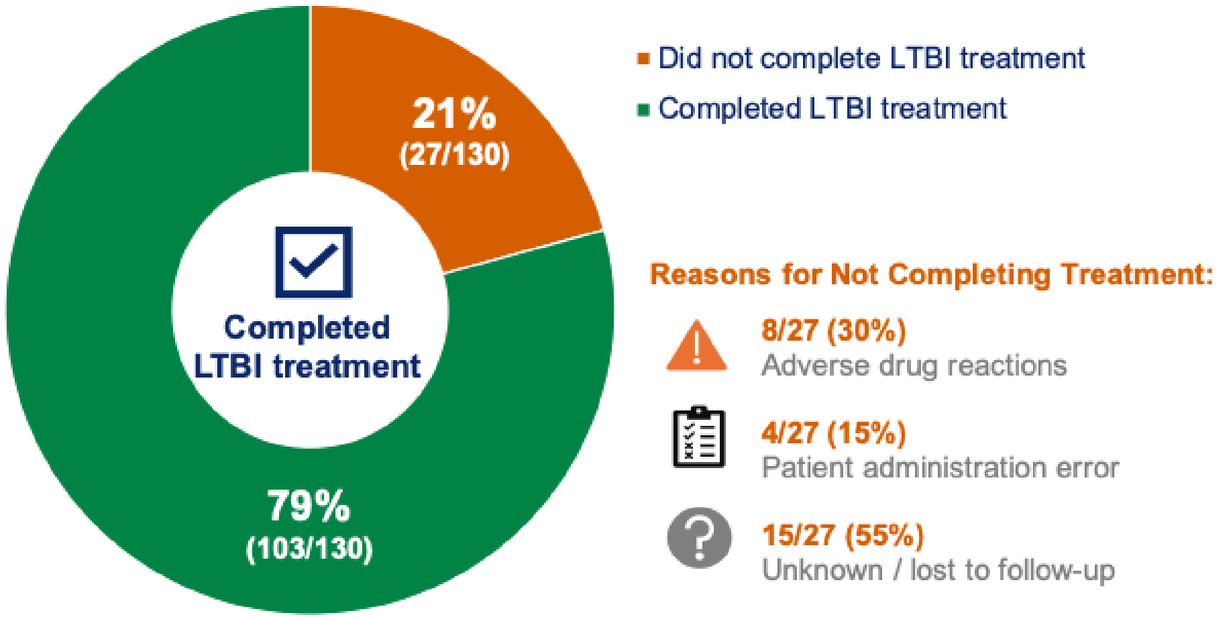
Treatment Initiation



166 persons were referred, of whom 95% (157/166) were started on LTBI treatment and 5% (9/166) did not start treatment (4 declined, 1 with TB disease, 1 undergoing TB disease evaluation, 3 pending).

Data not shown**: Rifamycin-based regimens were used 93% of the time (4R 61%, 3HP 32%)** with only 9 persons started on isoniazid monotherapy due to either drug-drug interactions or rifamycin intolerance.

