



Overview of Contact Identification Guidelines

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Has the following disclosures to make:

- No conflict of interests
- No relevant financial relationships with any commercial companies pertaining to this activity





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Overview of Contact Identification Guidelines

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Objective

- Discuss the impact of contact identification guidelines on existing contact identification procedure.
- Links to document:

<https://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf>
(.pdf)

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a1.htm> (.htm)





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Why do we perform contact identifications?

Example #1

- 21 year old exposed to a patient with TB disease. Tested QFT positive when initially evaluated and was non-adherent with all follow-up requests from the health department.
- One year later (22 years old), patient is diagnosed with active TB disease.
 - Patient has 1 y.o. child at home requiring window treatment.
 - Patient babysits a 3 y.o. child, also requiring window treatment.
 - Patient was enrolled in school at the time, requiring testing of school contacts.
 - Patient continues to have ongoing side effects to her medication regimen.



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A hopeful start

“Contact investigations are complicated undertakings that typically require hundreds of interdependent decisions, the majority of which are made on the basis of incomplete data, and dozens of time consuming interventions.” p. 1

Excerpt from Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, 2005



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Methodology

- Based upon on epidemiologic and other relevant scientific studies and established practices in conducting CIs.
- CI has not been researched by a controlled trial or study, but through expert opinion from years of common practices.
- These guidelines are not “one size fits all”.



Decision to Initiate Contact Identification

General issues

- Competing Demands
 - Limited resources that may be allocated
 - Limited staff
- Prioritizing Persons with TB
 - Which cases are the most and least likely to involve transmission of disease?
 - Which have the highest priority individuals exposed to TB?
 - Which are the highest profile?



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Decision to Initiate Contact Identification

TB transmission factors

- Only patients with **pulmonary, laryngeal** or **pleural TB** can transmit their infection (*with few exceptions*).
 - In some rare instances, extrapulmonary disease can cause transmission during medical procedures that release aerosols (autopsy, embalming, and irrigation of a draining abscess).
- Patients with extrapulmonary disease should not be given high priority unless accompanied by pulmonary, laryngeal or pleural disease.



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Decision to Initiate Contact Identification

TB transmission factors

- Anatomical site of disease
- Sputum bacteriology
- Radiographic findings
- Behaviors that increase aerosolization of respiratory secretions
- Age
- HIV status
- Administration of effective treatment

