Connecticut Epidemiologist

Volume 38, No. 1 January 2018

Reportable Diseases, Emergency Illnesses and Health Conditions, and Reportable Laboratory Findings Changes for 2018

As required by Connecticut General Statutes Section 19a-2a and Section 19a-36-A2 of the Public Health Code, the Commissioner of the Department of Public Health (DPH) is required to declare an annual list of Reportable Diseases, Emergency Illnesses and Health Conditions, and Reportable Laboratory Findings. The list of reportable diseases, emergency illnesses and health conditions has two parts: (A) reportable diseases; and (B) reportable emergency illnesses and conditions. An advisory committee, consisting of public health officials, clinicians, and laboratorians, contribute to the process. There is 1 addition, 1 deletion and 1 modification to the healthcare provider list only; 1 addition and 2 modifications to the laboratory list only; and 1 deletion from both the physician and laboratory list. Reportable disease forms can be found on the DPH website at: http://www.portal.ct.gov/DPH/Communications/Forms/Forms.

Changes to the List of Reportable Diseases, Emergency Illnesses and Health Conditions

Part A: Reportable Diseases

Healthcare Associated Infections—Ventilator Associated Events (VAE)

Reporting of VAE has been added. VAE are now reportable from adult intensive care units (ICU) and wards in CMS-designated long term acute care hospitals (LTACHs). Reporting will be through the National Healthcare Safety Network (NHSN). LTACH patients needing mechanical ventilation may be at risk for VAEs. Reporting can assess risk and improve prevention.

Lead

Reporting of lead toxicity (blood level ≥ 15 µg/dL) has been removed. The DPH receives electronic laboratory reporting for lead, which allows local health departments to conduct follow-up.

In this issue...

Part B: Emergency Illnesses and Health Conditions

Hospitals report syndromic surveillance (SyS) data to DPH using EpiCenter, the Commissioner's approved method for data submission. For reporting requirements, please visit the DPH Meaningful Use webpage. SyS data may be used to monitor the following syndromes:

1. Influenza-like illness
2. Gastrointestinal illness
3. Drug and alcohol, including drug, opioid, and heroin overdoses
4. Sexually transmitted diseases
5. Chronic health conditions
6. Extreme weather events
7. Zoonotic and vector borne diseases
8. Toxic hazards
9. Indicators of bioterrorism
10. Other syndromes of public health importance

Changes to the List of Reportable Laboratory Findings

Candida auris

Laboratory reporting of *Candida auris* has been added. Recent healthcare-associated outbreaks in NY and NJ, and challenges related to identification and treatment have heightened concern about this emerging infection in Connecticut. Include samples from all sites for testing.

Hepatitis B

Laboratory reporting of hepatitis B results have been modified. Positive hepatitis B e antigen (HBeAg)

(Continued on page 4)

REPORTABLE DISEASES, EMERGENCY ILLNESSES and HEALTH CONDITIONS - 2018

PART A: REPORTABLE DISEASES

Physicians, and other professionals (see page 4 for list of persons) are required to report using the Reportable Disease Confidential Case Report form (PD-23), other disease specific form or authorized method. Reports should include the full name and address of the person reporting and attending physician, name of disease, illness or condition, and full name, address, date of birth, race, ethnicity, gender, and occupation of the patient. Forms can be found on the DPH website or by calling 860-509-7994. Mailed reports must be sent in envelopes marked "CONFIDENTIAL." Changes for 2018 are noted in **bold** and an asterisk (*).

Category 1 Diseases: Report immediately by telephone (860-509-7994) on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). On evenings, weekends, and holidays call 860-509-8000. These diseases must also be reported by mail within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone must be reported by mail within 12 hours of recognition or strong suspicion of disease.