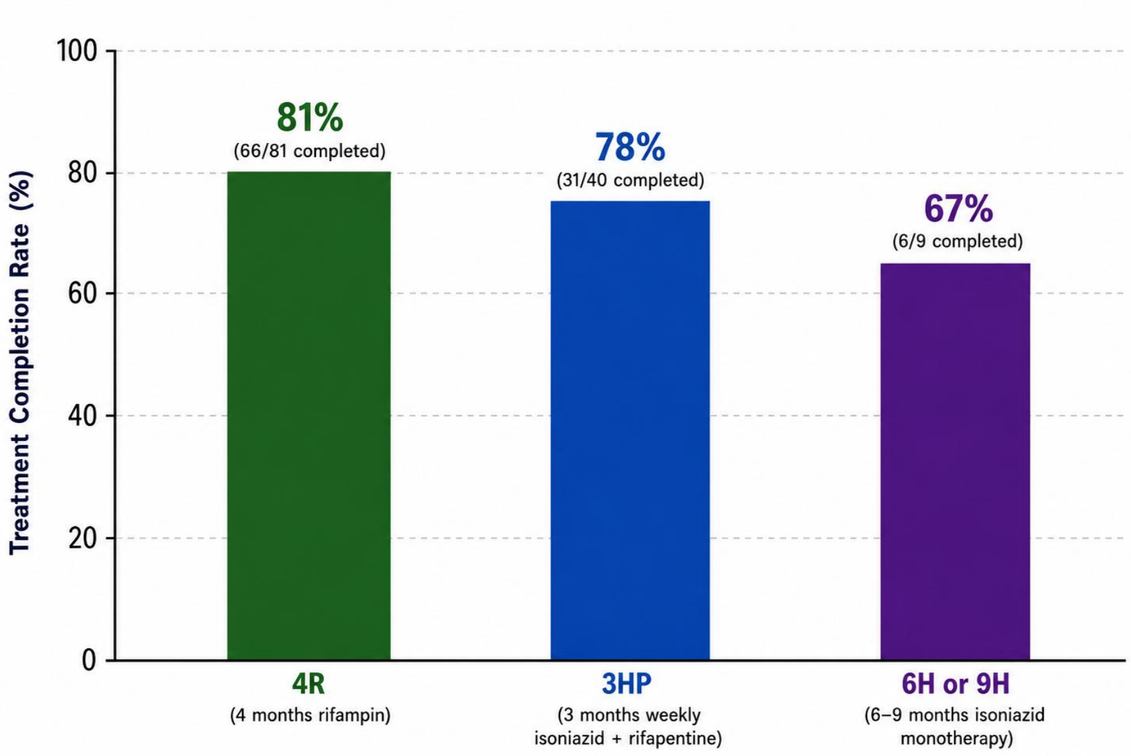
Treatment Completion



79% (103/130) of persons started on LTBI treatment completed, and 21% (27/130) did not complete treatment.

These data do not include 27 persons who initiated therapy during the study period but were still on treatment at the time of chart review.

Treatment Completion by Regimen



Rifamycin-regimen completion rates were higher (4R 81%, 3HP 78%) than for isoniazid monotherapy (67%). These data do not include 27 persons who initiated therapy during the study period but were still on treatment at the time of chart review.

Conclusions

- Strengths
  - Pharmacist-led completion rates comparable to published rates for MD-led LTBI care
  - Improved completion rates compared to ELA pre-pharmacy clinic baseline (45% in 2019)
  - Rifamycin regimens predominate
  - Successful task shifting
    - Steady visits during treatment with less burden on PMD's
    - Easier to identify and address side effects/adherence issues early
  - MD consultation for support
- Limitations
  - ELA leadership chose to convert budget item from mid level provider to pharmacist
  - No data on total number of new LTBI infections vs number who accept referral
    - Possible selection bias

Thank You!

TEA Mini-Grant: Lessons Learned

Central City Community Health Center, Inc.

Los Angeles County Department of Public Health
Tuberculosis Control Program

Central City Community Health Center, Inc.

August 27, 2026

Dr. Rosemary Reyes, CEO

Anna Melendez, Residential Care Director

Central City
Community Health Center

Central City
Community Health Center

AUGUST 2–8, 2026

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Protecting our community one shot at a time.

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Our Mission.

To provide high-quality, compassionate care that improves the health and well-being of our community.

Our Team.
Our Community.
Our Commitment.

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Thank you for trusting us with your care.

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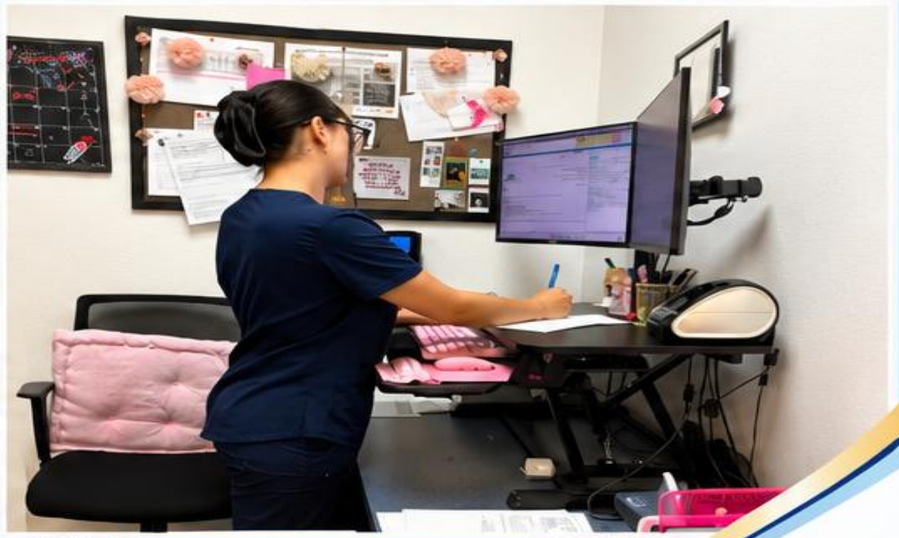

