California Medical Leadership Forum for Public Health/Preventive Medicine
48th Meeting (21st using Video)
September 9th, 2025, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for agenda topics were embedded in the agenda.

Introduction: Dr. Hattis began the meeting at 8:00 noting that Secretary, Traci Stevenson, is not present and will be generating minutes from the recording. Ron stated this is the September 9th meeting of the Medical Leadership Forum for California for Preventive Medicine and Public Health and Ron is the current chair. The Forum invited health officers, TB controllers, and IDAC members in practice of infectious disease to this particular meeting and will be talking about TB and a new law which may result in more referrals to health departments and ID practitioners. If the law is a success, there will be more screening of high-risk patients for TB.

Ron instructed attendees who are not regular representatives on this forum to please list name, affiliation, and email address in chat. He then provided a few words about this forum noting that it is meant to join physicians and representatives of medical and public health schools along with some government departments related to public health. The goal is to be a community and to develop collaborations, know what each other is doing, and identify and learn about emerging crises in public health in California.

Ron stated that we are going to have two special topics today in the agenda which was attached to meeting notices. We will begin with Part 1 of the special program, then roll call and reports, followed by the second part of the program. He requested if anyone needs to leave within the next half hour, to identify now. He once again summarized the agenda sharing the written version on his screen, noting part 1 is going to be a report from Peter Kerndt, who had an important role in TB control for USAID, on the catastrophe of its abolition and likely effects on global public health, and a few words about the status of global TB. Then introductions from your entity that relates either to TB, the effects of federal funding cutbacks, or anything significant like a development at your school, department, organization, or your private practice. Then part 2 of the special topic will be tuberculosis in California, and as part of that we will review the new law, known by its bill number last year AB 2132, which became effective this year. CDPH is still working on how to implement it and get the word out. Kristen Wendolf will be our guest presenter for that portion following which, Ron will spend a few minutes reviewing guidelines he has written on how to conform with the law which is also a brief summary of TB screening, treatment of latent TB infections, and active TB. There are links in the agenda to resources. Copies of Peter's and Kristen's slides will be sent out later. Ron noted that he did attach to the last reminder announcement a few slides from Kristen.

Ron noted there were 29 people on the call and repeated his request for anyone not a regular representative to list name, affiliation (private practice or school) and email address. Finally, Ron added that with regard to the cancellation of U.S. aid around the world, including the decimation of USAID, the world is very aware of the deaths that are occurring in Gaza and Ukraine and the climate disasters around the world, but over the last 20 years or so, the PEPFAR program (President's Emergency Plan for AIDS Relief) has been working in many countries providing treatment for HIV, and it is estimated that 26 million lives were saved. U.S. efforts and other World Health Organization efforts for TB, have saved as many as 79 million lives, so the discontinuation of all of the USAID could result in tens of millions of future deaths and morbidity. Ron stated it's the largest public health catastrophe he can think of and there's very little media coverage about it.

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1) **Approval of Minutes:**
   Ron noted that the minutes were attached to the agenda in the email notice, and that past minutes to all meetings are on the website and very educational, covering a wide variety of public health issues, at https://www.capreventivemed.org/medical-leadership-forum/. He then asked if there were any additions or corrections to the June meeting and if not, we will assume they are approved. There were no objectives or corrections noted, and the minutes were approved at approximately 8:12 am.

2) **Special Topic, Part I: Catastrophic Global Health Impacts of USAID Cancellation, with Peter Kerndt**:
   Ron introduced Peter as a friend for decades who worked for CDC early in his career as an epidemic intelligence service officer, spent years with the Los Angeles Department of Public Health, during which he was Director of AIDS, and after retiring from LA County he went back to CDC served in Mozambique. Ron noted that Peter has had a lot of other international assignments, most recently, with USAID, in charge of contact investigations.
   a. Peter stated that his most recent assignment with USAID, he was as institutional support contractor for almost the last 5 years and during that time he was in the Bureau of Global Health, Office of Infectious Disease and the TB Division.
   b. Peter shared his slide set and noted the mission of USAID was to engage Congress, the American public, to ensure foreign assistance reflects our values, and that we remain a powerful force for stability, economic growth, and national security. At the time of its destruction, USAID represented 40% of all funding for foreign assistance for TB globally, and 80% of that funding was in conflict-afflicted areas where over a quarter of the world's population currently reside with a budget that was less than 1% or 0.7 tenths of the U.S. budget.
   c. Peter added that USAID was a large agency and he is not familiar with all of it. Peter was in the Bureau for Global Health, Office of Infectious Disease and the TB Division, which was a small group of 45 people. They were in 24 of the highest TB burdened countries in the world and provided technical assistance to approximately 30 countries. He stated that as of February of this year the