Acquired Immunodeficiency Syndrome (1,2)
Acute flaccid myelitis
☎ Anthrax
Babesiosis
☎ Botulism
☎ Brucellosis
California group arbovirus infection
Campylobacteriosis
***Candida auris* ***
Carbon monoxide poisoning (3)
Chancroid
Chickenpox
Chickenpox-related death
Chikungunya
Chlamydia (*C. trachomatis*) (all sites)
☎ Cholera
Cryptosporidiosis
Cyclosporiasis
Dengue
☎ Diphtheria
Eastern equine encephalitis virus infection
Ehrlichia chaffeensis infection
Escherichia coli O157:H7 gastroenteritis
Gonorrhea
Group A Streptococcal disease, invasive (4)
Group B Streptococcal disease, invasive (4)
Haemophilus influenzae disease, invasive (4)
Hansen's disease (Leprosy)
Healthcare-associated Infections (5)
Hemolytic-uremic syndrome (6)
Hepatitis A
Hepatitis B:
- acute infection (2)
- HBsAg positive pregnant women

Hepatitis C:
- acute infection (2)
- positive rapid antibody test result

HIV-1 / HIV-2 infection in: (1)
- persons with active tuberculosis disease
- persons with a latent tuberculous infection (history or tuberculin skin test ≥5mm induration by Mantoux technique)
- persons of any age
- pregnant women

HPV: biopsy proven CIN 2, CIN 3 or AIS or their equivalent (1)
Influenza-associated death (7)
Influenza-associated hospitalization (7)
Legionellosis
Listeriosis
Lyme disease
Malaria
☎ Measles
☎ Melioidosis
☎ Meningococcal disease
Mercury poisoning
Mumps
Neonatal bacterial sepsis (8)
Neonatal herpes (≤ 60 days of age)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (9)

Pertussis
☎ Plague
Pneumococcal disease, invasive (4)
☎ Poliomyelitis
☎ Q fever
☎ Rabies
☎ Ricin poisoning
Rocky Mountain spotted fever
Rubella (including congenital)
Salmonellosis
☎ SARS-CoV
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
☎ Smallpox
St. Louis encephalitis virus infection
☎ Staphylococcal enterotoxin B pulmonary poisoning
☎ *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (1)
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (4,10)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (1)
Syphilis
Tetanus
Trichinosis
☎ Tuberculosis
☎ Tularemia
Typhoid fever
Vaccinia disease
☎ Venezuelan equine encephalitis virus infection
Vibrio infection (*parahaemolyticus, vulnificus*, other)
☎ Viral hemorrhagic fever
West Nile virus infection
☎ Yellow fever
Zika virus infection

FOOTNOTES:

1. Report only to State.
2. As described in the CDC case definition.
3. Includes persons being treated in hyperbaric chambers for suspected CO poisoning.
4. Invasive disease: from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous) bone, internal body sites, or other normally sterile site including muscle.
5. Report HAIs according to current CMS pay-for-reporting or pay-for-performance requirements. Detailed instructions on the types of HAIs, facility types and locations, and methods of reporting are available on the DPH website: http://portal.ct.gov/DPH/Infectious-Diseases/HAI/Healthcare-Associated-Infections-HAIs.
6. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the DPH Laboratory for antibody testing.
7. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza-Case Report Form in a manner specified by the DPH.
8. Clinical sepsis and blood or CSF isolate obtained from an infant ≤ 72 hours of age.
9. Individual cases of "significant unusual illness" are also reportable.
10. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.

How to report: The PD-23 is the general disease reporting form and should be used if other specialized forms are not available. The PD-23 can be found on the DPH website (http://www.portal.ct.gov/DPH/Communications/Forms/Forms). It can also be ordered by writing the Department of Public Health, 410 Capitol Ave., MS#11FDS, P.O. Box 340308, Hartford, CT 06134-0308 or by calling the Epidemiology and Emerging Infections Program (860-509-7994). Specialized reporting forms are available on the DPH website or by calling the following programs: Epidemiology and Emerging Infections Program (860-509-7994) - Hospitalized and Fatal Cases of Influenza, Healthcare Associated Infections (860-509-7995) - National Healthcare Safety Network, HIV/AIDS Surveillance (860-509-7900) - Adult HIV Confidential Case Report form, Immunizations Program (860-509-7929) - Chickenpox Case Report (Varicella) form, Occupational Health Surveillance Program (860-509-7740) - Physician's Report of Occupational Disease, Sexually Transmitted Disease Program (860-509-7920), and Tuberculosis Control Program (860-509-7722). National notifiable disease case definitions are found on the CDC website.

