

#	Comments	VPD TB Workgroup Response
1	<p>Page 1, Last Paragraph – We don’t necessarily think terminology is evolving, we just have different names for TB. Latent TB, TB infection and inactive TB have been terms that have been used, but we would say the official terminology is latent TB infection (LTBI) or TB infection for healthcare providers. We would say these are more synonyms rather than an evolution of terminology. Moving on to page 2, we would say the more appropriate terminology would be “latent TB infection (LTBI)” for healthcare professionals while often inactive TB is used for a more general audience.</p>	<p>Deleted the word "evolving" but kept our language the same, adding an explainer that "Inactive TB infection and latent TB infection are different names for the same condition." We will address terminology and nomenclature in the 2027 revision of the TB Guideline.</p>
2	<p>Page 2, About Tuberculosis, First Paragraph – it says TB is spread when someone coughs, sneezes, or spits. That is WHO language. We don’t hear the mention of spit anymore. Also, it doesn’t list those as examples, so the language could be updated to use those as examples. CDC says “when someone coughs, speaks or sings”.</p>	<p>Substituted the word "speaks" for "spits" and added the CDC reference, in addition to the WHO reference.</p>
3	<p>Page 3 – Factors to Consider – Some of these didn’t make sense to us to include as part of a TB Risk Assessment Program including what a response would be to someone with active TB (e.g., reporting, doing DOT, prescribing medication). Most public health jurisdictions would not typically expect universities to provide students with active TB disease with medications and DOT, management of nonadherence esp. if the student is infectious, etc. Universities should focus on identifying risk factors for TB infection or progression to active disease if infected, testing for LTBI, and then excluding active TB disease in persons who test positive for LTBI, followed by offering and encouraging treatment for LTBI. Any student diagnosed with active TB disease (would be a tiny fraction of the LTBI cases) should be reported to the local health department. Consider separating these questions into subsets for LTBI and active TB disease.</p> <p>Will students be referred to the local public health authority (LPHA)? Will campus staff oversee directly observed therapy (DOT)? How will students who are noncompliant with DOT or other treatment be managed?</p>	<p>Numbered "factors to consider" for ease of editing. Added "work with the local public health department for the administration of directly observed therapy" in #19. Will consider dividing into subsets in the 2027 revision.</p>
4	<p>Page 3: The question “How will foreign-born students react if they learn the test result was report to a public health authority” seems like it should be more general to ask how any student will react if they learn their test result was reported to PH.</p>	<p>Deleted "foreign born" in #14</p>
5	<p>Page 3: Would be valuable to consider how they would handle people who are prior positive with/without treatment in this program. On page 4 it says that students with documented positive tests should review their documentation and medical history with a college health provider to determine if additional testing and follow-up care is warranted, but the example Appendix A doesn’t have a pathway for those individuals via risk assessment.</p>	<p>Retained existing language. Will consider in the 2027 revision.</p>

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6	Page 4 end/Page 5 beginning- "... a cumulative period of one to three months or more should be tested for TB", could that just say a cumulative period of more than one month. We suggest choosing one time frame (one month is what California recommends).	Edited to "a cumulative period of at least one month."
7	Page 5 – It says that TB screening should occur no earlier than 6 months before the first term and should be completed by the second term registration. Is that also the requirement for immunizations? We had assumed all of this would be completed before the start of the first term, but maybe this doesn't want to risk delays in students starting if they don't complete their evaluation timely.	Retaining existing language. This timing is unique to colleges and universities due to matriculation timing, having access to TB testing (international students), giving time to come into compliance, and not creating barriers to a timely start to the term. The goal is to have the student actively engaged with health services well before the start of the term.
8	Page 5 – Under When to Screen what is meant by higher-risk students? Any student with risk from the questionnaire?	Clarified sentence to say, "students who answer "yes" to any question on the screening questionnaire.
9	Page 6 – Under Potential Harms to Students it also says only to test students who screen as high risk. Does that just mean people who have answered yes to a risk for TB on assessment?	Also changed this sentence to say, students who answer "yes" to any question on the screening questionnaire.
10	Page 6 – Targeted Testing – We more often see this terminology mentioned, as special efforts outside of routine screening to identify people at risk of TB infection. Since everyone would need to have a TB screening, we would suggest not using targeted testing here and remove the first paragraph. Then the section could be renamed “clinical evaluation” or “TB testing and clinical evaluation”	Retaining existing language.
11	Page 6 – “Testing should not be performed on individuals with written documentation of a previous positive test result or who have completed treatment for latent TB infection or active TB disease.” Consider adding, “Students with prior positive tests who did not complete treatment should be evaluated for treatment and encouraged to take treatment.”	Added sentence, Students with prior positive tests who did not complete treatment should be evaluated for treatment and encouraged to take treatment.
12	Page 6 “In addition, people found to be low risk should not be tested as it increases the possibility of a false positive test result and may divert resources from those likely to convert to active TB disease.” Suggest use “those likely to progress to active TB disease” instead because “conversion” has a particular meaning in public health TB control (usually, conversion of a negative TB screening test to a positive one).	Changed the word "convert" to "progress."
13	Page 7 – It says interpretation of blood test results vary based on risk of exposure (pre-test probability)... We don't understand that statement. TST varies in interpretation based on risk, but what do you mean for blood tests? Is this just talking about false positives/negatives?	Edited sentence to read, " Interpretation of blood test results vary based on risk of exposure."
14	Page 8 - It says “People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala” It is little bit strange to us that these countries have been specifically listed when the rest of the document talks about screening all students with birth, residence or travel to countries with TB incidence rate equal to or higher than 20 cases per 100,000 – which includes many more countries. We realize you are probably borrowing from CDC materials. Maybe say “including but not limited to” Mexico, etc... ?	Retained language as is, as it is directly taken from a CDC chart. Will address in the 2027 revision.

