

Regulatory Analysis Form		This space for use by IRRC	
(1) Agency Pennsylvania Department of Health		2001 NOV 26 PM 12:50 REVIEW COMMISSION	
(2) I.D. Number (Governor's Office Use) DOH Regulation No. 10-156		IRRC Number: #2119	
(3) Short Title Communicable and Non-Communicable Diseases			
(4) 28 Pa. Code Ch. 27 28 Pa. Code Ch. 211		(5) Agency Contacts & Telephone Numbers Primary Contact: James T. Rankin, Jr., DVM, MPH, PhD State Epidemiologist 717-787-3350 Secondary Contact: Joel H. Hersh, MEd, MPA Director, Bureau of Epidemiology 717-783-4677	
(6) Type of Rulemaking (Check One)		(7) Is a 120-Day Emergency Certification Attached?	
<input type="checkbox"/>	Rulemaking	<input checked="" type="checkbox"/>	No
<input checked="" type="checkbox"/>	Final Order Adopting Regulation	<input type="checkbox"/>	Yes: By the Attorney General
<input type="checkbox"/>	Final Order, Rulemaking Omitted	<input type="checkbox"/>	Yes: By the Governor
(8) Briefly explain the regulation in clear and non-technical language.			
<p>The Department's amendments to 28 Pa. Code Ch. 27 (relating to communicable and non-communicable diseases) (Chapter 27) and 28 Pa. Code Ch. 211 (relating to program standards for long-term care nursing facilities) will update the existing system for disease prevention and control within the Commonwealth. Most of the current provisions of Chapter 27 were adopted in 1955. Since that time, changes in technology, society, and the environment have caused changes in disease prevention and control. Mumps, measles, pertussis, polio, German measles, and typhoid fever, once significant health threats, are of a reduced concern. Now, the possibility of quickly spreading pandemics arising far from the Commonwealth, is a very real threat to its citizens. Diseases caused by once obscure pathogens, for example, cryptosporidium, Escherichia coli O157:H7, and the hantavirus, all of which may be fatal, now cause multi-state outbreaks of communicable disease.</p> <p>Because of the need to protect the citizens of the Commonwealth in changing conditions, the Department has performed and completed a review of its regulations relating to disease control and prevention set out in Chapter 27. This review has taken several years, and has resulted in amendments to those regulations. The regulations are intended to ensure that the Department is able to address the vastly different disease prevention and control needs of changing and emerging diseases and conditions, and other public health priorities of the twenty-first century. In order to meet these needs, the Department is deleting from its regulations outdated clinical treatment references, superseded public health methods and practices, outdated scientific or technical information and references, and unnecessary diseases and conditions. The Department is adding state-of-the-art public health practices and methods, current scientific and technical references and information, and emerging and important reportable diseases and conditions. These amendments have been presented to and</p>			

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approved by the Advisory Health Board (Board) in accordance with the Disease Prevention and Control Law of 1955 (35 P.S. §§521.1, 521.16) (the Act).

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

The Department's overarching authority to promulgate these regulations is found in the Act. Section 16(a) of the Act (35 P.S. §521.16(a)), gives the Board the authority to issue rules and regulations on a variety of issues relating to communicable and non-communicable diseases, including the following: which diseases are to be reported; the methods of reporting diseases; the contents of reports and the health authorities to whom diseases are to be reported; what control measures are to be taken with respect to which diseases; provisions for the enforcement of control measures; requirements concerning immunization and vaccination of persons and animals; requirements for the prevention and control of disease in public and private schools; requirements for the treatment of venereal disease, including patient counseling; and any other matters the Board may deem advisable for the prevention and control of disease and for carrying out the provisions and purposes of the Act. Section 16(b) of the Act (35 P.S. §521.16(b)), gives the Secretary of Health the authority to review existing regulations and make recommendations to the Board for changes the Secretary considers to be desirable.

There is also legislative authority for specific provisions of the regulations in other statutes. The Administrative Code of 1929 (71 P.S. §51 *et seq.*) (Code), contains several pertinent provisions. First, section 2102(g) of the Code (71 P.S. §532(g)), provides general authority for the Department to promulgate its regulations.

Section 2106(a) of the Code (71 P.S. §536(a)), provides the Department with additional authority to declare diseases to be communicable, and to establish regulations for the prevention and control of disease. Section 2106(b) of the Code ((71 P.S. §536(b)), provides the Department with the authority to establish and enforce quarantines to prevent the spread of disease, and section 2106(c) of the Code (71 P.S. §536(c)), gives the Department the authority to administer and enforce the laws of the Commonwealth with respect to vaccination and other means of preventing the spread of communicable disease.

Section 2111(b) of the Code (71 P.S. §541(b)), provides the Board with additional authority to promulgate regulations deemed by the Board to be necessary for the prevention of disease, and for the protection of the lives and the health of the people of the Commonwealth. That section further provides that the regulations of the Board shall become the regulations of the Department.

Section 2111(c.1) of the Code (71 P.S. §541(c.1)), also provides the Board with the authority to make and revise a list of communicable diseases against which children are required to be immunized as a condition of attendance at any public, private, or parochial school, including kindergarten. The section requires the Secretary to promulgate the list, along with any rules and regulations necessary to insure the immunizations are timely, effective, and properly verified. The regulations that primarily carry out this responsibility are set forth in Subchapter C of Chapter 23 (relating to school health) (sections 23.81-23.87).

Other statutes speak to the Department's authority to promulgate regulations in relation to specific diseases, infections, or conditions. The Newborn Child Testing Act of 1992 (35 P.S. §§621-625), provides the Department with the authority to promulgate regulations listing reportable diseases and conditions in the newborn child, and setting out the operation of a program of screening, follow-up, assessment and diagnosis of newborn children for these reportable diseases and conditions. (35 P.S. §§621.23 and 621.25). The Pennsylvania Cancer Control, Prevention, and Research Act (35 P.S. §§5631-5637), authorizes the

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Department to create a cancer registry to which persons in charge of hospitals and laboratories must report cases of cancer in accordance with rules and regulations adopted by the Department with the advice of the Pennsylvania Cancer control, Prevention and Research Advisory Board. (35 P.S. §5636(b)). This legislation has been impacted by federal legislation which was enacted in 1992, and which requires complete reporting of cancer cases to be made by all health care practitioners, and all hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer. (42 U.S.C. §280e, and §§e-1 – 2803-4). Finally, what is known as the “Turtle Law” (35 P.S. §§1071-1077), provides the Department with the authority to prohibit a person from bringing, causing to be brought, or transporting any live turtle into the Commonwealth, unless the turtle or lot of turtles is accompanied by a permit issued by the Department or another agency authorized by the Department to issue a permit. The permit may only be issued if there is adequate biological proof that the turtles are free from salmonella. The same permit is required when the turtles originate within the Commonwealth.

Several statutes provide the Department with authority to command disease prevention and control measures within certain institutions. Section 803 of the Health Care Facilities Act (35 P.S. §448.803), provides the Department with the authority to promulgate regulations relating to the licensure of health care facilities, and allows the Department to require certain actions relating to disease control and prevention to occur within health care facilities. Articles IX and X of the Public Welfare Code (62 P.S. §§901-1059), which provide the Department with the authority to license inpatient drug and alcohol abuse treatment facilities, play the same role with respect to the Department’s ability to require certain disease prevention and control methods in those facilities.

The Public School Code of 1949 (24 P.S. §1-101 *et seq.*), provides the Department with additional authority for disease prevention and control actions taken within schools. Section 1421(c)(2) of the Public School Code of 1949 (24 P.S. §14-1421(c)(2)), provides the Secretary of Health, in consultation with the Secretary of Education, with the authority to promulgate rules and regulations implementing the school health program. The requirements of the school health program are set out in Article XIV of the Public School Code, and provide, among other things, that pupils are released from compulsory attendance when they are prevented from attending by the health laws of the Commonwealth (24 P.S. §14-1417), that no persons having any form of tuberculosis in a transmissible stage shall be a pupil, teacher, janitor, or any other employee in a school, unless it is a special school. (24 P.S. §14-1418). Section 1303a of the Public School Code (24 P.S. §1303a), provides that the Advisory Health Board will make and review a list of diseases against which children must be immunized, as the Secretary of Health may direct, before being admitted to school for the first time. The section provides that the school directors, superintendents, principals, or other persons in charge of any public, private, parochial, or other school including kindergarten, must ascertain whether the immunization has occurred, and certificates of immunization will be issued in accordance with rules and regulations promulgated by the Secretary with the sanction and advice of the Board. Again, most of the regulations carrying out these responsibilities are set forth in Chapter 23.