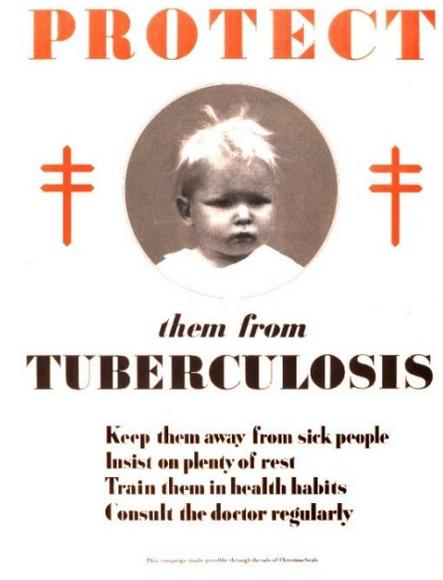
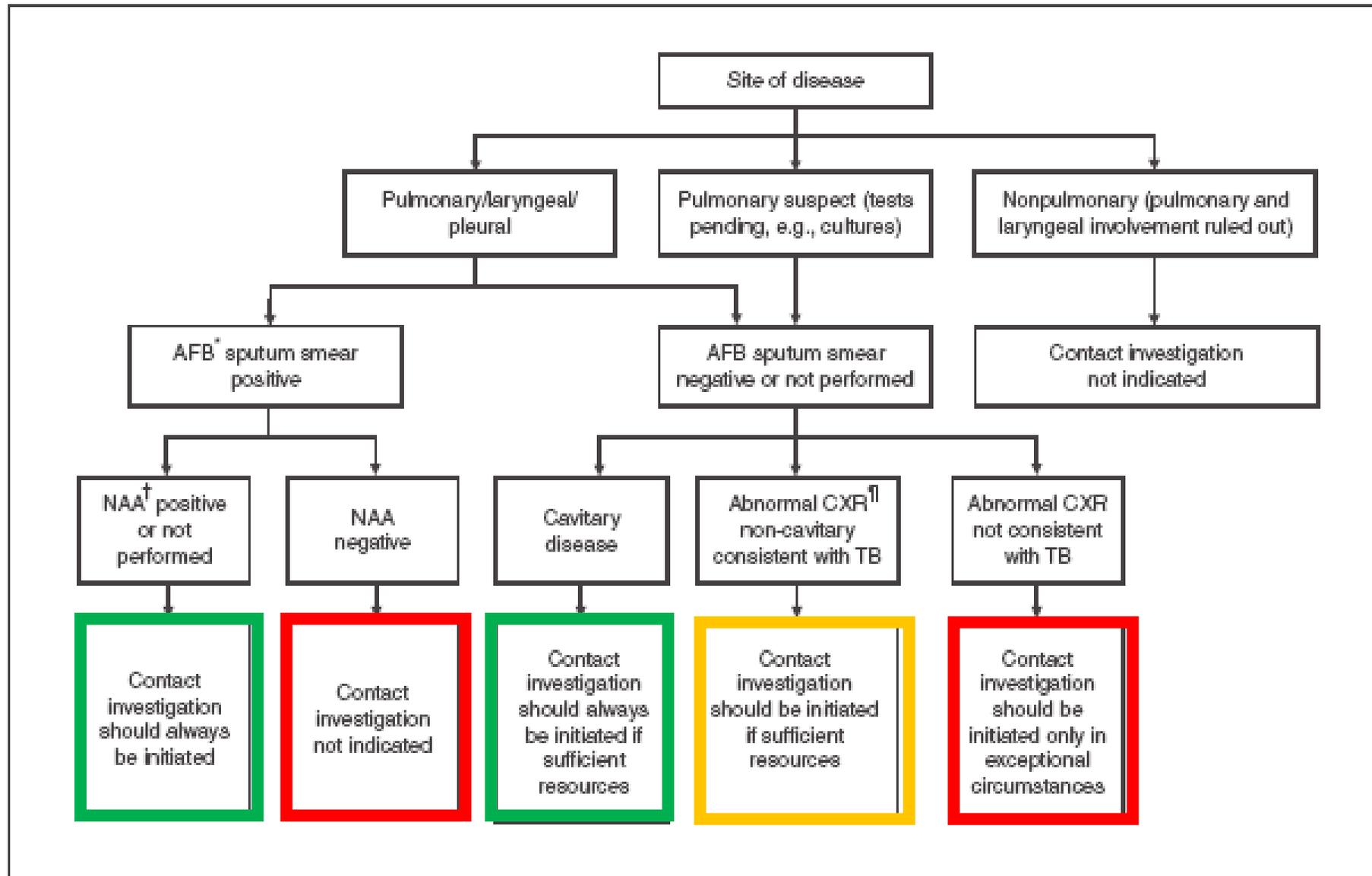


FIGURE 1. Decision to initiate a tuberculosis (TB) contact investigation



* Acid-fast bacilli.

† Nucleic acid assay.

§ According to CDC guidelines.

‡ Chest radiograph.

Interviewing patients

Patient interview

- Health department's responsibility to conduct CI.
 - Clearly state written policies and procedures.
 - Improves efficiency and uniformity.
- Establishing trust and consistent rapport with patients is critical.
 - Gain full information and cooperation during treatment.
- Interviews should be in primary language of the interviewee.



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Interviewing patients

Determining Infectious Period

- Infectious period
 - **3 months** before a TB diagnosis
 - 4 weeks before possible diagnosis if no symptoms, no positive sputum, no cavities
- In certain circumstances, an even earlier start date should be used.



