County of Santa Clara
Public Health Department

Public Health Administration
150 W. Tasman Drive, 2nd Floor
San José, CA 95134
408.792.5040

DATE: September 10, 2024

TO: District Superintendents
School Nurses
Health Care Providers

FROM: Sara H. Cody, MD
Health Officer
Ann M. Loeffler, MD
Tuberculosis Controller

RE: **Update Concerning Tuberculosis (TB) School Mandate: Universal Risk Assessment, Targeted Testing and Treatment**

Santa Clara County has had a Tuberculosis School Mandate requiring TB screening for students entering school since 1989. The Health Officer Mandate was implemented at that time because TB rates had rapidly increased. It was intended to increase the likelihood that children with TB infection or disease were diagnosed early and treated appropriately.

In the subsequent 35 years, we have learned that universal TB testing (skin test or blood test) of low-risk populations has a very low yield and can lead to unnecessary, expensive and anxiety-producing testing and treatment. Instead of universal TB testing, it has become standard practice to use a questionnaire with several evidence-based questions to identify risk of TB. This is called TB screening or risk assessment. We **test** only those folks with risk factors for TB.

We have been TB screening children by questionnaire before school entry for about 10 years. Since that change was made in 2014, Santa Clara County has had a decline in pediatric TB cases, with only 3 children under 15 years of age and only 1 school-aged child diagnosed with active, but non-contagious TB in 2023. National guidelines now advise that children be screened for TB risk factors at each pediatric well-child visit throughout childhood.

TB screening at the point of school entry is unlikely to identify children with contagious tuberculosis, but still has value. The screening helps to identify latent or inactive TB infection in children and families and thus helps to facilitate treatment and education regarding TB in our community. We should therefore continue to facilitate and encourage families to complete the TB screening process.

SCC Tuberculosis (TB) Screening Requirements for School Entrance

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TB screening for Santa Clara County schools is comprised of:

1. A brief questionnaire listing risks for TB exposure.
2. Blood test or skin test ("TB test") if the student has new TB risk factors since their last screening (and no prior positive test).
3. Medical evaluation and chest X-ray (CXR) for children with a new positive TB test.

A. What are the tuberculosis (TB) screening requirements for school entrance in Santa Clara County?

- Students enrolling into a Santa Clara County school for the first time into kindergarten or upon transfer to any grade must undergo a one-time TB risk assessment. Each student needs to be evaluated by a provider who will assess TB exposure risks based on the Santa Clara County Public Health Department TB Risk Assessment for School Entry form. If the provider identifies no risk factors and the child has no symptoms of TB disease, no further evaluation is needed. The family will provide the school with the questionnaire or an After Visit Summary or similar printout from the visit stating the risk assessment results.
- TB risk assessment documentation is valid for up to twelve months before registration for school.
- Students with a positive risk assessment should have a TB test (preferably Interferon Gamma Release Assay (IGRA) blood test, especially for children who have received the BCG vaccine). If the student has a negative TB test no further evaluation is needed. All children with a positive TB test should undergo a medical evaluation, including a symptom review, physical exam, and CXR. The provider should include the results of the CXR on the form. See below if the CXR is not normal or if the child has any signs or symptoms of TB disease.
- The provider is not required to order a CXR for children who have no symptoms and have documented prior treatment for TB disease or latent TB infection (LTBI).
- If a child has a positive TST and a confirmatory IGRA is desired by provider or parents, they still need a CXR, symptom review, and physical exam. If the subsequent IGRA is negative, the CXR, symptom review and exam are normal, the child is deemed to NOT have LTBI and deserves no treatment.
- If the child has no symptoms of TB, they may attend school pending risk assessment/TB testing if their parent/guardian has made an appointment for screening. Primary school aged children are not contagious even if they have TB disease. The purpose of this TB screening is to raise awareness about TB and TB risk factors and to promote the treatment of LTBI through the medical home. Children should not be excluded from

school, unless they have symptoms suggesting TB. Schools should encourage families to return the Risk Assessment paperwork, even when it is finalized belatedly, but children should not be excluded from school if the family does not return the paperwork.

- If the child has TB symptoms or an abnormal chest x-ray suggesting TB disease, the child must undergo further evaluation and cannot enter school unless the provider excludes active TB disease, or the child has started treatment. The provider should immediately call SCC TB Prevention & Control at 408-885-2400 and request a consultation with the TB controller or school liaison or alternatively, fax or email a Tuberculosis CMR Form and an abnormal chest x-ray report to the TB Prevention and Control Program at (408) 885-2331 within one working day.