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Services for the whole family
COMMUNITY FOCUSED
Committed to a healthier community
Better Health.
Stronger Community.

Lincoln Clinic – *Mission in Action!*

Our Mission: "To provide quality health and human services to the underserved and low-income populations in a culturally sensitive manner."

Quality Health and Human Services

Working together to remove barriers and improve access to the services our patients need.

Serving the Underserved

Improving access to healthcare for individuals and families in our community.

Culturally Sensitive Care

Providing respectful, inclusive care that reflects the diverse cultures, languages, and needs of our community.

Total Patients and Ages

Total Patients and Ages	2021	2022	2023	2024	2025
Total Patients	**32,664**	**31,076**	**29,860**	**33,087**	**33,632**
Ages (% of total patients)					
% Children (< 18 years)	17.18%	16.51%	16.63%	16.04%	15.57%
Children (< 18 years)	5,611	5,157	4,967	5,307	5,168
% Adults (18 – 64 years)	73.76%	72.72%	71.86%	72.69%	72.96%
Adults (18 – 64 years)	24,092	22,599	21,458	24,062	24,519
% Older Adults (Ages 65 and over)	9.07%	10.68%	11.50%	11.27%	11.47%
Older Adults (Ages 65 and over)	2,961	3,320	3,435	3,718	3,925

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Community Health Center

Patients By Race & Ethnicity
(% known)

Patients By Race & Ethnicity (% known)	2021	2022	2023	2024	2025
% Racial and/or Ethnic Minority Patients	82.50%	82.77%	84.94%	84.39%	84.85%
Number of Racial and/or Ethnic Minority Patients	24,402	23,132	22,481	25,951	26,459
% Hispanic, Latina/o, or Spanish Origin Patients	67.72%	68.02%	70.68%	70.26%	70.10%
Number of Hispanic, Latina/o, or Spanish Origin Ethnicity Patients	20,431	19,474	19,264	22,100	22,344
% Non-Hispanic, Latina/o, or Spanish Origin White Patients	20.39%	21.15%	18.07%	18.34%	18.84%
Number of Non-Hispanic, Latina/o, or Spanish Origin White Patients	5,175	4,815	3,986	4,801	4,723
% Total Asian Patients *	5.14%	5.91%	6.38%	6.47%	7.52%
Number of Total Asian Patients *	1,306	1,346	1,408	1,695	1,885
% Native Hawaiian/Other Pacific Islander Patients *	0.48%	0.47%	0.44%	0.51%	0.57%

**Includes patients self-identified as more than one race.*

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Community Health Center

Income Status

(% of patients with known income)

Patient Characteristics	2021	2022	2023	2024	2025
Income Status (% of patients with known income)					
Total Patients with Known Income (Denominator)	**27,713**	**25,888**	**22,945**	**23,937**	**21,496**
% Patients at or Below 200% of Federal Poverty Guideline	97.17%	95.00%	94.78%	93.91%	92.74%
Patients at or Below 200% of Federal Poverty Guideline	26,928	24,594	21,748	22,479	19,935
% Patients at or Below 100% of Federal Poverty Guideline (included in above)	77.57%	74.37%	80.04%	77.45%	72.87%
Patients at or Below 100% of Federal Poverty Guideline (included in above)	21,498	19,252	18,366	18,539	15,664

Central City
Community Health Center

Insurance Status

(% of total patients)