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15	Page 9 – Confirmatory testing. Our usual practice is CXR to exclude active TB disease among persons being considered for LTBI treatment must be completed within 3 or 4 months, regardless of symptoms or immune status. The issue with allowing 2 years for the CXR that patients may have progressed to active TB disease in the two years since the CXR was done. This could lead to treatment of active TB disease with a single drug (for “LTBI”), which can select for drug resistance. There is increased attention of late to subclinical TB, in which patients may be asymptomatic but have radiographically evident and culture/PCR positive active TB disease.	Edited language to read, "...or within three months of starting treatment (if asymptomatic new converters, HIV+ individuals, and those who are severely immunocompromised)." Changed terminology from "chest radiography" to "chest X-ray" for consistency throughout document.
16	Page 9 – Last paragraph – For the statement “If needed, the local health department will help coordinate sputum sample collection for analysis.” Not all LHDs will do this in house, some might refer to a local hospital, pulmonology practice, or respiratory therapy outpatient clinic. Maybe instead of saying “will help” say “could help”.	Edited language to read, "...could help..."
17	Page 11- Can it be called out that students should be informed their test will likely remain positive even if they take treatment. We see that on the treatment card, but it would be valuable to offer education too	Retained existing language. Will consider in the 2027 revision.
18	Page 12, Tx of Active TB Disease, first paragraph – mention newer four-month HPMZ regimen especially as students/younger people otherwise in good health with active TB are most likely to be offered this regimen.	Removed language about specific treatment regimens in general.
19	Page 12, Tx of Active TB Disease – “The period of isolation depends on the severity of the case, and release from isolation requires three consecutive negative sputum smears and at least two weeks on medication therapy.” There are new guidelines allowing discontinuation earlier for community settings – not based on smear status, but based on clinical improvement, adherence to an effective treatment regimen, and a certain duration of therapy (between 5 to 14 days) depending on burden of TB disease at diagnosis. NTCA Guidelines for Respiratory Isolation and Restrictions to Reduce Transmission of Pulmonary Tuberculosis in Community Settings Decisions about discontinuation of isolation in a congregate setting such as a college dorm would be case-by-case in consultation with the local health department.	Edited language to read, "The period of isolation depends on the severity of the case, and decisions about discontinuation of isolation would be made on a case-by-case basis in consultation with the local public health department."
20	Page 12, Tx of Active TB Disease, last paragraph – maybe rephrase that local PH dept provides medication and provides directly observed therapy to all patients with active TB disease. Then document could include that local PH depts may coordinate DOT with the school if in the best interest for the individual’s adherence to treatment and report any adverse events immediately to the nurse case manager before DOT is completed.	Retained existing language. Will consider in the 2027 revision.