Telephone reports of Category 1 disease should be made to the local Director of Health for the town in which the patient resides, and to the Epidemiology and Emerging Infections Program (860-509-7994). Tuberculosis cases should be directly reported to the Tuberculosis Control Program (860-509-7722). For the name, address, or telephone number of the local Director of Health for a specific town contact the Office of Local Health Administration (860-509-7660).

For public health emergencies on evenings, weekends, and holidays call 860-509-8000.

REPORTABLE LABORATORY FINDINGS—2018

The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases. The Laboratory Report of Significant Findings form (OL-15C) can be found on the DPH website or by calling 860-509-7994. The OL-15C is a supplement to the physician report, and is used for verification of diagnosis. Pathogens on the OL-15C are listed in alphabetic order; however, there is a separate section for possible disease indicators of bioterrorism. Changes for 2018 are noted in **bold** and an asterisk (*).

Anaplasma phagocytophilum by PCR only
Babesia: ☐ IFA IgM (titer) _____ IgG (titer) _____
☐ Blood smear ☐ PCR ☐ Other _____
☐ *microti* ☐ *divergens* ☐ *duncani* ☐ Unspeciated
Bordetella pertussis (titer) _____
☐ Culture (1) ☐ Non-pertussis *Bordetella* (1) (specify) _____
☐ DFA ☐ PCR
Borrelia burgdorferi (2)
California group virus (3) spp _____
Campylobacter (3) spp _____ ☐ Culture ☐ PCR ☐ EIA
***Candida auris* (1,4) ***
Carbapenem-resistant *Acinetobacter baumannii* (CRAB) (1,5)
Carbapenem-resistant Enterobacteriaceae (CRE) (1,5)
Genus _____ spp _____
Carboxyhemoglobin ≥ 5% _____% COHb
Chikungunya virus
Chlamydia trachomatis (test type) _____
Clostridium difficile (6)
Corynebacterium diphtheria (1)
Cryptosporidium spp _____ ☐ Culture ☐ PCR ☐ EIA
☐ Microscopy ☐ Other:_____
Cyclospora spp _____ ☐ PCR ☐ Microscopy ☐ Other:_____
Dengue virus
Eastern equine encephalitis virus
Ehrlichia chaffeensis by PCR only
Escherichia coli O157 (1) ☐ Culture ☐ PCR
Giardia spp _____
Group A *Streptococcus*, invasive (1,5) ☐ Culture ☐ Other _____
Group B *Streptococcus*, invasive (5) ☐ Culture ☐ Other _____
Haemophilus ducreyi
Haemophilus influenzae, invasive (1,5) ☐ Culture ☐ Other _____
Hepatitis A virus (HAV) IgM anti-HAV (7) ALT___ AST ___ ☐ Not Done
Hepatitis B HBsAg ☐ Positive ☐ Negative (7) ☐ IgM anti-HBc
☐ HBeAg (2)* ☐ HBV DNA (2)*
anti-HBs (8) ☐ Positive (titer) _____ ☐ Negative
Hepatitis C virus (HCV) ☐Rapid antibody ☐RNA (9) ☐ Genotype (9)
Herpes simplex virus (infants ≤ 60 days of age) (specify type) _____
☐ Culture ☐ PCR ☐ IFA ☐ Ag detection
HIV Related Testing (report only to the State) (10)
☐ Detectable Screen (IA)
Antibody Confirmation (WB/IFA/Type-diff) (1,10)
HIV 1 ☐ Positive ☐Neg/Ind HIV 2 ☐Positive ☐ Neg/Ind
☐ HIV NAAT (or qualitative RNA) ☐ Detectable ☐ Not Detectable
☐ HIV Viral Load (all results) (10)
☐ HIV genotype (10)
☐ CD4 count: _____ cells/uL; _____% (10)
HPV (report only to the State) (11)
Biopsy proven ☐ CIN 2 ☐ CIN 3 ☐ AIS
or their equivalent (specify) _____
Influenza virus: ☐ Rapid antigen (2) ☐ RT-PCR ☐ Culture-confirmed
☐ Type A ☐ Type B ☐ Type Unknown
☐ Subtype _____
Lead poisoning (blood lead ≥10 µg/dL <48 hrs; 0-9 µg/dL monthly) (12)
☐ Finger stick level _____ µg/dL ☐ Venous level _____ µg/dL
Legionella pneumophila
☐ Culture ☐ DFA ☐ Ag positive
☐ Four-fold serologic change (titers) _____
Listeria monocytogenes (1) ☐ Culture ☐ PCR
Mercury poisoning
☐ Urine ≥ 35 µg/g creatinine _____ µg/g
☐ Blood ≥ 15 µg/L _____ µg/L
Mumps virus (13) (titer) _____ ☐ PCR
Mycobacterium leprae
Mycobacterium tuberculosis Related Testing (1)
AFB Smear ☐ Positive ☐ Negative
If positive ☐ Rare ☐ Few ☐ Numerous
NAAT ☐ Positive ☐ Negative ☐ Indeterminate
Culture ☐ *Mycobacterium tuberculosis*
☐ Non-TB mycobacterium. (specify *M.* _____)
Neisseria gonorrhoeae (test type) _____
Neisseria meningitidis, invasive (1,5)
☐ Culture ☐ Other _____
Neonatal bacterial sepsis (14) spp _____
Plasmodium (1,3) spp _____
Poliovirus
Rabies virus
Rickettsia rickettsii
Rubella virus (13) (titer) _____
Rubeola virus (Measles) (13) (titer) _____ ☐ PCR
St. Louis encephalitis virus
Salmonella (1,3) (serogroup & type) _____ ☐ Culture ☐ PCR
SARS-CoV (1) ☐ IgM/IgG
☐ PCR _____ (specimen) ☐ Other _____
Shiga toxin (1) ☐ Stx1 ☐ Stx2 ☐ Type Unknown
☐ PCR ☐ EIA
Shigella (1,3) (serogroup/spp) _____ ☐ Culture ☐ PCR
Staphylococcus aureus, invasive (5) ☐ Culture ☐ Other _____
☐ methicillin-resistant
☐ methicillin-sensitive
Staphylococcus aureus, vancomycin MIC ≥ 4 µg/mL (1)
MIC to vancomycin_____ µg/mL
Staphylococcus epidermidis, vancomycin MIC ≥ 32 µg/mL (1)
MIC to vancomycin _____ µg/mL
Streptococcus pneumoniae
☐ Culture (1,5) ☐ Urine antigen ☐ Other (5) _____
Treponema pallidum ☐ RPR (titer) _____ ☐ FTA ☐ EIA
☐ VDRL (titer) _____ ☐ TPPA
Trichinella
Varicella-zoster virus, acute
☐ Culture ☐ PCR ☐ DFA ☐ Other _____
Vibrio (1,3) spp _____ ☐ Culture ☐ PCR
West Nile virus
Yellow fever virus
Yersinia, not *pestis* (3) spp _____ __ ☐ Culture ☐ PCR
Zika virus