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Interviewing patients

Determining Infectious Period

- Stringent criteria should be applied when susceptible people exposed to TB are involved:
 - At least 3 consecutive negative sputum AFB smear results from sputum collected \geq 8 hours apart (with one specimen collected during the early morning)



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Interviewing patients

Closing Infectious Period

- Infectious period is closed when:
 - Effective treatment for **≥ 2 weeks**
 - Sometimes after 5 days of treatment if AFB smears are all negative
 - Diminished symptoms
 - Mycobacteriologic response
 - AFB smears are trending downward or are negative



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Interviewing patients

Things to remember

- Interview multiple times.
- Interview at patient's residence at least once. (Look for clues of other people.)
- Obtain medical records and information regarding the patient's illness.
- Conduct at least one interview (preferably the first) in person or with a proxy.
- Take the environment into consideration.
- Finding those exposed to TB is an ongoing process.



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Prioritization and Evaluation

Assigning priorities

- Most recently infected contacts cannot be distinguished right away.
- Create a line list and ensure that every person has a break-in-contact (BIC) date.
- Repeat testing done 8-10 weeks after the BIC will help to identify recent conversions that are most likely indicative of recent infection.



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Prioritization and Evaluation



How to categorize

- Likelihood of infection depends on:
 - Intensity
 - How many germs was the person exposed to?
 - Frequency
 - How often was the person around the patient?
 - Duration of exposure
 - How long was the person around the patient?
 - Risk factors
 - Does the person have any age or medical risk factors that would place him or her at a greater risk of infection or disease?



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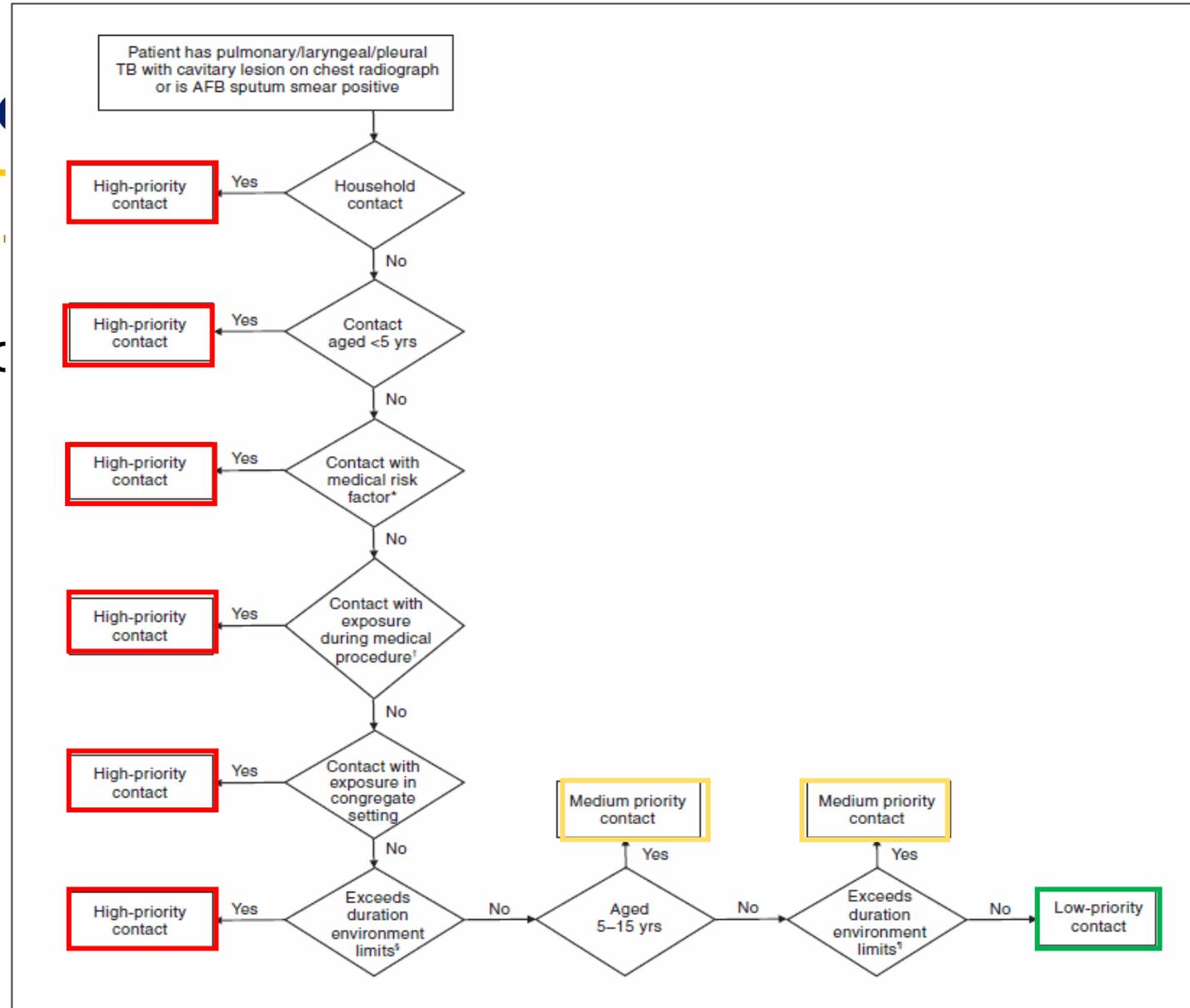
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FIGURE 2. Prioritization of contacts exposed to persons with acid-fast bacilli (AFB) sputum smear-positive or cavitary tuberculosis (TB) cases