Insurance Status (% of total patients)	2021	2022	2023	2024	2025
% None/Uninsured Patients	19.38%	14.53%	11.37%	3.85%	4.08%
None/Uninsured Patients	6,329	4,516	3,196	1,275	1,371
% None/Uninsured Children (<18 years)	1.28%	2.71%	2.13%	1.32%	2.52%
None/Uninsured Children (<18 years)	72	140	106	70	110
% Medicaid/CHIP Patients *	58.16%	61.76%	65.45%	70.46%	69.98%
Medicaid/CHIP Patients *	18,997	19,154	18,544	23,312	23,599
% Medicare Patients	14.30%	13.81%	14.88%	15.18%	15.14%
Medicare Patients	4,671	4,291	4,442	5,021	5,092
% Dually Eligible (Medicare and Medicaid)	8.20%	5.61%	8.35%	6.40%	13.16%
Dually Eligible (Medicare and Medicaid)	2,699	1,742	2,643	—	—

** Includes Medicaid and CHIP patients.*

Central City
Community Health Center


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Central City
Community Health Center

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TEA Mini-Grant

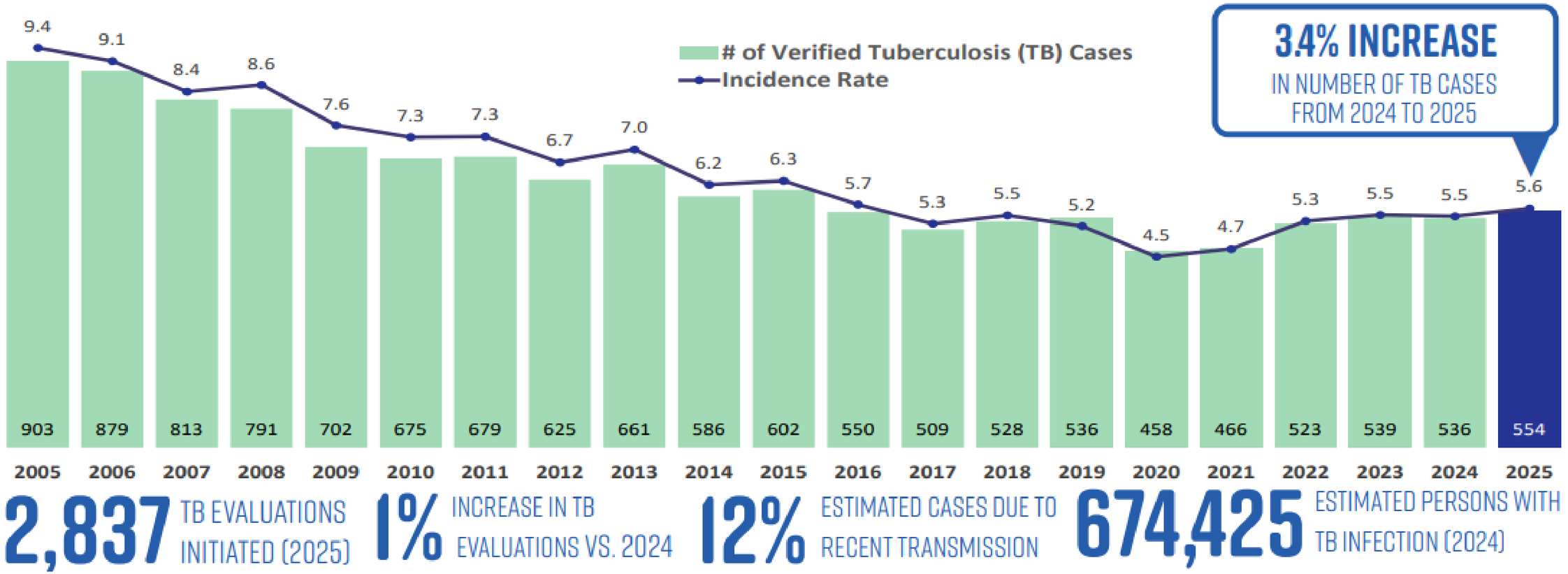
Melissa Zhang
Program Analyst
Los Angeles County Department of Public Health
Tuberculosis Control Program

Goal of TEA Mini-Grant

To build Central City Community Health Center, Inc. (CCCHC) internal provider capacity to independently test, screen, diagnose, and treat latent tuberculosis infection (LTBI) in underserved, uninsured, migrant, and housing insecure populations at elevated risk within the regions they serve.