BIOTERRORISM possible disease indicators (15)

Bacillus anthracis (1)	*Brucella* spp (1)
Burkholderia mallei (1)	*Burkholderia pseudomallei* (1)
Clostridium botulinum	*Coxiella burnetii*
Francisella tularensis	Ricin
Staphylococcus aureus - enterotoxin B	Variola virus (1)
Venezuelan equine encephalitis virus	
Viral agents of hemorrhagic fevers	*Yersinia pestis* (1)

1. Send isolate, culture or slide to the DPH Laboratory for confirmation. For *Salmonella*, *Shigella*, and *Vibrio* tested by non-culture methods, send the isolate from reflex testing or if positive by CIDT and no isolate or culture results send stool specimen. For Shiga toxin-related disease, send positive broth or stool in transport media.
2. Only laboratories with electronic file reporting are required to report positive results.
3. Specify species/serogroup/serotype.
4. **Include samples from all sites. ***
5. Sterile site: defined as sterile fluids (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), or other normally sterile site including muscle. For CRE and CRAB, also include urine or sputum, but not stool; and for CRAB also include wounds.
6. Submit reports of all *C. difficile* positive stool samples according to DPH instructions.
7. Report the peak liver function tests (ALT, AST) conducted within one week of patient's HAV IgM positive test, if available. Check "Not Done" when appropriate.
8. Negative HBsAg and all anti-HBs results are reportable only for children ≤ 2 years old.
9. Report all RNA results. Genotypes and Negative RNA results only reportable by electronic file reporting.
10. Report all HIV antibody, antigen, viral load, and qualitative NAAT results. HIV genotype (DNA sequence) and all CD4 results are **only*** reportable by electronic file.
11. If adequate tissue is available, send fixed tissue from the specimen used to diagnose CIN 2, 3 or cervical AIS or their equivalent for HPV typing according to DPH instructions.
12. Report lead results ≥ 10 µg/dL within 48 hours to the Local Health Director and the DPH; submit ALL lead results at least monthly to the DPH only.
13. Report all IgM positive titers, but only IgG titers that are considered significant by the laboratory performing the test.
14. Report all bacterial isolates from blood or CSF from an infant ≤ 72 hours of age.
15. Report by telephone to the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.