Prioritization

Sub

- 1 c



* Human immunodeficiency virus or other medical risk factor.

† Bronchoscopy, sputum induction, or autopsy.

‡ Exposure exceeds duration/environment limits per unit time established by the health department for high-priority contacts.

§ Exposure exceeds duration/environment limits per unit time established by the health department for medium-priority contacts.

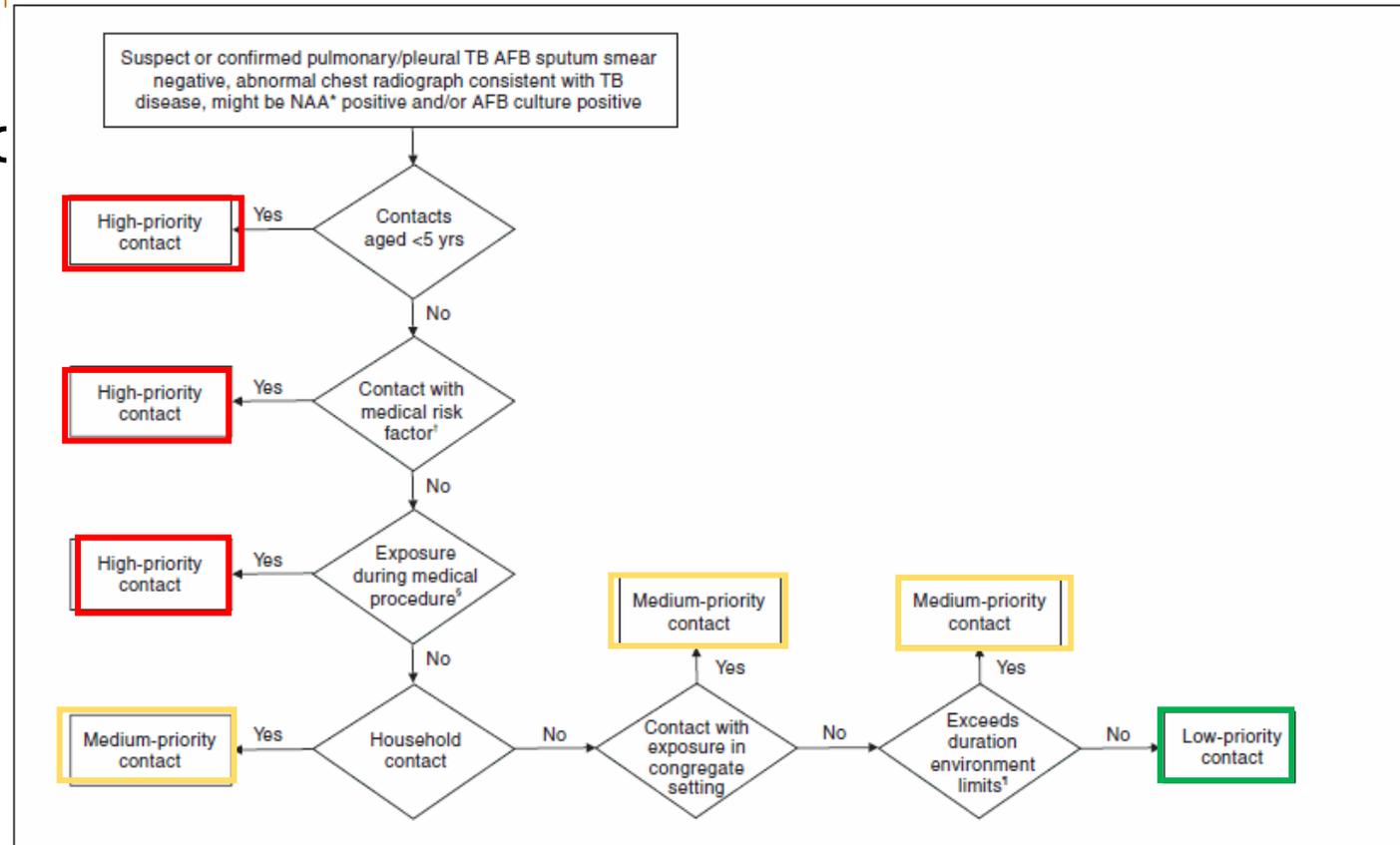


Prioritization and Evaluation