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

These final regulations are not mandated by any federal or state law, court order or federal regulation. A change in the section of the current regulations pertaining to cancer reporting is necessary to comply with the Cancer Registries Amendments Act of 1992, 42 U.S.C. §280e-1 through 280e-4. Although under the current regulations health care practitioners are not required to report, the 1992 law requires complete reporting of all

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cancer cases by all health care practitioners and all hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer. 42 U.S.C. §280e(c)(2)(D)(i) and (ii). Further, revisions to the lead poisoning reporting sections are necessary to comply with the Centers for Disease Control and Prevention (CDC) guidelines lowering reportable lead levels from the current levels included in the regulations. The Department is mandated to prevent and control the spread of disease by the Disease Prevention and Control Law, 35 P.S. §521.1, et seq. and those other related laws listed in Section 8 above.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

These final regulations are intended to address the problem of the changing landscape of infectious disease by amending current regulation to account for changes in communicable and non-communicable diseases and conditions. These changes are intended to address the changes in society, technology, and the environment which call for rapid responses to serious and rapidly spreading diseases. Dramatic changes in society, technology, and the environment, together with the diminished effectiveness of certain disease control methods have propelled the world, and, with it, the Commonwealth of Pennsylvania, into an era of increased risk. The spectrum of communicable diseases is expanding, and many diseases, for example, tuberculosis, thought to be successfully contained, are again on the rise. The ease, cost, and quickness of worldwide travel has significantly increased the risk of rapid spread of disease. Further, antimicrobial drugs have become less effective against many infectious agents, to the degree that experts in infectious disease are concerned about a "post-antibiotic era." To attempt to counteract these problems, the Department and the Board are amending Chapters 27 and 211.

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

Infectious diseases remain the leading cause of death worldwide. The Department is the State agency with the responsibility for controlling and preventing the spread of these infectious diseases. The regulations provide the Department with the appropriate tools to identify communicable diseases and conditions posing an increased or unacceptable health risk to the citizens of the Commonwealth, and to impose appropriate disease prevention and control programs and intervention strategies aimed at reducing or removing increased health threats. Health threats attributable to the reportable diseases and conditions not only affect those persons living within the borders of the Commonwealth, but can easily spread across state lines if they are not identified and controlled.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

All citizens of the Commonwealth will benefit from the Department's increased ability to respond to and identify diseases and conditions which pose significant threats to their health, safety, and welfare. This benefit extends beyond the boundaries of the Commonwealth to citizens of other states, since, with the increased ease and rapidity of travel, the spread of disease occurs much more quickly and much easier than in the past.

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

Persons ordered by the Department to undergo some type of quarantine, isolation, segregation, or treatment may consider themselves adversely affected by the regulations, although the Act itself permits for these

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actions to be taken when the health, safety, and welfare of the citizens of the Commonwealth require them. Further, workers who are prohibited from returning to work with an infectious disease and their employers may consider themselves adversely affected; however, the citizens of the Commonwealth who are not exposed to that disease because of the Department's regulations are benefited by the requirements. In the same way, children in a childhood group setting, students, and teachers who are prevented from returning to that school or setting until the requirements of the regulations are met may also consider themselves to be adversely affected. Businesses which are involved in the Department's investigation of outbreaks may consider themselves to be adversely affected. Persons who own or are attempting to import into the State animals or animal products which are suspected of having, or which have a reportable disease or condition may consider themselves to be adversely affected. It must be remembered, however, that the Department's actions in these situations are taken solely to prevent the spread of disease to other Commonwealth citizens.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

In general, members of the Commonwealth who have or are suspected of having a reportable disease, infection or condition are required to comply with the regulations. Household contacts of persons with certain enumerated reportable diseases, infections or conditions, for example, typhoid or paratyphoid fever, are required to comply with these regulations. Employers of persons with certain enumerated reportable diseases, infections or conditions, for example, shigellosis, are required to comply with the regulations. Health care facilities, health care practitioners, clinical laboratories, veterinarians, institutions maintaining dormitories and living rooms, schools, and child care group settings are required to comply with the regulations. Persons owning or attempting to import animals or animal products which have, or are suspected of having, a reportable disease or condition must comply with the regulations. Local health authorities are required to comply with the regulations.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The Department reviewed Chapter 27 internally over at least a ten-year period, and developed the regulations internally as well. The Department empanelled a stakeholder group, which was made up of representatives from hospitals, laboratories, and physicians, to review and advise on these regulations.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures that may be required.

There should be no additional costs to the regulated community, since the regulations are merely an update of the existing reporting system. Savings to the regulated community cannot be accurately quantified, although the Department believes that there will be savings based upon a decrease in serious illnesses which would affect both businesses and individuals. Decrease in serious illnesses will result from the application of Nationally accepted state-of-the-art public health practices and communicable disease prevention and control strategies within Pennsylvania contained within these regulations.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures that may be required.

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There should be no additional costs to local governments, since the regulations are merely an update of the existing reporting system. Savings to local governments cannot be accurately quantified, although the Department believes that there will be savings based upon a decrease in serious illnesses. The decrease in serious illnesses will result from the application of Nationally accepted state-of-the-art public health practices and communicable disease prevention and control strategies within Pennsylvania contained within the final regulations.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulations, including legal and accounting or consulting procedures that may be required.

The Commonwealth will benefit in a manner directly proportional to the numbers and types of disease cases and disease outbreaks prevented by the adoption of the nationally accepted state-of-the-art public health practices and communicable disease prevention and control strategies contained in the final regulations. Arguably, reduction in disease will reduce state health care costs.

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government and state government for the current year and five subsequent years.

	CFY Yr	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS **						
Regulated Community						
Local Government						
State Government						
TOTAL SAVINGS						
COSTS ***						
Regulated Community						
Local Government						
State Government						
TOTAL COSTS						
REVENUE LOSSES: ****						
Regulated Community						
Local Government						

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State Government						
Total Revenue Losses						

** Savings cannot be accurately quantified, although the Department believes that there will be savings based upon a decrease in serious illnesses. The decrease in serious illnesses will result from the application of nationally accepted state-of-the-art public health practices and communicable disease prevention and control strategies within Pennsylvania contained in the regulations.

*** No additional disease prevention and control costs are expected, as the reporting system is already in place, and the regulations merely amend the current regulations to bring procedures up to date, to add and delete obsolete diseases and procedures, and to add new diseases.

**** No additional revenue losses are expected.

(20a) Explain how the cost estimates listed were derived.

An exact estimate cannot be calculated because savings estimates would have to be based on an assumption that prevention reduces health care costs due to a commensurate reduction in illnesses. The Department believes that if the numbers of cases of current and emerging reportable diseases were to be compared to the continually increasing per capita health care costs within the Commonwealth, some savings could be expected. No estimate can be made to quantify the costs associated with disease morbidity, mortality, human suffering, and work-time lost when disease prevention and control is unsuccessful, or is not undertaken quickly.

(20b) Provide the past three-year expenditure history for programs affected by the regulation.

	1997-98	1998-99	1999-2000	2000-01
Program	FY - 3	FY - 2	FY - 1	Current FY
Bureau of Epidemiology	\$2,759,000	\$2,702,200	\$4,153,829	\$4,189,700
Bureau of Communicable Diseases	\$49,860,500	\$43,035,500	\$41,799,921	\$40,371,400
Bureau of Family Health	\$226,626,283	\$233,644,841	\$233,882,024	\$237,197,100

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

The regulations will create health care savings while costing little to implement, since the disease reporting system is already in place, few new diseases have been added, and the final regulations have eliminated unnecessary and outdated practices and procedures and diseases. If and when electronic reporting is required of reporters, the Department will provide the electronic application, and will still allow reports over the telephone.