TB reporting levels in 2025 are at 2016 levels – progress lost

Tuberculosis in Los Angeles County 2025



2,837 TB EVALUATIONS INITIATED (2025)

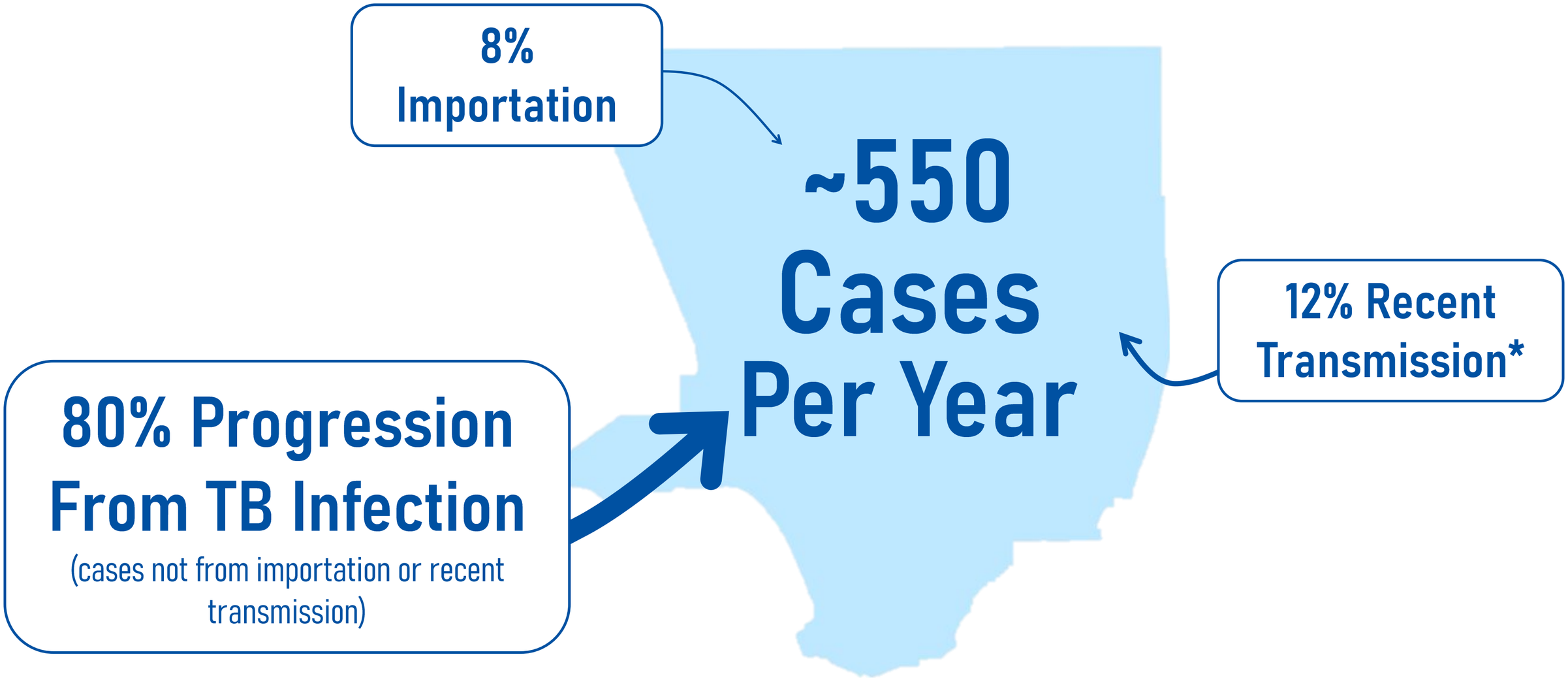
1% INCREASE IN TB EVALUATIONS VS. 2024

12% ESTIMATED CASES DUE TO RECENT TRANSMISSION

674,425 ESTIMATED PERSONS WITH TB INFECTION (2024)

TB Elimination = 1/1,000,000 case rate or 10 cases in LA County reported per year

How do TB incidents occur in Los Angeles County?