FIGURE 3. Priority assignments for contacts exposed to persons with acid-fast bacilli (AFB) sputum smear-negative tuberculosis (TB) cases

Sub

- 1 c



* Nucleic acid assay.

† Human immunodeficiency virus or other medical risk factor.

‡ Bronchoscopy, sputum induction, or autopsy.

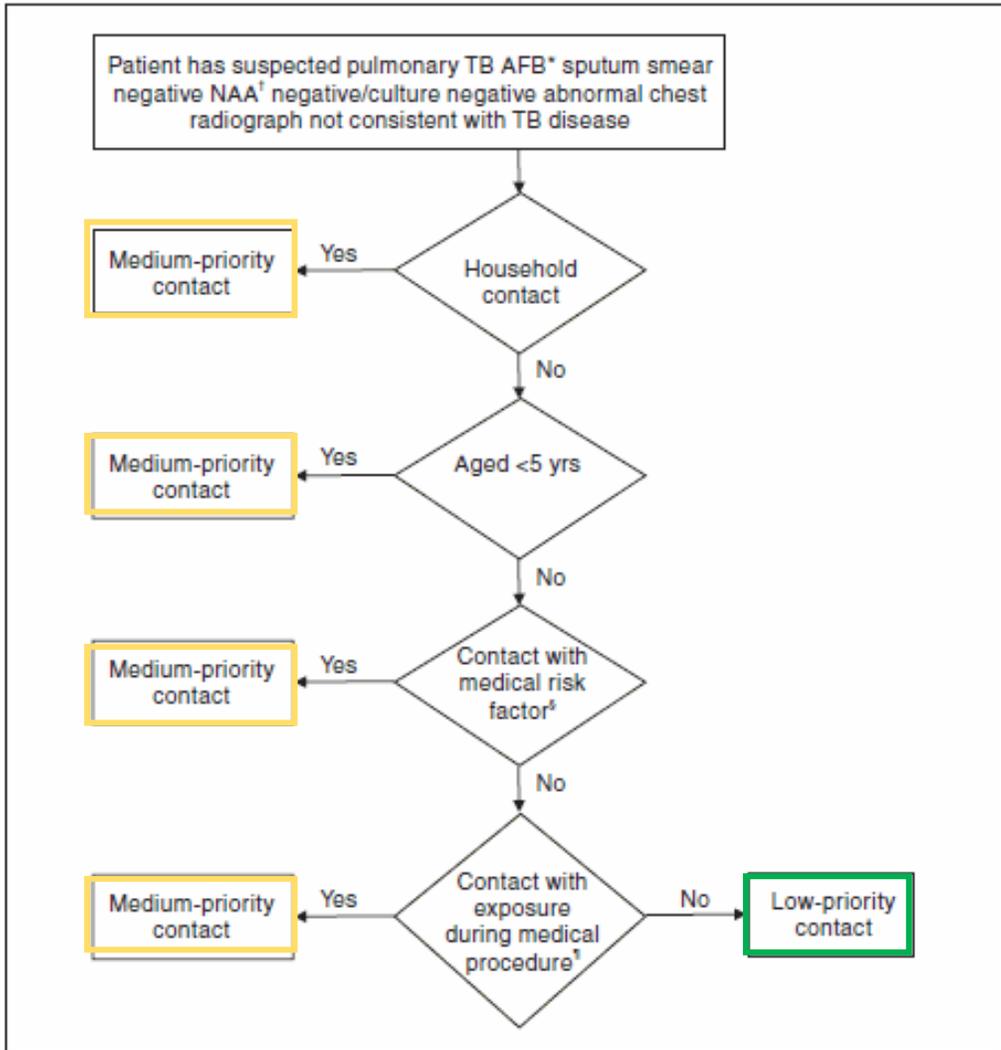
§ Exposure exceeds duration/environment limits per unit time established by local TB control program for medium-priority contacts.