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(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

No nonregulatory alternatives were considered, as the Act and the other statutes listed in Section 8, require that regulations be used to set out reportable diseases and conditions, and the procedures and practices used in handling those diseases and conditions. See 35 P.S. §521.16, and the other citations listed in Section 8. The Department is updating those existing regulations with the approval of the Board, and may only do so through regulation.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No alternative regulatory schemes were considered.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No, there are no provisions that are more stringent than federal standards.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

These regulations will bring Pennsylvania in line with other states and the policies and procedures espoused by National public health organizations, including the disease prevention and control strategies recommended by the CDC.

(26) Will the regulation affect existing or regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The final regulations do not effect existing or proposed regulations of the promulgating agency or any other state agency. The Department has considered the Department of Public Welfare's regulations relating to day care (See 55 Pa. Code Chs. 3270-3290), and changed its definition of "child" to accord with revisions to those regulations. The regulations do take into account the 1992 amendment to the Newborn Child Testing Act, 35 P.S. §621.1 *et seq.*, which added two metabolic conditions to the list of conditions for which the Department's Newborn Screening Program tests newborn children. These two conditions have been added to the list of diseases and conditions made reportable to the Department for the sake of consistency. The final regulations also reference the Dog Law, 3 P.S. §§459-101 through 459-1205, and specifically state that law takes precedence. See §27.162. The final regulations also reference the Food Employee Certification Act, 3 Pa. C.S. §§6501-6510, and the regulations promulgated thereunder at 7 Pa. Code §§78-41 – 78.43 (relating to health and disease control of employees.)

(27) Will any public hearings or information meetings be scheduled? Please provide the dates, times, and locations, if available.

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The Department has no public hearings or information meetings scheduled. A meeting of the Board was held on April 21, 1998, to discuss the regulations; notice of that meeting was published in the Pennsylvania Bulletin, and the meeting was open to the public. A public comment period of 30 days was included in the proposed regulations. The Board met again on _____ to review the final regulations; that meeting was a meeting open to the public.

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports that will be required as a result of implementation, if available.

The amendments to Chapter 27 are essentially a "fine-tuning" of an already existing disease reporting system. Newly listed reportable diseases will be reported and investigated in a manner similar to that of the diseases currently listed, using national case-definitions and investigation forms provided by the CDC. The Department also encourages electronic reporting by laboratories, although it has not yet required that reports be made electronically. The Department will require electronic reporting of reporters as its electronic disease surveillance system, based on the National electronic disease surveillance system (NEDSS) is implemented. That system is being phased in at this time. The Department will give reporters 6 months notice of the need to report electronically, and will provide the application by which reporting is to be done to reporters. The Department will also continue to accept reports by telephone from reporters who lack the means with which to report electronically.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

There are no special provisions included in the regulations. Given the nature of disease prevention, the regulations must be applicable to the entire Commonwealth.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The regulations will be final upon publication in the Pennsylvania Bulletin, with the exception of the provision relating to reporting of varicella by health care practitioners and health care facilities. That provision is effective 3 years after final publication of the regulations.

(31) Provide the schedule for continual review of the regulation.

The Department will review the final regulations and update them as necessary.

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WITH THE LEGISLATIVE REFERENCE BUREAU

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#2119

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REVIEW SUBMISSION

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<p>Copy below is hereby approved as to form and legality. Attorney General.</p> <p>BY _____ DEPUTY ATTORNEY GENERAL</p> <p>_____ DATE OF APPROVAL</p> <p>9 Check if applicable. Copy not approved. Objections attached.</p>	<p>Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:</p> <p><u>DEPARTMENT OF HEALTH</u> (AGENCY)</p> <p>DOCUMENT/FISCAL NOTE NO. <u>10-156</u></p> <p>DATE OF ADOPTION: _____</p> <p><i>Robert S. Zimmerman Jr.</i> BY <u>ROBERT S. ZIMMERMAN JR.</u></p> <p>TITLE <u>SECRETARY OF HEALTH</u></p>	<p>Copy below is hereby approved as to form and legality. Executive or independent Agencies.</p> <p>BY <i>Howard B. Gule</i> _____</p> <p><u>November 13 2001</u> DATE OF APPROVAL</p> <p>(Deputy General Counsel) (Chief Counsel, Independent Agency) (Strike inapplicable title)</p> <p>9 Check if applicable. No Attorney General approval or objection within 30 days after submission.</p>
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NOTICE OF FINAL RULEMAKING

TITLE 28. HEALTH AND SAFETY

DEPARTMENT OF HEALTH

[28 PA. CODE CH. 27]

COMMUNICABLE AND NONCOMMUNICABLE DISEASES

[28 PA. CODE CH. 211]

PROGRAM STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

The Department of Health (Department) and the State Advisory Health Board (Board) hereby adopt amendments to 28 Pa. Code Chapters 27 and 211 (relating to communicable and noncommunicable diseases; and program standards for long-term care nursing facilities) to read as set forth in Annex A.

A. PURPOSE AND BACKGROUND

The Department's regulations relating to communicable and noncommunicable diseases in Chapter 27 were first promulgated in 1959. Since that time, there have been dramatic changes in society, technology, and the environment that make revision of these regulations a necessity. Where once outbreaks of disease could be held within geographical boundaries, today, the speed of air travel and the global economy are fostering the worldwide spread of life-threatening pathogens. Persons infected in one place can be on the other side of the world by the time symptoms appear. New infectious agents are emerging which require new prevention and control techniques. New conditions are becoming recognized which benefit from early detection and treatment. Disease outbreaks continue to occur, antibiotic resistance of some diseases is spreading, and previously controlled agents are in resurgence. Although more exotic diseases like Group A streptococcus (flesh eating bacteria), the hantavirus, and the ebola virus receive most of the attention from the media, other infectious diseases continue to pose public health problems. For example, within the past several years there have been outbreaks of cryptosporidiosis, E. coli 0157:H7, Salmonella enteritidis, hepatitis A, and shigellosis. There are strains of multi-drug resistant tuberculosis, which reduces the ability to treat the disease, and in recent years there have been reports from Japan of evidence of resistance

of *Staphylococcus aureus* to the drug, Vancomycin, long considered the last line of defense.

The Commonwealth of Pennsylvania is not immune from these public health threats. A few examples of threats to the public health within the Commonwealth over the past few years include a 1996-1997 outbreak of cyclospora caused by Guatemalan raspberries, ongoing *Salmonella enteritidis* outbreaks caused by, among other things, infected eggs; rabies outbreaks from 1991 to the present; a shigellosis outbreak in 1996 that spread from Ohio to Pennsylvania; multi-drug resistance to tuberculosis; and the ongoing epidemic of Lyme disease. More recently, concerns relating to the possibility of bioterrorism and the Commonwealth's response have arisen. The Department has chosen to revise the regulations to ensure that the disease control and prevention needs of changing diseases and conditions, and current health care priorities are adequately addressed.

The Department, with the approval of the Board, published proposed rulemaking in the *Pennsylvania Bulletin* on May 27, 2000, and provided a 30-day public comment period. (See 30 Pa. B. 2715 (Part II) (May 27, 2000)). One commentator raised an issue regarding the telephone number for contacting the Department listed in the proposed regulations. The number did not work, and the commentator requested that the public comment period be extended for 1 week. The Department chose not to extend the comment period since the commentator did manage to contact the Department by telephone and provide written comments, and an accurate address for the submission of comments was included in the regulation.

The Department received many comments to the substance of the proposed rulemaking as well. The comments and the Department's responses to them appear in the summary of this final rulemaking.

If a section is not mentioned in the summary, no comments were received on that section, and it was adopted as proposed.

B. SUMMARY

**CHAPTER 27. COMMUNICABLE AND NONCOMMUNICABLE DISEASES
SUBCHAPTER A. GENERAL PROVISIONS**

General Comments

Several of the general comments that the Department received involved the manner in which the Department requires reporting to be done.

Comment

These reporting requirements would require a separate system that would duplicate, and be less comprehensive and less current as a health promotion tool than the existing reporting system in place for child care centers and group homes regulated by the Department of Public Welfare (DPW), using a child health assessment form, no. CY51. This form uses a nationally recommended routine preventive health services schedule, including vision, hearing, anemia, growth and lead, health history and physical examination findings as well as documentation of vaccinations. This form should not be

duplicated or supplanted by any form or reporting requirements developed by the Department. Doing so would lessen the effectiveness of the more comprehensive system in place in DPW licensed facilities.