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21	Page 14 – Concentric circle – second paragraph –We think this should say 8-10 weeks for second round testing and we were confused by the delineation of approaches to ring 1 and ring 2. Generally, we either test both ring one and ring two at baseline and followup 8-10 weeks later or we test both rings once about 8-10 weeks after exposure (we don't just do symptom checks for ring 2 on baseline). This usually depends on when we became aware of the case and how soon we are able to do testing. Sometimes the last exposure was already 10 or more weeks ago by the time we become aware of the case, in that case we would only do one round of testing.	Edited to read 8-10 weeks.
22	Page 15 – Occupational health – This should mention that the N95s for staff should be fit tested and also having alternatives like CAPR/PAPR available for those who fail fit testing for N95 use (or who have beards). If they have occupational health guidelines related to fit testing, it would be good to reference that here if they don't want to get into those specifics in the document. We feel at minimum in this document they should say that employees need wear a fit-test approved N95 respirator.	Edited to include "...and CAPR/PAPRs for those who fail fit testing for N95 use (or who have beards)."
23	Page 16 – says “emphasize that inactive TB infection is not infectious to others and usually does not make a person feel sick”. Suggest removing “usually”.	Removed the word "usually."
24	Appendix A – question 3 – can “cumulative period of one to three months or more” say 1+ months instead of the range.	Edited to say, "at least one month..."
25	Appendix A – question 4 – Would delete nursing home or residential healthcare facility and focus on jail/prison and homeless shelters – see below for comments re USB healthcare workers	Retained existing language. Will consider in the 2027 revision.
26	Appendix A – question 6 – We found the inclusion and framing of this question confusing. Substance use, and being low income, and being medically underserved are modest risk factors for TB infection. There are a lot of other modest risk factors for TB infection and/or progression to TB disease. But BY FAR the biggest risk factor for TB infection is being from a TB endemic country. We would suggest instead of using these appendix questions, using this model TB risk assessment, which has been thoroughly vetted and tested for usability and understandability widely for years: California Adult Tuberculosis Risk Assessment (>18 years old) We would avoid generally focusing on healthcare settings in the US. This is going to end up catching a lot of low-risk US-born students who will get tested, some of whom will be false positives. Note that the risk of TB infection in US born healthcare workers is LOWER than the risk in the general population. This is why CDC has recommended eliminating annual TB testing for most healthcare workers. If you keep this risk assessment, would delete Q5 and Q6.	Retained existing language. Will consider in the 2027 revision.

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27	Appendix F – first paragraph, last sentence – “we can treat you with antibiotics that can prevent you from getting sick” – we hesitate with the existing language in the sentence because it seems like the person will get definitively sick if they are not treated, which isn’t necessarily the case. Suggest “we can treat you with antibiotics to prevent you from getting sick in the future”	Edited to add, "in the future."
28	Appendix F – second paragraph, second to last sentence (e.g., no masking, no quarantine) this should be i.e. (in other words) not e.g. (for example)	Edited to "i.e.,"
29	Appendix F – second paragraph, third sentence – should also mention that they may receive a call from their local public health department, not just the school representatives.	Edited to include "You also may receive a call from the local public health department."
30	I was a bit surprised that you recommend a CXR even if the IGRA is negative is the student had a positive TST.	Retained existing language. A CXR is needed in this situation.
31	Having the link to the High risk countries through WHO lead you directly to their current list versus having to shuffle through their site would be beneficial	That would of course be ideal but unfortunately the link does not exist. WHO doesn't publish a list of high risk countries, nor even a simple list of TB incidence that we are aware of (if the commenter knows of something like this please advise). That's the reason ACHA publishes its own list - there's no other source for this. TB incidence rates are found in the raw WHO data, which has to be extrapolated from a database and downloaded. They provide a tool to do that, and it's what ACHA does each year to create the list. Importantly, the designation of "high risk" is made by ACHA based on our own criteria, not WHO.
32	Very helpful as a resource for all the questions that do come up.	Thank you! No action.
33	Please clarify accepting documentation of TST for high risk, incoming Health Science students who work as a CNA, and have documentation of a negative TST that is older than the stated 6 months prior to start of classes. Should they a have a second test within 12 months to meet the 6 month recommendation?	We will consider a future FAQ to address this question.
34	One of the questions that is most discussed if someone answers that they were born in one of the list countries, that makes them high risk. My question is how long since they have been in the country should we do further testing? If someone was born in the DR, but have been in the US for 18 years, should we still screen, despite them being in the US health system. When I started doing the immunization and TB compliance, I had read 5 years to do testing, otherwise not needed, but I can not find that reference any more. It would be nice to have this addressed as multiple times in the local colleges we have had this discussion with no definitive answer.	Appendix . This situation is still a risk. Reference Article.
35	Thank you for doing the work to keep these guidelines up to date. I think the section on LTBI risk assessment is particularly important. This is great, clearly communicated information.	Thank you! No action.
36	No comments.	No action.

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37	No comments.	No action.
38	I do question if two office visits are necessary after a + IGRA or PPD. One to order the chest xray and one to discuss the results and treatment.	We will consider a future change to the Guideline or FAQ to address this question.
39	So very helpful for many years!! I use this guidance every April to prep for incoming students completing their questionnaire starting in May. One thought - on the Appendix 6: Example of Inactive TB Treatment Completion. This is great! Should there be a similar form to use when a student declines the medication - showing their test results, what is advised, includes risks, and has their signature? I appreciate your section under Treatment Management addressing when a student declines. Yes, very helpful. Thank you for including Q22.	We will consider a future change to the Guideline or FAQ to address this question.
40	Does anyone have info on exempting a student born in a high incidence TB country who has been in the US for many years from TB testing? Do any schools do this? The document liked above does not mention this exemption. I have a student pushing this and want to make sure I have all of the info before making a determination. I don't see any such exemption in ACHA guidelines.	Added new FAQ Q12 and A12.
41	IGRA TB testing -discordant results	Added new resource to Q10/A10.