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FIGURE 4. Prioritization of contacts exposed to persons with suspected tuberculosis (TB) cases with abnormal chest radiographs not consistent with TB disease



* Acid-fast bacilli.

† Nucleic acid assay.

§ Human immunodeficiency virus infection or other medical risk factor.

¶ Bronchoscopy, sputum induction, or autopsy.



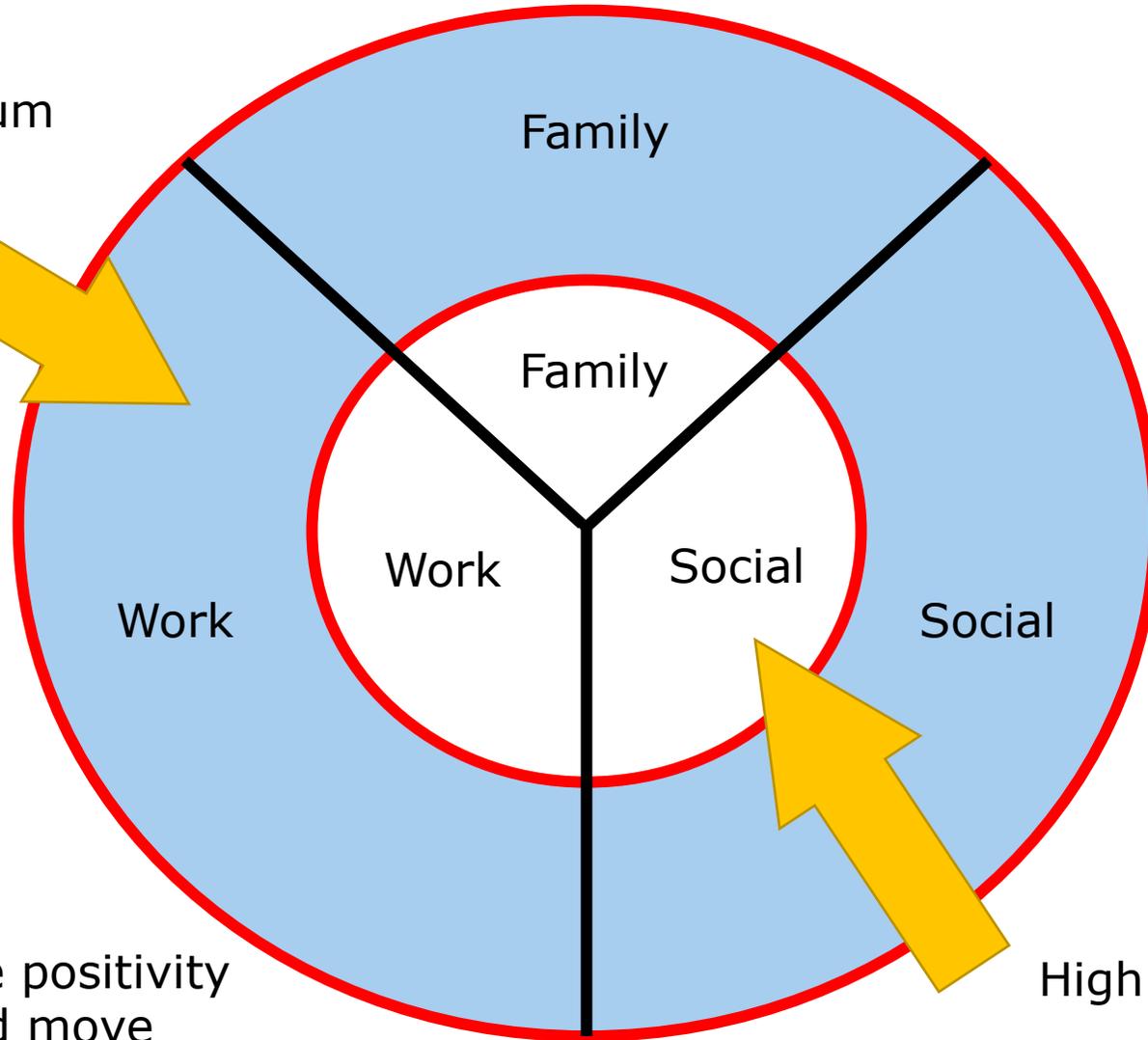
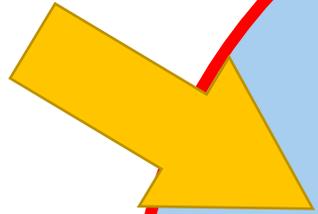
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Low -
medium
risk