Response

The Department has not changed the proposed regulations in response to this comment. The Department is the State agency responsible for disease control and prevention throughout the Commonwealth, and has the authority to require reporting of those diseases, infections and conditions that it, with the review and approval of the Board, determines should be reported to the Department to carry out this responsibility. See generally, the Disease Prevention and Control Law of 1955 (act) (35 P.S. §§521.1-521.21.) DPW, as the licensing agency for certain facilities, has certain statutory responsibilities, which differ from those of the Department. The information the two agencies gather is different. The Department does not require reporting of vision, hearing, anemia and growth data through its communicable and noncommunicable disease regulations, nor of complete health histories or physical examinations, since the Department is not responsible as part of its disease prevention and control function for the healthy growth and development of each individual within a licensed facility. The Department is responsible for the health and welfare of all the citizens of the Commonwealth. The list of reportable diseases, infections and conditions that the Department determines should be reported, the information included in those reports, and the manner in which the reporting is to be done, are driven by this broader role.

Comment

The reporting requirements are burdensome, since a reporter is first required to determine the appropriate local agency for a patient's residence, or which agency is able to intervene. Then when reporting is made to the Department, the point of submittal differs by the disease being reported. The Department should review the process and explain why this system is necessary.

Response

The Department made some changes to the regulations based on these comments.

The Department will not require, at this point, that all reports be made electronically, and to one location within the Department, given the cost and technological issues involved.

The Department has added language to the regulations stating its intent to phase in electronic reporting for all reporters as it implements components of the National Electronic Disease Surveillance System (NEDSS). See §27.4(b) (relating to reporting cases). At the time this occurs, reports will be made to one location within the Department, or to the appropriate LMRO.

The Department intends to begin piloting its modifications to NEDSS in several of its health districts in the fall of 2001. As the Department becomes ready to implement its electronic system for the reporting of various diseases, the Department will notify in writing all reporters who are licensed in the Commonwealth (for example, hospitals, physicians, nurses, day care centers, drug and alcohol abuse treatment facilities), and will

also publish notice of this requirement in the *Pennsylvania Bulletin*. Notice will be given at least 6 months in advance of the date on which electronic reporting is to occur.

The Department is providing reporters with the electronic application to be used to make reporting electronically easier and less costly. Further, reporters who may not have access to the web may still make initial reports of cases by telephone. When this occurs, the Department explains to the reporter how the complete report should be made. This will continue to occur. See §27.4(c).

Paper reports of the listed diseases, infections and conditions will continue to be made by reporters, including laboratories, to one of the local morbidity reporting offices (LMROs), which will consist of the Department's 6 district offices and the 10 county and municipal health departments (local health departments), until the Department notifies reporters that reports must be made electronically.

The Department is currently encouraging electronic reporting by laboratories, because having laboratories report electronically is quicker than paper reporting and makes it easier for the Bureau of Epidemiology to review and disseminate important information to the various Departmental public health programs (the Department's TB program for example), the district offices, and the local health departments that utilize that information for case management and other services. The Department is aware that large National and regional laboratories performing testing for many states find it burdensome to sort Commonwealth reports for transmission to different locations within the

Commonwealth. If electronic reporting is done by laboratories, however, the Department is requiring that those electronic reports be made to a single location in the Department.

The Department requires laboratories to report directly to it rather than to the LMROs because many of the laboratory's reports could be reports of repeat testing. Patients may also visit more than one provider and be tested multiple times. The laboratory has no way of knowing whether a test is the initial test a provider orders on a patient or a repeat test, or a repeat test ordered by a second provider. The Department, in the Bureau of Epidemiology, is able, with software it possesses, to electronically match information in those reports with information from reports it already received and placed in its Statewide reporting databases. The Department can then identify multiple reports on the same individual and consolidate unduplicated useful information in one case record. Local health departments and the Department's district offices do not have this capability at the present time.

The Department is requiring all reports other than electronic laboratory reports to be made to LMROs for several reasons. In order for local health departments and the Department to provide follow-up services and information, the local health department or district office should have a relationship with the practitioner-reporter. This required contact by the reporter will enable the reporter to begin that relationship. From the standpoint of efficiency, the requirement will provide the information to enable and expedite case tracking and other services directly to the local health departments and

Department staff that do the actual case investigation, follow-up, counseling, referral and partner notification.

Further, to require that all paper reports go to one office within the Department would be burdensome for that office, and would take too long to sort and redirect. Certain reports are time sensitive, for example, reports of diseases of the newborn. A child with MSUD must be identified and treatment begun within 7 days of birth or serious impairment to or death of the child will occur. For this reason, the regulation requires those reports to be sent directly to the specific office within the Department with responsibility for managing that disease, infection or condition.

With respect to issues involving the requirement of multiple reporters, the Department requires reporting from all different types of reporters, including practitioners, facilities, laboratories, other providers and the public for several reasons. The Department does not want possible reporters to self-censor, based on their assumption that another person will make the report. That could lead to under-reporting, and jeopardize the ability of the public health system to positively impact the health of infected individuals and their contacts. If the Department and local health departments are unaware of cases, they will be unable to offer or provide follow-up, including counseling and referral information, and perform case investigation.

The Department also receives different information from different reporters. For example, a report by a laboratory is a confirmatory report of a disease or condition

diagnosed by a health care practitioner. From heads of institutions the Department will receive information that is neither a diagnosis nor a confirmed report, but a suspicion that may help to identify a disease outbreak. The monitoring of the disease in the patient is dependent on receiving information from a practitioner as well as a laboratory, as is the monitoring of the disease in the population as a whole. Information relating to opportunistic infections, referrals, mode of transmission and treatment are not shared by a practitioner with the laboratory, and, therefore, the Department would not be able to obtain this type of specific information from laboratories if laboratories alone were to report. A provider would not release this type of information to a laboratory because of its confidential nature. A laboratory does not need to be aware of the mode of transmission of a disease or types of referrals made for the individual to perform its licensed function – conducting laboratory tests of specimens.

The more specific the information received by the Department from all reporters, the more likely it is that the Department will be able to match information obtained from other sources, sometimes incomplete, and obtain complete information on each reported case. The more complete the demographic picture of the individual whose results are being reported, the easier it is for the Department to track the disease in the Commonwealth for purposes of implementing prevention measures, including targeting funding to affected populations. Further, the more complete the information on a specific individual the Department obtains, the easier it becomes for the Department and local health departments to provide follow-up services to that individual. For example, with a case of infectious tuberculosis, the Department will provide treatment, including directly

observed therapy, to ensure that the case is cured, and will also locate and test and treat contacts as necessary. In the case of sexually transmitted diseases, the Department and local departments locate and offer counseling and testing services to partners of individuals who test positive.

Section 27.1. Definitions.

This section explains the terms used in Chapter 27.

The Department has revised the proposed definition of “local morbidity reporting office (LMRO)” to match the language proposed for this term in 31 Pa. B. 2126 (April 21, 2001). The Department believes that the offices receiving reports should be limited to those local health authorities with the greatest experience in this area. These include only the Department’s 6 district offices and the 10 local health departments.

Comment

There are many different definitions of the term “child” used in the Commonwealth. The Department should explain why it has defined “child” as a person 15 years of age or younger.

Response

The Department took its definition of “child” from the definition of “child” used by the Department of Public Welfare (DPW) in its definition relating to day care (see 55 Pa. Code Chs. 3270-3290). The Department has since been informed by DPW that DPW’s

definition of “child” may change during the revision of DPW’s regulations on these topics. The Department has, therefore, reviewed its definition, and has determined that it would be more appropriate in the context of these regulations to define a child as a person under the age of 18 years. Where the regulatory context requires a different age limit, for example, in the area of newborn screening, the language of the regulation reflects that fact.

Comment

The definition of “child care group setting” properly encompasses all types of group care in the Commonwealth, since group care among young children increases their exposure to and risk of contracting a communicable disease. By defining this term broadly, the Department has appropriately addressed that risk. However, the definition should be adjusted to account for the practical limitations of checking vaccination status in settings where group care is transient and infrequent, for example, in day care provided during church services, court proceedings, in shopping malls and other temporary settings. The Department should modify the regulations to apply where 4 or more children unrelated to the operator receive care for 10 or more hours in any week, or for 40 or more hours in any month.