*Preliminary estimate based on CDC number of 2023 recent transmission cases and number of total genotyped cases (not from plausible source case method)

Approach

Understand Needs	Equip and Train	Measure and Improve
• Provider needs assessment • Key informant interviews • Identifying barriers	• Tailored provider education • Clinical toolkit & resources • Patient-facing materials • Provider champions	• Data-sharing agreement • LTBI care cascade • EHR optimization • Ongoing QI

Provider Needs Assessment

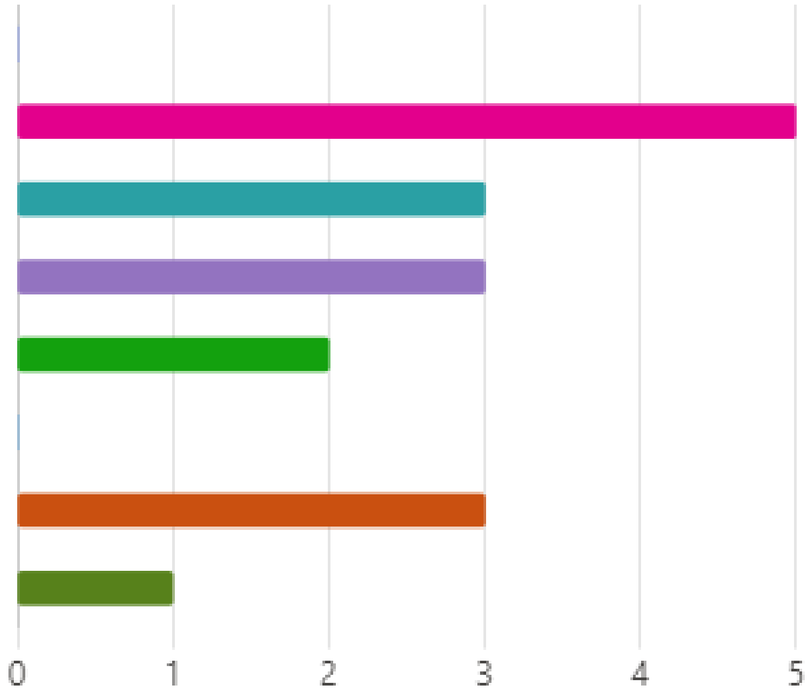
***Lesson #1**: Assess before you intervene*

- 8 providers engaged
    - MD, NP, PA, MA
    - Counties of Los Angeles, San Bernardino, Riverside and Orange
- 33-question needs assessment and key informant interviews
  - Providers already strong in:
    - TB risk assessment
    - Initial screening workflow
  - Greater opportunities identified
    - AB2132
    - TB testing & interpretation
    - LTBI regimen selection
    - Special populations
    - LTBI treatment management

Provider Needs Assessment, cont.

Training or technical assistance that would be most helpful:

How to implement LTBI services in my clinic/practice	0
Materials for training my clinic colleagues on LTBI screening, testing, and treatment	5
How to talk to my patients about LTBI	3
LTBI patient resources	3
Information on billing and/or insurance	2
EMR enhancements for ordering TB tests, diagnostics, and medications	0
Having a consultative line of support from Los Angeles County Department of Public Health TB...	3
Other	1