High risk

Calculate positivity
rates and move
outward accordingly

Prioritization and Evaluation

How to evaluate those exposed

- Initial encounter with high- and medium- priority exposed who are most at risk should be made **within 3 working days.**
 - Gather exposed's background health information.
 - Face-to-face assessment of the person's health.
 - Draw IGRA or administer TST at that time.



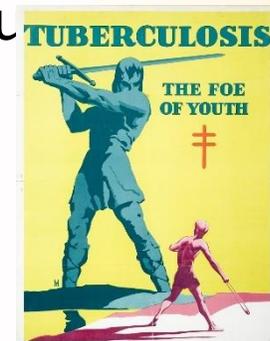
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Prioritization and Evaluation

How to evaluate those exposed

- The health department's evaluation for TB or LTBI should include:
 - Previous M.TB infection or disease and related treatment.
 - Exposed person's verbal report and documentation of previous TST results.
 - Current symptoms of TB illness
 - Risk factors or medical conditions making TB disease more likely
 - Mental health disorders
 - Type, duration, and intensity of TB exposure
 - Sociodemographic factors



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Prioritization and Evaluation

How to evaluate those exposed

- Test for infection using IGRA or TST.
 - Stick with one test if it is valid; don't do best 2 out of 3 results.
- For children less than 5 years of age, have HIV, or patients who are immunocompromised, perform a PA and lateral CXR.
- Evaluate for signs and symptoms of TB disease.
- Patient must be evaluated again 8-10 weeks after the BIC.



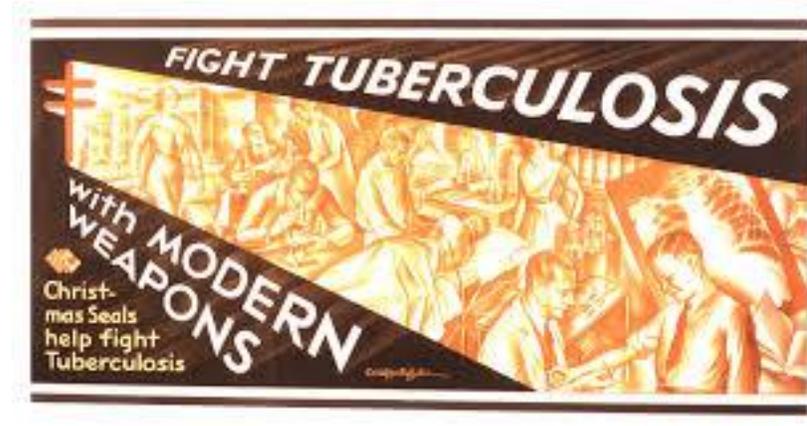
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Prioritization and Evaluation