Response

The Department has not changed the definition. It was not the Department’s intention to capture all the types of care settings discussed by the commentator through its regulations relating to immunization in child care group settings. The Department has included in

§27.77 (relating to immunization requirements for children in child care group settings) a provision which states that a caregiver who does not serve as a caregiver for at least 40 hours in at least 1 month is not covered by the regulation. (See §27.77(d)(iii)).

Comment

The definition of “communicable disease” is broad. Does this mean that if a disease is not listed in the regulations, it will not be regulated? Can a facility determine its own procedures for control of a non-listed disease?

Response

The definition of “communicable disease” is intended to be broad; the definition is taken from the act, which defines the term broadly. The Department has revised the definition to clarify it, and to make it clear that it is not the act of transmission that makes the disease communicable, but that fact that it is capable of being transmitted to a susceptible host.

If the disease is not listed in the regulations as a reportable disease (defined by the act as any communicable disease made reportable by regulation), it still comes under the act and regulation if there is an outbreak of that disease. A nonlisted disease becomes reportable if an outbreak of that disease occurs. “Outbreak” is defined as “any unusual increase in the number of cases of a disease, infection, or condition, whether reportable or not as a single case, above the number of cases that a person required to report would expect to see in a particular geographic area or among a subset of persons (defined by a

specific demographic or other features).” (Emphasis added) (see §27.1 (relating to definitions)).

With respect to the question concerning control procedures for a nonlisted disease, if there is not an outbreak of the nonlisted disease, the Department will most likely not be involved in the matter (unless requested to do so by the facility). If an outbreak is reported, the Department will be involved in the investigation, and will provide recommendations regarding disease control and prevention.

Comment

The definition of “health care facility” is not clear. It contains a provision excluding an office used primarily for the private practice of a health care provider where no clinically related health care service is offered. The Department should add a definition of “clinically related health care service” to clarify the definition.

Response

The Department’s intention was to use the definition of “health care facility” from the Health Care Facilities Act (35 P.S. §§ 448.101-448.904b). It has revised the definition to reflect the definition applicable to chapter 8 of that statute (35 P.S. §§448.801-448.821) (relating to licensure of health care facilities). The phrase, “clinically related health care services,” was in the definition of “health care facility” used in the certificate of need provisions in chapter 7 of that statute, which sunset in December of 1996. The Department has deleted that phrase from the definition in this section, and has revised the

definition to reflect the language in chapter 8 of the Health Care Facilities Act. The Department has expanded that definition to include drug and alcohol abuse treatment facilities as health care facilities for the purposes of these regulations. The client population in drug and alcohol abuse treatment facilities is particularly susceptible to certain communicable diseases, for example, tuberculosis. The need to control the spread of disease in this population is acute.

Comment

The definition of “local health authority” does not include a sanitary board. Unless sanitary boards fall under some other definition, they should be included here.

Response

The Department agrees, and has added language to the definition of “local health authority” to include sanitary boards.

Comment

The Department should add language to the definition of “local health department” stating that the Department will revise the list when a local health department is closed, as well as when one is established. This language should then be moved to §27.4 (relating to reporting cases), since the provision is a substantive one.

Response

The Department agrees that its list of local health departments should be revised when

local health departments are closed, as well as when they are established. The Department is removing the language from the regulation altogether, however, as the Department's intention to maintain this list need not be included in the regulations. The Department will maintain a list of local health departments and will update the list when any change occurs.

Comment

The definitions of "modified quarantine," "segregation" and "surveillance of contacts" appear in two places in the regulations. They are repeated on pages 2730 and 2731 of the *Pennsylvania Bulletin*.

Response

The definitions of these terms were not repeated. They were bracketed on page 2730 to identify language that the Department was proposing to remove from the definition of "quarantine," which had included definitions for all three terms. The Department has revised the definition of "quarantine" to remove definitions for "segregation," "modified quarantine" and "surveillance." The Department has separately defined "segregation" and "modified quarantine," and has added a definition for "surveillance of disease."

These changes are made because of the importance of each term in performing disease control.

Comment

The term "surveillance" has two different meanings. One meaning appears in the context

of surveillance of disease, the other in the context of surveillance of contacts. The Department should change the term “surveillance of contacts” to “monitoring of contacts” to take these differences into account.

Response

The Department agrees and has amended this section accordingly.

Comments

The definition of “health care practitioner” as written will include first responders, emergency medical technicians, prehospital registered nurses and paramedics. The training provided to these individuals will not necessarily prepare them to diagnose the diseases listed in the regulations. There will need to be a revision to training requirements to allow them to do this. Since patients are taken to hospitals, staff in emergency rooms will handle this reporting more appropriately. The Department should exempt persons identified in the EMS Act from being required to report, or should provide immunity from the reporting requirements.

What does the Department expect in reports from laymen? Can reports be based on symptoms and suspicions, rather than identification?

Response

Neither the act nor the regulations condition reporting solely based on diagnosis of disease. It is not the Department’s intention to require laymen, or health care

practitioners who are not trained or permitted by the scope of their practice, to make diagnoses. The act requires that knowledge or suspicion of a disease be reported. See 35 P.S. §521.4 (relating to reports). If a first responder, emergency medical technician, prehospital registered nurse or paramedic has reason to believe, through symptoms or for other reasons, that an individual has a reportable disease or condition, those individuals are required to report. A report from a layperson could include that person's observations of the physical state of the individual, or could be a relating of the person's concerns that the individual is exhibiting something unusual that should be reported to the Department. The Department will then ask the layperson questions designed to elicit information which will allow the Department to make a determination of what further action is necessary, if any.

As previously discussed, the Department intentionally drafted these regulations to require reporting from as many types of individuals as possible, even when reporting could be duplicative.

Comment

Does a certified nurse's aide (CNA) have to report communicable diseases?

Response

A certified nurse's aide is required to report the listed diseases, infections, and conditions to the same extent that any member of the public is required to report.

Comment

The Department should define the terms “pupil,” “school,” “school employee” and “child care provider.”

Response

The Department has replaced the term “pupil” with the term “child” or “children” throughout Chapter 27. Child is defined in the regulations. The Department has been unable to locate the terms “school employee” or “child care provider” in the regulations. The Department has not defined the term “school” since this is a term used throughout the Public School Code of 1949 (24 P.S. §§1-101 – 26-2606-B), and the regulations promulgated under that statute by both the Department (see, e.g., 28 Pa. Code ch. 83 (relating to school health)) and the Department of Education. (See, e.g., 22 Pa. Code (relating to education)).

Comment

The Department should simplify the definition of “outbreak.” An outbreak should be defined as the excess of the expected incidence of disease within a particular geographic area or population in a specified time period. This definition comes from the Epidemiological Handbook published by the Association of Professionals in Infection Control and Epidemiology (APIC).

Response

The Department disagrees with this comment. The definition of “outbreak” used by the

Department in its regulations is the definition of the American Public Health Association (APHA) and is a more universally accepted definition for this term. The Department has not changed the definition.

Comment

The definitions of “communicable disease,” “isolation,” “local health officer,” “quarantine” and “reportable disease” differ from the definitions of these terms included in the act. The Department must explain why these definitions have been changed.

Response

The Department has not changed its regulation in response to this comment. Since the statute was enacted in 1955, the meanings of these terms have been refined by public health practice. The Department has updated the language used in the statute, to clarify the meaning of these terms, but has not substantively changed them.

Comments

The definition of the term “isolation” should be clarified since it appears that the language could be interpreted to require isolation of any patient or resident with a communicable disease.

The Department should include the factors and situations used in determining whether the patient, resident or animal should be separated, and what degree of separation is required. This should be done in §27.61 (relating to isolation) and not in the definition of the term

“isolation” in this section.

Response

The Department has not changed the proposed definition of “isolation.” The purpose of §27.61 is to enable the Department or a local health authority to isolate a patient or resident with a communicable disease, depending upon the circumstances of the case. Whether isolation will occur, and what form it will take depends on the nature of the diagnosed disease, the characteristics of the individual (including how the individual is complying with disease control requirements), and the type of facilities available. However, a general determination of what control measures are necessary, not just decisions of how isolation would be effected, is based upon these considerations. Therefore, the Department has changed the language of §27.60 (relating to disease control measures) to include the relevant considerations, rather than §27.61, which relates specifically to isolation.