workforce comprised somewhere between 10,000 and 14,000 workers stationed domestically in Washington and in 60 missions throughout the world.

i. USAID operated out of embassies in these 60 locations, and he thinks the backbone of the work that was done was through foreign service nationals, of which there were about 5,000. Those were the people on the ground that oversaw implementation of contracts and projects and the boots on the ground that ensured that what was funded was actually done.
ii. Peter stated that in the TB division of USAID, the funding received was all accountable, and every year they provided a report to Congress documenting everything that was done, how all of those appropriated monies were spent. He noted that USAID had a global strategy aligned with the UN high-level mission, the global targets to reduce TB incidence by 35%, and mortality by 52% by 2030, and of ending TB by 2035.
iii. Peter stated much like PEPFAR, the USAID treatment program for HIV, they had established metrics that 90% of persons with TB diagnosed would be initiated on treatment, likewise for drug-resistant TB, with treatment success rate of 90% for both drug sensitive and drug-resistant state. He added that one of the challenges they faced was ensuring 30 million eligible people who had TB infection but not active disease were placed on preventive treatment. One of the biggest barriers to that was not knowing who was infected with certainty among the contacts.
iv. Some new diagnostics had just become available that they were about to implement, including a new antigen-based skin test. That would have allowed them to determine who among contacts really needed treatment.

d. USAID supported 24 of the highest-burden and poorest countries and provided technical assistance to others.
e. Peter shared a timeline of events, beginning in January after the inauguration and issuing of Trump's first executive order which put a 90-day pause on all U.S. foreign assistance for the so-called review to align with the project.
    i. On the same day, Trump also issued, an executive order establishing DOGE led by Elon Musk and USAID was the first target of the Doge working group.
    ii. On the 24th, a stop work order was issued to contractors.
    iii. On the 28th a waiver was issued. This waiver never was fully implemented due in large part to the termination of the workforce globally that would have been able to implement the project.
    iv. Effectively, by February 1st USAID was shut down. Employees were locked out of their computers and email systems. Direct hires were placed on administrative leave. Contractors, globally and domestically, were terminated. This was completed pretty much by early February. Peter Morocco was the designated acting director, and along with DOGE effectively eliminated 85% of all USAID contracts by that time. He subsequently left in April.

v. On February 11th Paul Martin, who then was the Inspector General for USA, issued a report, that there was potential for waste, spoilage and diversion of supplies and he was terminated the day after his report was issued.
vi. By February, headquarters in DC has been closed, employees had been terminated or placed on administrative leave, and the process began to move the remnants of USAID into the Department of State. As of July 1st, that has officially been done.
vii. Peter added that it's important to know that there really was a campaign against USAID for a considerable period of time. As Elon Musk came in and took over the agency in February, he issued about 160 tweets on his platform, X, calling USAID a 'criminal organization,' 'time for it to die', 'a viper's nest of radical left Marxists who hate America,' 'evil,' 'beyond repair,' and a 'ball of worms.' His attacks on the agency were unrelenting. Peter added that one interesting thing about what he did was that he would tweet and retweet from a conspiracy theorist. A slide showed these references.
    1. Musk would retweet from conspiracy theorist Mike Benz, a former speech writer for the GOP who had been actively involved over the last 2-3 years in discrediting USAID, promoting false narratives about what USAID did, that it was involved with the CIA and undermining operations around the world.
    2. A slide showed tht Elon Musk has a very large following and these tweets were viewed between 25 and 30 million times moving into the mainstream conspiracy theories about what USAID was and what it did.