IGRAs

- IGRA
 - QuantiFERON
 - T-spot
- Pros
 - One visit
 - Objective
 - Rules out false positives
- Cons
 - Expensive
 - Indeterminates, indicator of disease vs. infection
 - Immunosuppressed patients



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Prioritization and Evaluation

Follow-up

- Documentation of a previous positive result should be obtained before omitting the skin test from the diagnostic evaluation.
- Do not make a decision whether or not to test based on the exposed person's verbal report.
- Provide window prophylaxis for high risk groups (< 5 y.o., HIV+, immunosuppressed)
- Determine if legal action is required for those who refuse testing for their children.



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Data Management and Communications

Collecting Data

- Collect specific data needed for evaluation.
- Collect on standardized forms
- Use specified standardized data definitions and formats when possible.
- Have a plan for how you are going to collect, process, and analyze data from the beginning.



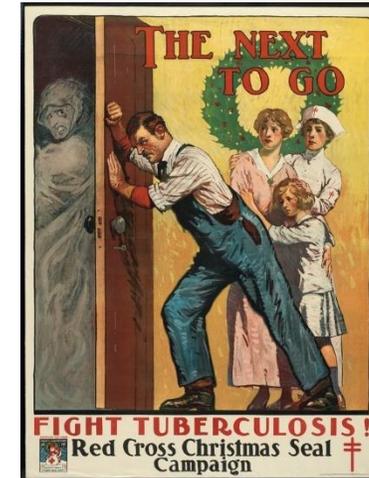
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Special settings and source case identification

Special settings

- Congregate or unusual settings for TB exposures
 - Correctional facilities
 - Workplaces
 - Hospitals and other healthcare settings
 - Schools
 - Shelters
 - Modes of Transportation
 - Drug and alcohol usage sites
 - Interjurisdictional identifications



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Special settings and source identifications

Outbreaks

- Definition with regard to TB:
 - During a CI, 2 or more exposed persons having TB disease
 - Any 2 or more cases occurring less than 1 year of each other are linked and not caught in a CI.
- May indicate lapse in regular TB control.
- Call for assistance when needed.
- The public may use the term “outbreak”, but a TB outbreak rarely occurs.



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Special settings and source identifications

Source case identification

- Reverse contact identification
 - Goal is to actively search for someone who has TB disease.
 - Recommended for children under the age of 5 years old who develop TB disease.
 - Start close and work your way out.
 - Searching for unexplained TBI is generally not recommended and if done should be limited to LTBI in children younger than 2 years of age.



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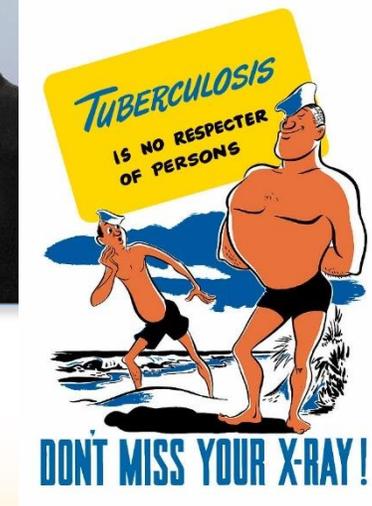
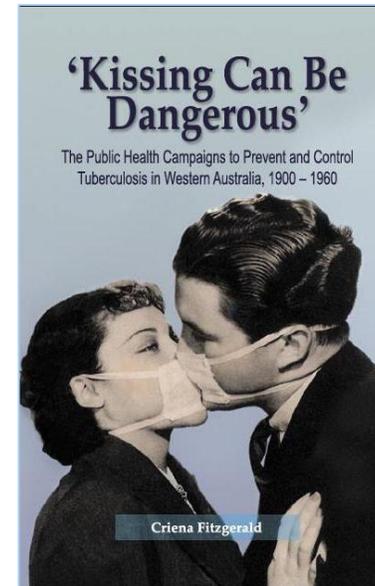


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Take away points

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- Maintain control
- Communicate effectively
- Stay organized
- Be flexible
- Always improve





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Thank you

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