Section 27.3. Reporting outbreaks and unusual diseases, infections and conditions.

This section requires the reporting of outbreaks of disease, and the incidence of any unusual disease, infection or condition by any person who suspects a public health emergency.

Comment

Is reporting of an unusual disease, infection or condition required when it is suspected, or when there is a microbiological or other test, such as sputum smear, confirming the

presence of the disease or infection? The Department should provide specific instructions with respect to reporting these matters.

Response

The Department has not changed the proposed regulation. This section specifically requires reporting of an unusual disease, infection or condition whenever a person suspects a public health emergency. The existence of a confirmatory laboratory report or other test is not required. This section is intended to reach anyone who may suspect that a public health emergency is occurring, regardless of whether that person has access to confirmatory test results. The instructions on how to report are included in §27.4 (relating to reporting cases).

Section 27.4. Reporting cases.

This section explains generally how and where reporting of diseases is to occur.

Comment

Will the Department provide health care facilities and health care practitioners with a list of address or phone number changes if there is a move of the locations to which diseases and conditions are to be reported? Will the Department notify individuals of the changes?

Response

The Department will provide a list of addresses and telephone numbers for the LMROs

and the specific Department offices to which certain specified diseases are to be reported. The Department will publish this list in the *Pennsylvania Bulletin*, and update it when it becomes necessary. The Department will also provide the list upon request.

Subsection (d), proposed as subsection (b), does contain the official names of the offices in the Department to which reports may be made. Individual regulations relating to specific diseases, infections or conditions specify to which of these offices the report is to be made. Although the names of the specific offices may change, the Department address, P.O. Box 90, Harrisburg, Pennsylvania, will not.

Comment

Subsection (a) requires health care facilities and health care providers to report cases to the local health authority where the individual resides. It is easier to report to the local health authority where the practitioner or facility is, rather than to determine to which local health authority to report. The local health authority then determines where to report. This is currently being done.

Response

The Department agrees, and has changed the regulation as recommended.

For clarification, subsection (a) refers to LMROs, and not local health authorities. An LMRO includes county/municipal health departments and the Department's 6 district offices, excluding all other local health authorities.

Comment

Clinical laboratories reporting electronically should be sending all reports, except cancer reports, to a central location. Proposed subsection (b)(2) through (7) which requires reporting to specified offices within the Department, should be deleted.

Response

The Department has made some changes to the proposed regulation in response to this comment. The changes go beyond what type of reporting is required by laboratories, since this section addresses reporting of all reporters. Cases of cancer, AIDS, PKU, MSUD, hypothyroidism, sickle cell hemoglobinopathies, and lead poisoning will still be reported to the particular office designated in the sections relating to reporting those matters. See, e.g., §27.33 (reporting cases of cancer). If and when the Department becomes ready to integrate reporting of these diseases, infections and conditions into its electronic disease surveillance system, the Department will publish notice of that fact 6 months before the change in reporting is to occur. Until that time, reports of these diseases infections and conditions will continue to be made to specific offices within the Department. The remainder of the reportable diseases, infections and conditions listed in Subchapter B will, however, either be reported to the LMRO where the case is diagnosed or identified, in the case of paper reports, or to the Division of Infectious Disease Epidemiology, in the case of electronic reporting by laboratories. The Department has therefore deleted proposed subsection (b)(3)-(5) in what is now subsection (d).

Comment

Proposed subsection (c) requires reporting to be done using the appropriate case format. The Department should explain what the case format is.

Response

Proposed subsection (c) is adopted as subsection (e). The Department, as part of a National effort, is developing a web-based disease reporting system with a generic report format that will capture disease specific information. However, providers will still be able to make initial reports by telephone if their financial considerations or lack of state-of-the-art reporting equipment so dictates. The Department provides paper case report cards to reporters. These cards, when returned to the Department, provide basic information regarding the case, and enable the Department to begin its case investigation.

Section 27.5a. Confidentiality of case reports.

This section states the general rule that all information gathered by the Department and local health departments under the act is confidential and will not be released, and also states the limited exceptions to that rule.

The Department received no comments on this section, but has added language to clarify that only those employees of the Department and local health departments who have a legitimate reason to view the information may do so.

Section 27.6. Disciplinary consequences for violating reporting responsibilities.

This section states that a licensed facility or practitioner who fails to comply with the regulations may be referred to the appropriate licensure board for disciplinary action.

Comments

The Department has no legislative authority to threaten that disciplinary action might be taken against a practitioner's license as a result of the practitioner's failure to report in any particular instance. The provision should be deleted.

The Department should modify its regulations to state that only a willful violation of the regulations or a demonstrated pattern of noncompliance will be reported to the appropriate disciplinary board, since the reporting requirements are complex.

Response

The Department has not changed the proposed regulations in response to these comments. The Department does not need specific legislative authority to refer a failure to comply with the law of the Commonwealth to a disciplinary board or licensing agency. The decision to take action is up to the disciplinary board or licensing agency. Further, these reporting requirements, with very little change, have been in place since 1955. The Department has written the regulation to apprise practitioners that the Department has the discretion to refer a practitioner's failure to satisfy reporting responsibilities to the appropriate licensure or disciplinary board. The Department's decision to do so would be

based on all the circumstances involved in the case, including the nature of the violation, and whether it is part of a demonstrated pattern of noncompliance.

Comment

The language in the regulation that refers to disciplinary consequences against a physician who fails to report is troublesome. There is not sufficient detail in the regulations to understand under what circumstances disciplinary consequences would occur, whether there is an appeal process, and what actions would be taken against physicians. If the Department wishes to increase reporting, it should establish a simple process for doing so that is available 24 hours per day, 7 days a week.

Response

As already stated above, the regulations state that a physician's failure to report may be referred to the appropriate licensing board. That board, if it found sufficient reason to take action, would provide the necessary due process requirements. The Department itself cannot take disciplinary action against a physician. The Department does, however, have the authority under the act to institute a prosecution to fine someone who fails to comply with the act.

With respect to the comment regarding a continuous reporting system, the Department currently maintains on-call staff to respond as quickly as possible, 24 hours-a-day, 7 days-a-week, to reports of those diseases and infections that require immediate intervention. The Department's electronic reporting system will allow for 24-hour

reporting of all diseases, infections and conditions even though the regulations do not require 24 hour reporting for all diseases, infections and conditions.

Comment

There should be a more aggressive educational approach toward improved physician reporting of diseases. Disciplinary action should not be taken against practitioners for failure to report. Subsection (c) should be deleted.

Response

The Department has not changed the proposed regulation in response to this comment. While the Department agrees that education is necessary, and is pleased with the commentator's willingness to aid in this undertaking, the Department believes it is important to underscore the necessity of prompt and complete reporting for every reportable disease and condition. Subsection (c) states that the Department may refer a practitioner's failure to report to the appropriate disciplinary board for action; it is not the Department's intention to do so unless the action is repeated and flagrant. It is up to the licensing boards, of course, to investigate and determine whether disciplinary action is necessary under the terms of the relevant statutes, for example, the Medical Practice Act of 1985 (63 P.S. §§422.1-422.45) and the regulations promulgated thereunder.

Comment

This section does not contain disciplinary consequences for child care group settings.

Response

The Department agrees that language relating to child care group settings parallel to that for other licensed facilities and practitioners should be included in the regulation. The Department has added that language stating that the Department may refer the child care group setting to the appropriate licensing agency for appropriate action. The decision to take action would then be up to that licensing agency.

Comment

Will there be an expected order of reporting, so that one person reports first, another reports second, and so on? If one report is filed, does every other person connected with that case have to file a report? Who is required to file what reports?

Response

Who is required to report what is clearly set out in the Department's regulations. The reporting responsibilities in the Department's regulations are categorized by the type of person or entity that is required to report them. For example, §27.22 (relating to reporting of cases by clinical laboratories) lists the diseases, infections and conditions clinical laboratories are required to report. Section 27.21a (relating to reporting of cases by health care practitioners and health care facilities) lists the diseases, infections and conditions health care practitioners and facilities are required to report.

The Department has already addressed why multiple reports of the same case are required when multiple persons have knowledge of the case.

Comment

Do reporting practitioners have to communicate to other involved health care practitioners that a report has been made? Do reporting practitioners have to report the findings in a timely manner to other health care practitioners that need to know the information?