B. Who can enroll/register in a Santa Clara County school before TB screening requirements are complete?

- Pending TB risk assessment, Santa Clara County schools can immediately enroll students:
    - who have completed the risk assessment process or,
    - who have an appointment scheduled for screening or,
    - who fall under the provisions of the McKinney-Vento Homeless Assistance Act or
    - who have an IEP or,
    - are in Foster Care.
- Santa Clara County still requires TB screening for these students, and their parents/guardians should book an appointment to complete the screening promptly before or after their school registration.
- Santa Clara County recommends a TB blood test (IGRA) or a tuberculin skin test (TST) at least 8-10 weeks after a student arrives in the US because developing an immune response to TB infection can take this long. Consequently, if these students have no symptoms of TB disease, the IGRA or TST can be deferred until then.
- **A student can enroll before the TB risk assessment process if they have no TB symptoms (new or worsened persistent cough, unexplained fever, or weight loss, etc.) and a scheduled appointment with a provider (either medical home or TB screening site).**

C. Who is exempt from these requirements?

- All students who have previously met the TB screening requirements of Santa Clara County AND who have not been residing outside the county for greater than 12 months. This includes students with prior completion of the Santa Clara County Public Health Department TB Risk Assessment for School Entry form for Transitional Kindergarten (TK) or other school-based early learning program in Santa Clara County (school programs begin after age 3).

- Students transferring from one school to another within Santa Clara County AND have previously met the TB screening requirements.

D. How were the risk assessment questions chosen?

- The questions on the TB Risk Assessment for School Entry form were adapted from the American Academy of Pediatrics Guidelines and the California Department of Public Health recommendations.

E. What are acceptable TB tests?

- Interferon Gamma Release Assay (IGRA) blood test, which must be done in the U.S., US Territories or US Military Base Medical Facility.
- Mantoux Tuberculin Skin Test (TST), which must be done in the U.S., US Territories or US Military Base Medical Facility.
- Exception to above: A positive IGRA or TST shall be accepted from any country.

F. What is the definition of a positive TB test?

- A positive IGRA result interpretation is included in the laboratory report.
- A positive TST is 10 millimeters (mm) or more of induration (swelling). Redness alone at the skin test site is not considered a positive reaction.
- If an individual has had recent contact to a person with active infectious TB or if they are immunosuppressed, or have an abnormal CXR, signs or symptoms of TB, they are considered to have a positive TST if there is 5 mm or more of induration.

G. What does a positive TB test mean?

- A positive TB test suggests that the student has been infected with the bacteria that causes TB. It is important for students with a positive TB screening test to undergo medical evaluation to determine whether they have latent TB infection (LTBI) or active TB disease. This is done by CXR, symptom review and physical exam.
- If active TB disease has been excluded, the child should be treated for latent TB infection (LTBI). LTBI treatment is not mandated for school enrollment as LTBI is not infectious (cannot be transmitted to others), but treatment is advised to prevent the child from developing TB disease in the future.

H. What is the next step for a student with a positive IGRA or positive TST result? Note: positive means past positive or current positive result

- Students with a positive IGRA, positive TST, or symptoms or signs of TB disease must submit evidence that they are free of pulmonary TB disease. This includes one of the following:
    - Result of chest x-ray done in the United States, US Territories or US Military Base Medical Facility up to 6 months prior to school registration that does not show evidence of active pulmonary tuberculosis.
        - Written documentation of prior treatment for latent TB infection. See

Table on page 9.
    - Written documentation of ongoing treatment for latent TB infection.
    - Written documentation of prior treatment for active TB disease.
    - Written documentation of current treatment for active TB disease.
- If the student's evaluation is underway and they don't have signs or symptoms of active TB (as documented by a medical provider), they may enroll, pending the results of the chest x-ray.

I. What is the next step for a student with an indeterminate IGRA test?

- Students who have a positive TB risk assessment, an indeterminate IGRA test result, and a negative symptom review by a primary care provider may enter school.
- Note to providers: If result is indeterminate, consider repeating the IGRA or placing a TST.

J. What should a school do if a student does not have a primary care provider?

- If a student does not have a source of regular care, provide our list of community clinics that offer IGRA or TST testing.

K. What records must students provide to meet the requirements of the TB Mandate?

- The Santa Clara County Public Health Department TB Risk Assessment for School Entry form completed by a primary care provider or designee in the U.S., U.S Territory or U.S. Military Facility.
- An After Visit Summary or similar questionnaire printout from the visit can replace the Risk Assessment form. The documentation should list the risk assessment results, and whether there are signs or symptoms of TB. No TB test is required for students with no new risk factors and no symptoms of TB.
- Students who are currently being treated or have completed treatment for TB or latent tuberculosis infection (LTBI) must provide written documentation from their health care provider. This should include medication name, dosage, date started, and date completed. This student does NOT require an additional chest x-ray.
- Students who have a positive TB test results can present the Santa Clara County Public Health Department TB Risk Assessment for School Entry or an After Visit Summary stating that follow up testing and evaluation completed by a primary care provider in the U.S., U.S Territory or U.S. Military Facility

L. Who can sign the TB Risk Assessment Form?

- An LVN, RN, PA, NP, or physician can administer the Risk Assessment form.
- If the Risk Assessment and TB test are positive and requires a physical exam and chest x-ray, a PA, NP, or physician needs to sign the form.