f. Nick Enrich who was the Acting Assistant Minister for Global Health really was the first person who truly documented what was happening to USAID in real time and was the first to begin to try to quantify the impacts of stopping funding on mortality and morbidity.
    i. Peter showed a slide that estimated that for Malaria, there would be an additional 12 to 17 million cases and 71 to 166,000 deaths. There would be estimated increases by a third in MDR (multiple-drug-resistant) TB and drug-sensitive TB. He reported there likely will be increase of over 62,000 additional deaths to TB.
    ii. Enrich also documented the changes in the workforce. He documented these in memos and the day after his March 4th memo he was placed on administrative leave and became a whistleblower. He presented at the House Committee on Foreign Affairs. This, however, was a shadow hearing, not one the full committee would allow at the time.
g. Looking at the impact on global TB, Peter notes that the U.S. government provides between $200 and $250 million dollars in funding and had provided

$200 - $250 million annually in bilateral funding for TB response at the country level.

i. This is approximately a quarter of the total amount of international donor funding for TB, and these cuts have put 18 of these 24 highest burden countries at risk as almost 90% of their care was funded by USAID. The African region was the hardest hit.
ii. They have seen the drug supply chains break down due to staff suspensions, lack of funds, and data failures which have jeopardized access to treatment and prevention services.
iii. Labs were severely disrupted as well as sample transport which many of our partners did. There were procurement delays and consumables were not available, which has delayed and prevented diagnoses.
iv. The surveillance systems have largely collapsed, undermining routine reporting. Community efforts, including case finding with community health aides, went away.
v. USAID had been one of the largest funders for research. That all was halted.

h. Regarding the impact on PEPFAR, from 2024 to 2030 PEPFAR expected to be able to prevent at least 5.2 million AIDS related deaths, over 6 million new infections, and more than 4 million children from becoming orphaned by AIDS.
    i. Halting to program could lead to an increase in AIDS-related death by more than 400% and doubling of orphaned children in 12 high-burden countries.
    ii. Peter stated that as Ron mentioned in the beginning, 25 to 26 million lives have been saved through the PEPFAR program since its inception in 2003 under the George W. Bush administration. There were approximately 30 million people on treatment, representing 77% of all people living with HIV.
        1. Of people living with HIV nearly three-quarters have suppressed viral load, which is essential to achieving the goal of an AIDS-free generation by 2030.
        2. Peter noted that this is a minimal cost: $60 a year, $5 a month.
i. Peter shared some modeling studies that suggests that defunding will add an additional 1.4 million cases of TB with over 500,000 additional deaths by 2035.
    i. This erases a decade or more progress in reducing incidents and mortality.
j. Peter showed a retrospective impact evaluation forecasting study that estimated USAID prevented over 91 million deaths during this 21-year period and could result in more than 14 million additional deaths by 2030 and 4.5 million among children.
k. The shut-down threatens to undo decades of progress in infectious disease control including the 65% reduction in mortality from HIV that we have seen, 51% from malaria and 50% from other neglected tropical diseases.