and positive hepatitis B DNA (HBV DNA) results are reportable to the DPH for those laboratories with electronic file reporting only. These changes will align hepatitis B surveillance with the national hepatitis B case definition.

Carbapenemase-producing (CP)- Carbapenem-resisant Enterobacteriacea (CRE)

Laboratory reporting of CP-CRE has been modified. Laboratories should continue to submit clinical CRE isolates for further characterization at the State Public Health Laboratory. In addition, cabapenemase genes identified during screening/surveillance must be reported to the DPH for those laboratories with the capability (e.g. Cepheid GeneXpert) to detect CP -CRE locally.

Changes to Both Lists

Rotavirus

Reporting of rotavirus has been removed. Rotavirus incidence has declined significantly in recent years, most likely due to rotavirus vaccine use.

Persons Required to Report Reportable Diseases, Emergency Illnesses and Health Conditions

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease, emergency illness or health condition shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the Department of Public Health.
2. If the case or suspected case of reportable disease, emergency illness or health condition is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and Department of Public Health. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease, emergency illness or health condition is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable disease, emergency illness or health condition shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the Department of Public Health by:
   A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease, emergency illness or health condition;
   B. the person in charge of any camp;
   C. the master or any other person in charge of any vessel lying within the jurisdiction of the state;
   D. the master or any other person in charge of any aircraft landing within the jurisdiction of the state;
   E. the owner or person in charge of any establishment producing, handling, or processing dairy products, other food or non-alcoholic beverages for sale or distribution;
   F. morticians and funeral directors

Persons Required to Report Reportable Laboratory Findings

The director of a laboratory that receives a primary specimen or sample, which yields a reportable laboratory finding, shall be responsible for reporting such findings within 48 hours to the local director of health of the town in which the affected person normally resides. In the absence of such information, the reports should go to the town from which the specimen originated and to the Department of Public Health.

IMPORTANT NOTICE

Persons required to report must use the Reportable Disease Confidential Case Report Form PD-23 to report Reportable Diseases, Emergency Illnesses and Health Conditions on the current list unless there is a specialized reporting form or other authorized method available. The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases using the Laboratory Report of Significant Findings Form OL-15C or other approved format by the DPH. Reporting forms can be found on the DPH website (http://portal.ct.gov/DPH/Communications/Forms/Forms) or by calling 860-509-7994. Please follow these guidelines when submitting reports:

- Mailed documents must have "CONFIDENTIAL" marked on the envelope.
- All required information must be completed, including name, address, and phone number of person reporting and healthcare provider, infectious agent, test method, date of onset of illness, and name, address, date of birth, race, ethnicity, gender, and occupation of patient.
- Send one copy of completed report to the DPH via fax (860-509-7910), or mail to: Connecticut Department of Public Health, 410 Capitol Ave., MS#11FDS, P.O. Box 340308, Hartford, CT 06134-0308.
- Send one copy of the completed report to the Director of Health of the patient's town of residence.
- Keep a copy in the patient's medical record.

Raul Pino, MD, MPH
Commissioner of Public Health

Matthew L. Cartter, MD, MPH
State Epidemiologist

Lynn Sosa, MD
Deputy State Epidemiologist

Epidemiology and Emerging Infections	860-509-7995
Healthcare Associated Infections	860-509-7995
HIV & Viral Hepatitis	860-509-7900
Immunizations	860-509-7929
Sexually Transmitted Diseases (STD)	860-509-7920
Tuberculosis Control	860-509-7722

Connecticut Epidemiologist

Editor: Matthew L. Cartter, MD, MPH

Assistant Editor & Producer:
Starr-Hope Ertel