Response

The Department's regulations do not require reporting to any entity other than the Department or an LMRO.

Comment

A clinical laboratory must rely upon information provided by other individuals to comply with the regulations. Information that is not provided to the laboratory when solicited will result in a failure to comply with the regulations. The Department should add the following language "unless due to circumstances beyond the control of the clinical laboratory," to the end of subsection (a).

Response

The Department agrees that the clinical laboratory should not be responsible in situations where the solicited information is not forthcoming. The Department has added the recommended language to subsection (a).

Section 27.7. Cooperation between clinical laboratories and persons who order laboratory tests.

This section requires laboratories to give a person requesting a laboratory test a form on which information necessary for the laboratory to complete a case report can be provided to the laboratory. The section also requires the person ordering the test to provide the laboratory with the information solicited by the form that the person ordering the test currently has or may readily obtain at the time the test is ordered.

Comment

The Department should clarify who “the person requesting the test” is. Is there a difference between the person ordering the test, and the person requesting the test. The Department should use one term or the other. In a long term care setting, the person who orders the test is the doctor, however, a nurse fills out the requisition for the test.

Response

Nurses as well as doctors have reporting responsibilities under the act and these regulations. This section, however, does not focus on reporting responsibilities, but, rather, states requirements for what information should be included with the order for the test. The person ordering the test must provide the necessary information to the laboratory so that it, in turn, can fulfill its reporting responsibilities to the Department. If, in order to do this, the staff of the facility or office must provide information, or fill out the form, then they should do so. It is, however, the responsibility of the person ordering the test to ensure the necessary information is present. In the example presented

by the commentator, this would be the doctor who orders the test, not the nurse or other person who prepares the form requesting the test. The Department has changed the regulation to clarify this.

Comment

If the laboratory is to provide the appropriate laboratory requisition slips, who is responsible for obtaining them? In a long term care setting, the long term care provider contracts with a laboratory for services and has no control over the laboratory. Frequently results are delayed in reporting and real and potential problems in communications exist between the laboratory and the long term care provider. The regulations should take these concerns into account.

Response

The Department has not changed the proposed regulation in response to this comment. The question of who is responsible for obtaining laboratory slips and communications between a laboratory and a health care practitioner should pose no problems in reporting. The health care practitioner or facility required to report is to do so as soon as there is a clinical determination that a reportable disease, infection or condition exists. There is no need to wait for laboratory confirmation of the disease, infection or condition.

Section 27.8. Criminal penalties for violating the act or this chapter.

This section reiterates the penalties for violation of the act and regulations included in sections 19 and 20 of the act (35 P.S. §§521.19 and 521.20).

Comment

This section includes penalties for persons with tuberculosis and other communicable diseases who fail to comply with the act and regulations. These penalties will not serve as a deterrent against leaving facilities, particularly if a person is destitute or homeless. This section is not enforceable, or in the best interests of quality care. A hospital cannot detain these people, and local law enforcement will not take any action.

Further, it is unclear whether these incidents should be brought to the attention of the State or a local health department. The Department should provide guidance about what is to be done when a person leaves a facility against advice.

Response

The Department has not changed the proposed regulation to address this comment. This section reiterates penalties for violations of the act and regulations that are contained in statute (35 P.S. §§521.19 and 521.20). The Secretary of Health is given broad powers to enforce the law and these regulations, particularly the law and regulations relating to quarantine:

He may issue warrants to any sheriff, constable or policeman to apprehend and arrest such persons who disobey the quarantine orders or regulations of the department of health. Every warrant shall be forthwith executed by the officer to whom directed, who shall make due return of the execution thereof to the [Secretary].

(71 P.S. §1402). Although the Department has not in recent history sought imposition of these statutory penalties, and agrees that illness should not be criminalized, it has used the

threat of penalties to obtain cooperation from individuals who have been and could continue to be noncompliant with treatment and control measures. This has been done with the cooperation of law enforcement officials, who are required, by law as discussed above, to cooperate with the Secretary in these matters.

It is not the Department's intention to make the facility responsible for detaining a patient. It is the Department or local health department that is responsible for ensuring patient compliance. If the facility is within the geographic area over which a local health department has jurisdiction, it should call that local health department regarding these incidents. The facility, when in doubt, may always call the Department, which can determine where jurisdiction lies. Intervention by the departments after notification at the earliest possible time of all suspected and confirmed cases of tuberculosis will provide the departments the opportunity to take necessary action, including petitioning courts for aid, if necessary, to detain noncompliant patients. The act gives the Department, or, depending upon the location of the patient, the local health department, the authority to take action when a patient refuses to be tested for a communicable disease, or is noncompliant with the orders of the Department or local health departments regarding the treatment and control of that disease. (See 35 P.S. §§521.7 and 521.11). When an individual agrees to treatment at a particular facility, or is court-ordered to treatment in a particular facility recommended by the Department, the Department pays the facility according to contracts it has with that facility. The Department has, on occasion, provided funds for security to enforce the quarantine.

Comment

There is concern about the extended period of time acute care hospitals are used essentially to house tuberculosis patients that require isolation or are noncompliant. The payer may determine that this is not medically necessary, so that hospitals are not getting reimbursed at the level needed to care for these patients. The Department should develop alternative placement arrangements for patients who no longer require hospital services. The Department should also address reimbursement issues with governmental and commercial payers.

Response

As stated above, with respect to individuals with whom the Department is involved, the Department contracts with facilities for the provision of care at a rate agreed upon in the contract. The Department relies upon its contracted tuberculosis consultant physicians to advise upon the time limitations of the quarantine. Any hospital that does not wish to provide these services need not enter into a contract with the Department. If hospitals are unhappy about third party reimbursement rates, for example, medical assistance rates, hospitals must address those issues with the responsible agencies, not the Department. These regulations are not an appropriate venue for those conversations. If a hospital has an issue with anything done by a local health department with respect to tuberculosis, the issue should be addressed with that health department.

Comment

The Department must believe that there is considerable lack of compliance to justify

criminal penalties. The regulations must be very specific concerning who is to take what action and how the action is to occur, since failure results in criminal penalties.

Response

The Department has not changed the proposed regulation to address this comment. The referenced penalties are all taken from the act. The requirements for reporting are carefully defined in the act and regulations. Since most of these requirements have existed for 50 years, compliance should not be difficult. The Department is currently considering how to provide educational sessions for persons who believe a “refresher” course in reporting would be useful.

Section 27.9. Authorized departures from the regulations.

The proposed section stated that the Department could decide against enforcing a provision of the regulations when it determines, with the agreement of the Board, that the provision is outdated, and that waiving the provision would be necessary to protect the health of the people of the Commonwealth.

Comment

The Department can only amend regulations by promulgating new rulemaking. The Department should add language to state that if the Board affirms, the Department will amend the regulations, or should explain its statutory authority for amending regulations without going through the regulatory process.

Response

The Department has not adopted the proposed section. The provision was not intended to allow the Department to amend its regulations without rulemaking. The Department was only announcing its intention to, upon the approval of the Board, cease enforcing certain regulations that are not parallel to a statutory requirement, when those regulations are outdated.

Comments

How does the Department intend to communicate in a timely fashion that it has decided upon an exception?

The regulations do not address the question of what would occur if the Board affirmed or rejected the exception.

The Department removed language similar to this from other parts of the regulations.

Did it intend to retain the language regarding exceptions in this section? How is it permissible to grant an exception without regulatory action?

Response

Because the Department has chosen not to adopt the proposed section, there is no need to respond to these comments.

Comment

The Department should consider incorporating the Morbidity and Mortality Weekly Report (MMWR), which would be a viable alternative toward authorizing an exception, if a regulation becomes outdated. Guidelines for documents that can be incorporated by reference are found at 45 P.S. §727 (relating to matter not required to be published) and 1 Pa. Code §3.41 (relating to matter not required to be published).