l. Another report from the Inspector General issued in February reported that there were over 500 thousand metric tons of food on the way or in warehouses around the world that was at risk of diversion or spoiling and without staff they were unsure to ensure proper vetting of this humanitarian assistance. (as mentioned earlier, the Inspector General was terminated after releasing his report).
    i. The situation that we now face is that all of the USAID resources worldwide are being disposed of currently. In fact, it is not certain where or how it is all being disposed but a great deal of it is being destroyed.
    ii. This includes 550 tons of food aid the had to be burned at a cost of $133,000. This food aid would have gone to Afghanistan and Pakistan.
m. Peter asked, "Okay, so who benefits?" He noted that there is a group that came together right after the terminations called 'Aid on the Hill.' Initially it was a bunch of former USAID employees but as terminations in the government increased they were joined by other terminated federal employees from NIH, Forest Service, and NOAA.
    i. For 13 weeks in a row, they went up to Capitol Hill and they formed relationships with members of Congress who did not really know what was going on. They were there to advise them as to what was happening and formed relationships with many of the members and their staff that were very supportive. They were a key source of information to them for advocacy.
    ii. Peter stated one of the concerns is who is going to move in and fill the void of USAID and in some, places China has already done so almost immediately. They moved in and picked up all of USAID's projects in Cambodia. Likewise, there are examples of where Russia has moved in.
    iii. Peter added that he thinks what most Americans don't realize is the extent to which USAID and the work that we did contributed to our national security. Something as simple as keeping people healthy, the stability that brings to the economy of the country when you don't have tens of thousands of people ill with or dying with HIV or TB.
n. What is now left (currently in the so called 'big, beautiful bill') ?
    i. There was about $8 billion in foreign assistance that was rescinded after being appropriated by congress when the Trump administration went back and got the congress to rescind the $8 billion in foreign assistance.
    ii. Fortunately, due to a lot of advocacy, $400 million of the rescission that had been planned for PEPFAR was removed and language was added prohibiting rescissions for HIV, AIDS, TB, malaria, nutrition programs, and maternal and child health.
        1. This was a very big win in a, environment where there have been very few wins.
    iii. Currently, there is another $5 billion in foreign aid that the administration is focusing on taking back. It is a bit complicated because it is a pocket

rescission, in other words, it has funding that expires by the end of September so there's more to be learned on how this all turns out.

- o. Peter concluded with answering questions and left his contact information.
  - i. Ron asked Peter if while he was working at USAID if he was assigned by CDC or an independent contractor. Peter answered that he was an institutional support contractor, which is very common in many federal agencies. The prime contractor was Credence LLC. and the sub on that contract was Public Health Institute of Oakland. Peter explained Credence was in the second year of an 8-year contract to provide personnel services for not just TB, but HIV, neglected tropical diseases, the whole, whole spectrum, all the activities that USAID may be involved in.
  - ii. Kristin from CDPH asked if there are there any aspects of the USAID-TB program that was capped and swept under Department of State, or is it all gone?
    1. Peter said that there are two people from his group of 45 that have been moved over to USAID adding that they are really great people and if anybody is able to do anything they will certainly be there trying. He added that the big issue is what State Department doesn't have. The State Department would set the policy, and USAID would implement the program, and State does not have the authorizing officials. These are the people that know the rules and the process for dispersing funding and tracking it. The State Department does not really have that capacity, they do not have the staffing to really put funding out and monitor it as it was done, and as it needs to be. It will be a long time bringing that back up.
    2. Kristen also wondered about interruptions in treatment for TB and drug resistance, both for people who had drug-susceptible TB but maybe were interrupted while they were on treatment, and certainly those on MDR-TB treatment inquired if there's anyone tracking those patients who had interrupted care? Peter said he thinks it's really difficult, because the surveillance systems and monitoring and evaluation are no longer there. People are trying to do whatever they can. He also thinks that as HIV increases and knowing that, in these high-burden countries, 20 to 30% have latent TB infection, that is going to contribute significantly to the new cases. And if they are not adequately treated, we can expect MDR cases also to increase.
  - iii. Jo Marie Reilly asked Peter to remind us how much money taken from USAID was ultimately restored into the State Department?
    1. Peter said that it was $400 million that the administration had proposed to take back from PEPFAR and the Senate Foreign Relations Committee fought to take that back. In order to pass the 'big, beautiful bill' that amount was put back to appease a few

lawmakers who would not vote for the bill without restoring PEPFAR.

2. Peter said that the last time PEPFAR was renewed it was 98-2 and was due to be renewed in March of this year but wasn't. He added that Marco Rubio was probably one of the strongest advocates for PEPFAR when he was a senator and it is extremely disappointing to see what he has done that contradicts everything he did and said when he was a senator about USAID.
3. Peter clarified that the PEPFAR money was partially restored but not the full amount. Ron added that PEPFAR had billions in its previous budget.