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Frequently Asked Questions

1. *Can I have a TB test on the same day as a COVID-19 Vaccine or MMR Vaccine?*
   There are no restrictions for the COVID19 vaccine with regard to TB testing. MMR and Varicella vaccines can be performed the same day. However, a TB test should not be performed within 4-6 weeks after an MMR or Varicella vaccine.

2. *Should a child who has history of BCG vaccination have a IGRA or TST?*
   Because Interferon Gamma Release Assays (IGRAs) have increased specificity for true TB infection in children vaccinated with BCG, IGRAs are preferred over the tuberculin skin test (TST) for children who have a history of BCG vaccination. If an IGRA is not done, the TST results can be utilized. Medi-Cal does not have an age restriction for IGRA reimbursement.

3. *Are there ever indications for doing both an IGRA and a TST?*
   In general, a provider should choose the appropriate test and avoid doing both tests. If a BCG-vaccinated child has a positive TST, an IGRA can be used to increase the acceptance of treatment for latent TB infection (LTBI). For children who are immunocompromised, consider performing both tests. In this case, if either the TST or IGRA is positive, and TB disease has been excluded, the child should be treated for latent TB infection.

4. *What if the student has documentation of a previous positive IGRA/TST from outside the U.S, US Territories or US Military Base Medical Facility?*
   The student with documentation of a positive IGRA/TST will need to have a medical evaluation, including a CXR in the United States, US Territories or US Military Base Medical Facility.

5. *If someone does not want to submit to a risk assessment, can they get a TB test?*
   Yes, a TB test (either IGRA or TST), performed up to twelve months prior to registration for school, may be completed instead of a TB risk assessment. If the test is positive, the child must have a medical evaluation by a licensed primary care provider in the U.S., US Territories or US Military Base Medical Facility, including a chest x-ray and physical exam, with documentation of these results on the risk assessment form and provided to the child's school.

6. *This student left the county for an extended vacation. Do they still need a TB screening test?*

   If the student has extended travel (e.g., >1 month) to a country **other than** the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe they should be evaluated for TB infection 8-10 weeks after they return but this will not be required for school re-entry. If the child has been residing outside of Santa Clara County for >12 months, the school entry risk assessment must be completed again.

7. *What is considered an adequate regimen for latent TB Infection?*

   Recommended treatment for latent TB infection is listed in the following table. Short-course regimens (rifampin daily for four months,12-dose weekly isoniazid/rifapentine or Isoniazid and Rifampin daily for 3 months) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid. If a student was previously treated with 6-9 months of isoniazid for LTBI, this is also considered adequate treatment.

8. *Where can I get more information?*

   Please visit our website Tuberculosis Prevention and Control Program | Providers | County of Santa Clara (santaclaracounty.gov) or call County of Santa Clara Public Health Department TB Prevention & Control Program: (408) 792-1381

TABLE 1.1 LATENT TUBERCULOSIS INFECTION TREATMENT REGIMENS FOR CHILDREN

Drug(s)	Duration	Dose	Frequency	Total Doses
Rifampin (RIF)	4 months	Children: 15-20 mg/kg Maximum dose: 600 mg	Daily	120
Isoniazid (INH) and Rifapentine (RPT)	3 months	• Isoniazid 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg) ≥ 12 years old: 15 mg/kg rounded up tonearest 50 or 100 mg (max. 900 mg) • Rifapentine 10.0-14.0 kg: 300 mg 14.1-25.0 kg: 450 mg 25.1-32.0 kg: 600 mg 32.1-50.0 kg: 750 mg >50 kg: 900 mg • Vitamin B6 50 mg weekly	Once weekly	12
Isoniazid (INH) and Rifampin (RIF)	3 months	Children: INH: 10-20 mg/kg; 300 mg maximum RIF: 15-20 mg/kg; 600 mg maximum	Daily	90
Isoniazid (INH)	9 months	10 mg/kg (range, 10-15 mg/kg) Maximum dose: 300 mg Recommended pyridoxine dosage: 25 mg for school-aged children (or 1-2mg/kg/day)	Daily	270

*Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine or Isoniazid and Rifampin daily for 3 months) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid.
**Rifampin (RIF) is formulated as 150 mg and 300 mg capsules. Rifapentine (RPT) is formulated as 150 mg tablets inblister packs that should be kept sealed until usage. Isoniazid (INH) is formulated as 100 mg and 300 mg tablets. INH suspension is available commercially but causes stomach upset in many children. Rifampin can be compounded into a liquid, but many families successfully crush tablets or open capsules into soft foods or a little liquid

References:

1. American Academy of Pediatrics. Tuberculosis. In Kimberlin DW, *et. al.* eds. Red Book: 2024- 2027 Report of the Committee on Infectious Diseases. 33rd ed. Itasca, IL: American Academy of Pediatrics.
2. *California Pediatric TB Risk Assessment and User Guide (August 2024)*
3. Testing and Treatment of Latent Tuberculosis Infection in the United States: A Clinical Guide for Health Care Providers and Public Health Programs 3RD EDITION 2024 LTBI Clinical Recommendations (tbcontrollers.org) and User Guide 2024.