Provider LTBI Training

Lesson #2: *Tailor Education to the Local Context*

Patient Surveys

Lesson #3: Patient perspective changed the intervention

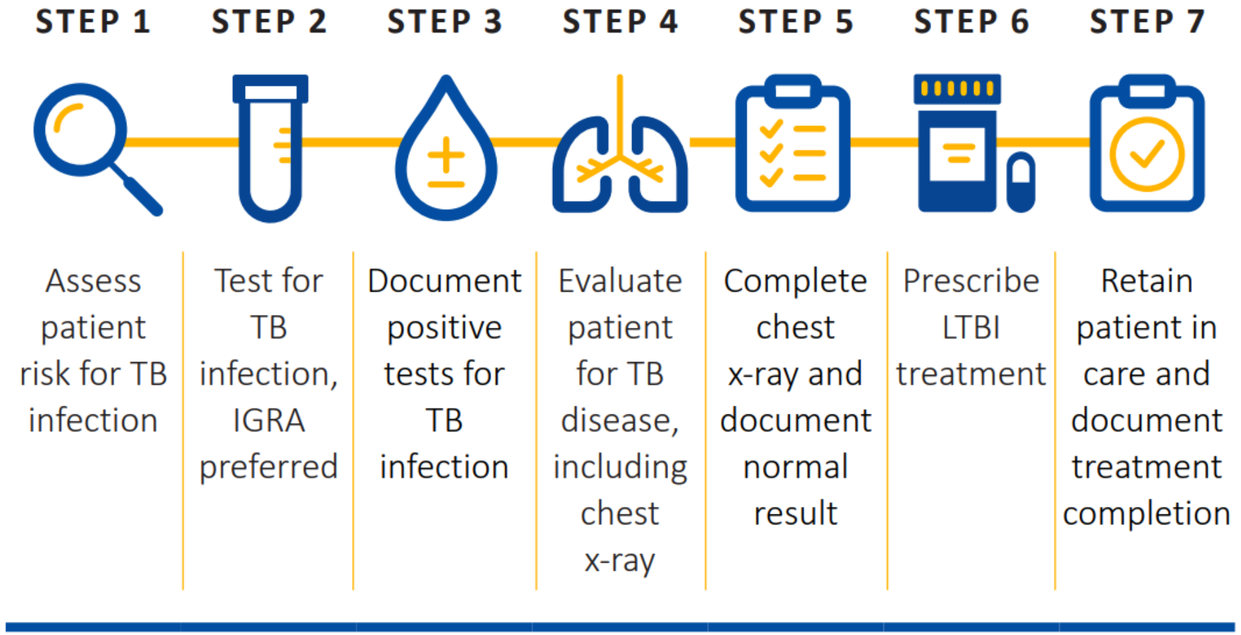
- 15 patients surveyed
  - What we heard:
    - General awareness of TB higher than expected
    - Fear related to immigration/law enforcement
    - Work schedule conflicts
    - Transportation
    - Questions about LTBI vs. TB disease
    - BCG misconceptions
  - Patient materials expanded beyond TB education:
    - TB vs LTBI
    - BCG misconceptions
    - TB risk among non-US born individuals
    - Family-focused messaging
    - Immigration “Know Your Rights” resources

Systemizing Routine Data Reports

- Established data sharing relationship with CCCHC's Informatics Team
- Biannual aggregate data pulls
- Conducted baseline data review of LTBI outcomes across all CCCHC facilities for CY2025

***Lesson #4**: Visualizing LTBI care cascade translates numbers into actional QI tool*

***Lesson #5**: Developing process for routine data sharing establishes a sustainable framework for monitoring beyond grant award period.*



What is next post-TEA Mini-Grant?

- Engage with CCCHC leadership to workshop solutions for patients that have lost Medi-Cal coverage
- Complete and distribute provider conversation guide
- Set up provider warm-line with DPH
- Explore EHR enhancements to capture LTBI treatment completion data
- Explore CalCONNECT text messaging pilot project for engaging patients that fall off after IGRA is ordered
- Explore funding for out-of-house QFT Testing

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  - Zarine Harutyunyan
  - CDC Team
    - Colette Cosyn
    - Sophia Hsu

Thank you.


UNLOCKED DURING BUSINESS HOURS
TB
Why should I be tested for Inactive Tuberculosis (TB)?
Think
TB
¿Por qué debo hacerme la prueba de detección de tuberculosis inactiva (TB)?
Pensar
Central City

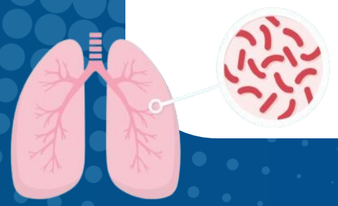
Discussion

1. How has California TB Screening Law AB2132 been incorporated in your practice, if at all?
2. How does your practice go about healthcare personnel testing?
3. (For LHJs) What is your school entry TB policy?

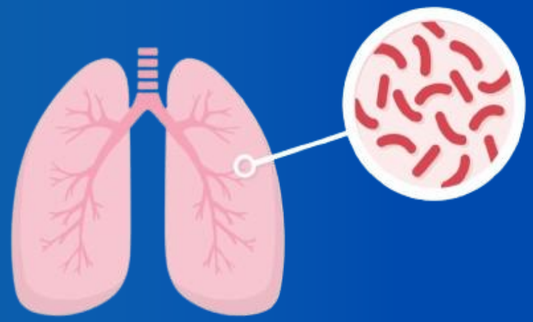
Future meetings

November (Date TBD)	**Topic TBD**

Topics and presenters subject to change



County of Los Angeles Public Health



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Thank you!