iv. Romina Beltran from Contra Costa County asked since PEPFAR has been partially restored, what are the plans to use the funding that is still there?
    1. Peter replied that he doesn't know for sure adding that things have changed a lot. There's still the Global Fund which was about $18 billion and a third of that was funded by the U.S. government. One thing that USAID was careful about when implementing any programs was not to duplicate what others were funding and doing. The issue being, however, when USAID represented 40% of all the funding, then discontinued so abruptly, even with partial restoration it is unrealistic to expect things to continue normally. This is a very, very difficult period and he thinks there is still extremely important advocacy on this as the 2026 budget gets set. There is also the threat of the budget not going forward and we will have to wait and see.

v. Jo Marie Reilly also asked is there anybody else in the world, any other countries that are taking up the slack? She noted that he mentioned China is in Cambodia and that Russia probably is in some locations. She wondered if there is anybody in Europe or anybody else that are allies and more trusted?
    1. Peter replied that unfortunately even the UK had to cut their foreign assistance budget. China has committed to providing $500 million to the WHO to support their activities and step into this, void. But there are not a lot of other players out there that could make contributions like this.
    2. He thinks that it is forcing the issue in some of these countries and one thing they have tried to do all along is shift as much as possible to the domestic funding, to the countries themselves, pushing them to increase their budgets for care, treatment, and diagnostics. And that was the localization plan they had to built capacity, to turn over programs where they would be sustained. Some is going to come from the budget of these individual countries, a few from the European Union, but he doesn't see

major funders in a position to increase support substantially, with the exception of China.

vi. Ron noted, for sake of time, we needed to move on, recognizing we could spend an entire meeting on this issue. He thanked Dr. Kerndt for his excellent presentation and invited him to come back to discuss more in the future. Meera noted that she will reach out to Peter .There is an organization called the California Communicable Disease Controllers for which she is the president. Perhaps Peter could give a similar talk to their group. Meera clarified a question from Ron, noting that their group is for communicable diseases but excludes TB, HIV and STI's.

3) Roll Call (at Least 35 Individuals Participated including Presenters)

Ron Hattis requested new participants to include their names and contact information in the chat.

California Academy of Preventive Medicine

1) Ronald Hattis, President, led the meeting and was a co-presenter on TB.
2) Sumedh Mankar, Vice President, facilitated the roll call.
3) Donald Lyman, Legislative Director and CMA Delegate

State of California Surgeon General

Lauren Groves: Office of the California Surgeon General, was in attendance.

California Department of Public Health

1) Jessica Nunez de Ybarra, with the California Department of Public Health, Office of Policy and Planning, noted that this office was recently funded via infrastructure funds from the State Future of Public Health fund. They are involved with academic partnerships, and among other things, work directly with the director.
2) Lisa Bandong, also with the CDPH Office of Policy and Planning, is the Coordinator for Academic Partnership. She is here to connect with CDPH and academia throughout the state.

Health Officers Association of California

Kat DeBurgh, Executive Director, was present.

Medical Schools

Loma Linda University

Karen Studer, Chair of the Department of Preventive Medicine and Program Director of the Preventive Medicine Residency Program.

Karen shared that she was asked to be on the ACGME milestones development committee to develop milestones around nutrition. Karen also shared that the Lifestyle Medicine Residency Curriculum is in place and available to all residency programs. It has 10 hours of didactic nutrition and 20 hours of application activity ideas so there are a lot of interesting developments going on with the nutrition movements.

a) In the chat Lisa asked if this would include first food, breastfeeding. Karen replied that it was mentioned in the ACGME nutrition forum that she was a part of and the subsequent paper in JAMA.
b) Julie added the following information in chat: LCME requirements summary from chat GPT, The Liaison Committee on Medical Education (LCME) does not define specific nutrition content but requires that medical school curricula include content from biomedical, behavioral, and socioeconomic sciences, which implicitly covers nutrition. LCME assesses the location and impact of nutrition within a medical school's curriculum through annual surveys and the data collection instrument for Element 7.3. While there are no explicit requirements for quantity or specific learning objectives, schools must demonstrate that their nutrition education addresses relevant competencies and is integrated across preclinical and clinical courses.
c) Karen included the following link in which is the paper they wrote on what competencies should be included in medical school and residency: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2824217
d) Jo Marie added in chat that as stated there are currently no specifically required LCME and ACGME hours towards nutrition and the vetting of it is loose. Until last year there were no vetted nutrition competencies. Last year there was a national effort which competencies helped create these and link is in chat.

Stanford

Julie Parsonnet: Ron introduced Julie, noting that she is joining this meeting from Rome, and highlighting that she, along with her husband, have been active in SAFE, an organization in a lot of medical schools that deals with gun safety. Julie is a professor of epidemiology and infectious dseases at Stanford and a former EIS officer. A lot of her research is on TB and they are doing work right now on wastewater in Brazil, South Africa and the United States. Julie included an announcement in chat that they are planning a Bay Area Gun Violence Injury Prevention Workshop with physicians and community groups at UCSF on March 13th and 14th. If interested in participating or know community groups that might want to engage please feel free to let Julie know at parsonnt@stanford.edu or at Allison Volkman avolkman@standsafe.org.

University Southern California (USC)

Jo Marie Reilly, Co-representative from the Department of Population and Public Health at the University of Southern California, USC. She is part of some state and national committees that are looking at the impact of nutrition education, and lack thereof, on the public health, epidemic of obesity and is excited to join with Traci Stevenson to present on that (nutrition) and the recent mandate by our Secretary of Health and Human Services, Kennedy, that nutrition education is included in all medical schools. She shared that it is unclear what the penalty for not doing it will be, but there is a deadline of September 10th. She hopes they will be able to have an update on that, as well as some things about food additives, which is another priority of this Secretary.

a. Ron added that one of the values of this forum has been to establish cooperation and collaboration among people from the different entities and that we've had an offer for a presentation at our next meeting (either in December or it might be deferred to January) on nutrition as a public health issue.
b. Traci, our secretary, is from Touro University Osteopathic School and they (Traci and Jo Marie) would probably never have met one another If not for this forum, but will be co-presenters next time if there is no objection.

UC San Diego

Francesca Torriani, MD, Medical Director of Infection Prevention, was also present.

<u>Public Health Schools</u>

Loma Linda University

Adam Arechiga, Dean of the School of Public Health at Loma Linda University. Adam shared that they just launched a 3-year undergraduate degree in global health. This is the first 3-year degree approved by WASC, their Western Regional Accreditor, and they're very excited.

UC San Diego

Megan Ryan works at Naval Medical Center of San Diego in the Defense Health Agency's Immunization Program and teaches at UCSD mostly focused on immunizations. Megan noted the Secretary of Health and Human Services has a lot of challenging feelings about immunizations and they are engaged with that.

<u>Special Guests, Public Health, with identified agencies</u>

1) Jacqueline Aguilar Alvarez, Supervising Clinical Laboratory Scientist, Microbiology, Harbor UCLA Medical Center.
   Jaguilar22@dhs.

2) Erica Dykehouse: Public health nurse at Humboldt County Public Health working in TB for about 7 years. Erica stated she is listening to gain more awareness of what we anticipate hitting our lower incidence jurisdiction in the future.
   edykehouse@co.humbolt.ca.us
3) Susanna Graves, Director of the Tuberculosis Branch for San Francisco Department of Public Health, TB Program. Susanna said it's fun to be in this forum and see people she worked with in San Diego as well as Francesca Toriani who she worked with in Mozambique on protections for workers from tuberculosis.
4) Kimberly Hernandez, Kern County Public Health
   hernankim@kerncounty.com
5) Peter Kerndt, presenter on global health effects of cancellation of USAID.
6) Ed Moreno, Public Health Director for the County of Monterey. Ed shared that one of their biggest concerns is that it was already challenging to get people to cooperate when we're doing disease investigations, and now it seems to be more challenging as folks are less willing to provide information about close contacts and in the area of TB, this is one way that they've been hit, probably from the federal actions. Ed also shared that they and others in public health in California are having ongoing discussions that include surveillance teams about what demographic information they should collect on TB patients and other others affected by chemical diseases into data systems because of the concern that other parts of our government in the United States may look into that to try to find or recreate identifying information that would identify folks.
   morenoel@countyofmonterey.gov
7) Prisci Quijanda, San Diego County Health and Human Agency TB Prevention and Care (Prisci.quijada@sdcounty.gov.ca)
8) Gary Richwald, MD MPH, Herpes Cure Advocacy (VP), Beyond AIDS Foundation (president), lecturer on HSV and HPV epidemiology/health services at USC.
   drgary@usnz.net
9) Aimee Sisson, Health Officer, Yolo County
10) Meera Sreenivasan, TB Controller Contra Costa County.
   Msreeniv@cchealth.org
11) Judith Thigpen: Executive Administrator of the California Tuberculosis Controllers Association which supports the work that the local health department TB control leaders and staff do with the state TB control branch to improve practice and work on legislation to prevent and control TB.
   jthigpen@ctca.org

12) Denise Tirol, Public Health Nurse with the Orange County Health Department. Denise states she works with many colleagues who handle TB and she will be sure to share scripts from meeting with their TB Controller.
13) Kristen Wendorf, Medical Officer, TB Branch, California Department of Public Health (CDPH), lead presenter on TB.

Special guests, agencies not identified, not available during roll call

1) R. Arya
2) Romina Beltran
3) V. Bowman
4) Susan Levy, MD FAAP
5) Susan Long
6) Christie Mitchie
7) Gabriel Villareal
8) Kristie M.
9) Jackie (last name not caught)

4) **Special Topics, Part II: Tuberculosis, with Kristen Wendorf and Ron Hattis:**
Ron introduced Kristen Wendorf, Medical Officer in the TB branch of CDPH and who talked about AB 2132.
    1) Dr. Wendorf shared slides and provided a link to AB 2132, a 2024 California bill which became law as of January 1st, 2025, in the Health and Safety Code. She stated this was modeled after a hepatitis bill and requires clinics and medical offices that provide primary care to offer a TB screening test. This would be the IGRA blood test or the TST skin test for all patients 18 years and older if they have TB risk factors. Most positive tests will be in patients without symptoms of active TB, and will indicate LTBI (latent TB infection). If LTBI is treated, future active TB cases will be greatly reduced. Julie inquired in chat what are the consequences of non-compliance by PCPs? Kristen answered that there are not any consequences for providers who do not provide TB testing or follow-up.
    2) The bill also requires providers to offer follow-up care, either follow-up care in the clinic or a referral for follow-up care for anyone with a positive TB screening test. There are several exemptions, and the law is aimed at those practicing primary care rather than the ED. There is a link to the law in the slide and Ron also provided a link in the agenda.
    3) The law requires primary care providers to screen those at-risk age 18 and older. The slide contained a QR code to the California Adult TB Risk Assessment. Dr. Wendorf added that the document is several pages long and helps walk through whom to test, why to test, and complexities around LTBI testing.
    4) Some things that CDPH has supported, along with the CD controllers, is creation of a specific AB 2132 tab on their website that consolidates some of this information, including a letter sent to the California Nursing, Medical and Physician Assistants

Boards to go out to all their member providing information about the law and links to resources. They also wrote up an FAQ document answering common questions about this law. And, with the TB controllers in California, they created a two-page printable PDF algorithm for primary care clinicians as a kind of basic starting block to walk through how to screen and test for TB. Kristen's slide showed the first page of that with a QR code to find the information on their website.

   a. Ron asked if they also contacted the Osteopathic board. Kristen said if they are a separate board, she didn't think they got their own letter but would be happy to send them a letter. He also mentioned how this Forum can function to help improve communications.
   b. The initial letters to the different boards provided links for training. To date they have trained more than 1,500 California medical providers on LTBI, TB screening, and treatment. Trainees have included MDs, DOs, PAs, NPs, RNs, PHNs and a variety of different specialties. Additional trainings are ongoing throughout the year.

5) The group also supports communities of practice that now exist in Northern California region, LA, and San Diego that are combining public health and primary care providers to improve cascades of care and clinician uptake of LTBI screening.
6) The group at CDPH specifically provides direct clinical consultation to physicians and other medical providers who are treating complicated LTBI scenarios. They consult on a couple hundred patients typically each year.
7) They are also increasing monitoring efforts. LTBI testing happens with a blood draw and positive IGRA results are reportable to public health. There is a new system that they have been working to build to promote follow-up of patients with latent TB infections in California.
   a. It is called CalConnect and will help send text messages to people who have a positive LTBI test to help connect them with the next steps.
   b. They are monitoring positive tests in the population over time to try to measure changes to general practice and identify gaps in testing of high-risk populations.
   c. They also monitor the TB drug supply and have a small cushion to replace drugs when there are interruptions.
   d. They also have a baseline LTBI care cascade they can review over time to assess how things are changing.
8) Dr. Wendorf also provided a QR link to more LTBI medical provider resources.
   a. This includes basic statewide CDPH TB data
   b. National and Ca specific guidelines for TB screening.
   c. Tools for talking about LTBI with everything from written provider scripts, videos of people, physicians, talking to patients that help know how to answer general questions such as around BCG vaccine.
   d. Treatment guidance including LTBI treatment options and very importantly, a rifamycin drug interactions guide since we're using more rifamycin for LTBI treatment.

    e. Guidebook that walks through incorporating TB screening into routine primary care, this includes general changes to EPIC and how to monitor a cascade in a primary care setting.

9) Kristen concluded by noting that there are a large amount of LTBI patient resources. Anyone who would like to use them should go to the website. There are posters and patient handouts in many different languages. There are videos in different languages telling patients about TB and LTBI. There's been a lot of work going into these. Some of these resources are still have available in print form and they can provide to people.
    a. Kristen hopes that people continue to use the resources, some which were created by them while a lot came to them in a question form. For example, they were asked if they can make a resource for pregnant people, talking about LTBI and why it's important to get evaluated and tested.
    b. Erika noted in chat that this could be great a tool for guidance for lower incidence and small/rural jurisdictions without robust TB programs or a full time PH officer.
10) Ron inquired if the tab to get to that website is easy to find from the main CDPH homepage?
    a. Kristen said she thinks the easiest way to find it is to google *'TB Free California'* and that it is very clearly seen on the side of the main page of TB Free California.
11) Ron then shared a document he created, Clinical Guidelines for High Risk TB Testing and Follow Up, that he urges to be among the (CDPH) resources. He shared the document on his screen and outlined the sections including:
    a. Section 1 outlines which patients should be screened for TB and addresses risk factors since the law does not say who has risk factors requiring screening and thus who the law actually applies to.
    b. Section 2 addresses who is exempted by the law.
    c. Section 3 explains the screening tests and how to use them. Ron also asked Kristen what proportion of TB screening tests now utilizes IGRA. Kristen states she can only make estimates since they only get blood reporting results.
        i. Ron stated that IGRA has better sensitivity and specificity and is the way to go for people who've had BCG vaccine, which can cause a false positive TST skin test. However, while the document recommends IGRA, it also gives detailed instructions and references on how to do a proper TB skin test.
    d. Section 4 considers what follow up is necessary if a TB test is positive and how to differentiate active TB from latent infection. Information covers what symptoms that could be active TB, necessary tests such as CXR, who should get sputum tests and how to evaluate a patient with a positive TB test.
    e. Section 5 discusses treatment.

f. Section 6 considers how active TB should be managed, including reporting to public health, isolation, initiation of drugs, etc.
g. Ron feels this will be a supplementary resource for the CDPH website. Kristen stated it is being reviewed.

5) **Topics For Next Meeting and Conclusion**: There was discussion regarding holding the next meeting in December or delaying until January of the new year. Jessica suggested we consider December since many things are going on such as cuts and we may need to 'rally' and share information by December. The December date will be the 9th. As discussed earlier in the meeting, there has been an offer by Jo Marie and Traci to present a special topic on nutrition. There were no alternate proposals. Ron offered an opportunity for final comments and anyone who may have been missed during role call to introduce themselves, and there were none. The meeting was then formally concluded.

These minutes were submitted by Secretary Traci Stevenson with editing by Chair Ron Hattis. They were accepted at the December 9, 2025 meeting.