Response

The Department does consider the MMWRs relating to disease prevention and control, as well as other guidelines and recommendations from the Centers for Disease Control and Prevention (CDC) and its Council of State and Territorial Epidemiologists in making decisions concerning what diseases, infections and conditions to add to the list of reportable diseases. The Department is not, however, required by any entity to accept these recommendations and guidelines in their entirety. It is up to the Department, with the approval of the Board, to determine when and how to add diseases, infections and conditions to the list. (See 35 P.S. §521.16(a) and 71 P.S. §536(a) with respect to the Department's authority to issue rules and regulations on communicable and noncommunicable diseases, declare diseases to be communicable, and to establish regulations for the prevention and control of disease). These decisions must be made on a state-by-state basis, since they depend upon the different populations of the state and their needs, and other characteristics of each state.

**SUBCHAPTER B. REPORTING OF DISEASES, INFECTIONS AND
CONDITIONS**

Section 27.21. Reporting of AIDS cases by physicians and hospitals.

This section states the requirements for physicians and hospitals reporting AIDS.

Comment

The Department erred in deleting requirements from its regulations that both hospitals and physicians report cases of AIDS. To only require reporting by physicians could lead to underreporting of AIDS cases.

Response

The Department agrees that both hospitals and physicians should report cases of AIDS. The deletion of the requirement relating to hospitals was inadvertent. The section has been revised accordingly.

Section 27.21a. Reporting of cases by health care practitioners and health care facilities.

This section lists the diseases, infections and conditions reportable by health care practitioners and health care facilities. This section also provides the time frames in which the disease, infection or condition must be reported.

The Department has made some minor changes to the list from the proposed regulations for the sake of accuracy. The Department has changed the term “Legionnaire’s disease” to the more technically accurate “Legionellosis.” The Department has also deleted yellow fever from the regulations since yellow fever is an arbovirus, and there is no need to list it separately.

Comment

Under subsection (b)(1) (now subsection (a)(1)) a health care practitioner or a health care facility is not required to report if that health care facility or practitioner has already reported the case. The Department should clarify that a health care facility is also not required to report if its laboratory has reported previously. Currently, hospitals are not reporting if their laboratories are reporting. If the Department does not agree to this change, it should explain why duplicate reports are necessary, and how the benefits of this reporting outweigh the costs.

Response

The Department has not changed the proposed regulation in response to this comment. Reporting by practitioners and facilities as well as laboratories, what is referred to as the “dual pathway” of reporting, is not unique to Pennsylvania. It is the National standard for ensuring completeness of reports. Ideally, the practitioner or facility should make the initial case report. Historically, however, there has been significant noncompliance. Through the identification of practitioners and facilities in laboratory reports, the Department is able to contact practitioners and facilities and obtain from them a completed case report on a particular patient whose test result has been reported to the Department by a laboratory but for whom no report has been made by the provider. This approach is consistent with the CDC protocols and with protocols in other states. A more detailed explanation of why reporting from all possible reporting entities is necessary for a successful disease prevention and control program has been provided in the

Department's response to general comments concerning reporting.

Comment

The Department's need for potentially overlapping information from facilities, practitioner, clinical laboratories and persons in charge of group facilities is unclear.

Response

The Department has not changed the proposed regulation in response to this comment. The Department is seeking overlapping information from providers, facilities, and the public, to ensure that it obtains the widest variety and amount of information possible. The need for all relevant and available information, and the manner in which the Department resolves duplicate reports, has been discussed.

Comment

Does this section supersede 28 Pa. Code §211.1 (relating to reportable diseases in long-term care nursing facilities)?

Response

Section 211.1 is based on the requirements of this chapter. By this rulemaking, the Department is also amending §211.1 to state that reportable diseases, infections and conditions are those diseases, infections and conditions listed in this section. The reporting requirements in §211.1 do not eliminate the reporting requirements for a health care facility under Chapter 27.

Comment

The Department should move the following diseases from subsection (a)(2) (now subsection (b)(2)) which contains a listing of all diseases infections and conditions to be reported within 5 days, to subsection (a)(1) (now subsection (b)(1)) which contains a list of all diseases infections and conditions to be reported within 24 hours: animal bite, anthrax, arbovirus disease, enterohemorrhagic E. coli and legionellosis. With these diseases and conditions, action must be taken to prevent serious consequences to the individual within a shorter time frame than 5 days. With respect to anthrax, since there is the possibility of a bioterrorist attack using this disease as a weapon, it should be reported within a shorter time frame than 5 days.

Response

The Department agrees with the comments, and has moved these diseases and conditions from the list requiring reporting within 5 days to the list requiring reporting within 24 hours. See subsection (b)(1) and (2).

Comment

The Department should add the following diseases to the list of diseases that must be reported within 5 days: Creutzfeldt-Jakob disease; streptococcus pneumoniae drug resistant invasive disease, and staphylococcus aureus, Vancomycin resistant (or intermediate) invasive disease.

This comment also applies to §27.22 (relating to reporting of cases by clinical laboratories).

Response

The Department agrees with the comment, and has added these diseases to the list of diseases that must be reported within 5 days. See subsection (b)(2). That action is consistent with National reporting standards recommended by the CDC.

The Department has made similar revisions to §27.22(b).

Comment

There is a concern that this section would require emergency management technicians (EMTs) to report cancer. While this would not include patients already diagnosed, it could be confusing to EMTs who do not know the complete history of the patient. Further, EMTs cannot diagnose cancer.

Response

It was not the Department's intention to require health care practitioners to perform diagnoses who cannot, within the scope of their licensure or training, diagnose diseases, infections or conditions. The diseases, infections and conditions listed in subsection (b), (proposed as subsection (a)), are only to be reported in accordance with subsection (a), (proposed as subsection (b)), and the remainder of the chapter. Cancer, which only certain specified health care practitioners and facilities are required to report (see §27.31

(related to reporting cases of cancer)), would not be reportable by EMTs. Because this section has generated some confusion among commentators, the Department has rearranged subsections (a) and (b), and added language to clarify that if there are specific requirements in other sections for the reporting of certain diseases, those provisions must be read in addition to this section.

Further, the Department has added language to subsection (d) to clarify that health care practitioners as well as health care facilities are to look to §27.31 (relating to reporting cases of cancer) to determine how to report cancer cases. The Department has also attempted to provide additional clarity by adding subsection (a)(4), as well as similar language to §27.31(a) and (b), which states that only those facilities and practitioners actually providing services relating to the individual's cancer are required to report the case as a cancer case.

The Department has also revised the language in this section that requires reporting of identified diseases, infections and conditions to clarify the meaning of the word "identify." A disease, infection or condition is reportable when it has been identified by symptoms, appearance of the individual or diagnosis. Consequently, a diagnosis is not needed to trigger a duty to report.

Comment

While *Haemophilus influenzae* should be reportable within 24 hours, the Department should delete the reference to "type B invasive disease" from the list of reportable

matters. Many clinical laboratories do not conduct serotyping, and laboratories that do conduct serotyping may not have results for several days. Since action may need to be taken sooner than it would take the laboratory to conduct the serotyping, the Department should make *Haemophilus influenzae* reportable within 24 hours. This comment pertains to §27.22(b)(1) (relating to reporting of cases by clinical laboratories) as well.

Response

The Department agrees with this comment, and is deleting “type B” from the reference to *Haemophilus influenzae* in subsection (b), (proposed as subsection (a)).

Comment

All types of hepatitis should be reported, and should be reportable within 5 days of identification of the disease.

Response

The Department agrees that all forms of hepatitis should be reportable, and has revised the regulations to make hepatitis reportable within 5 days of the identification of the disease. The Department has divided reportable diseases into two categories, those reportable within 24 hours, and those reportable within 5 days, to eliminate some burden from those entities required to report. Only those diseases that need quick public health intervention are required to be reported within a 24-hour period. The Department agrees that hepatitis does not need to be reported within that time frame due to the manner of its transmission.

Comment

The regulation should require the reporting of chronic cases of hepatitis C as well as acute cases. More extensive reporting of hepatitis C cases is necessary so that reputable and inclusive data can be used to make an accurate assessment of the public health threat of hepatitis C to citizens of this Commonwealth. This issue should not be allowed to languish through a long regulatory process. This same comment is applicable to §§27.22 and 27.43a (relating to reporting of cases by clinical laboratories; and reporting by local morbidity reporting offices of outbreaks and selected diseases).

Response

The Department has added language to the regulation to clarify that it is requiring the reporting of all cases of hepatitis C, chronic as well as acute. The Department looks at all reported cases of hepatitis C to resolve whether an individual is an acute or chronic case. It makes this assessment by determining whether the individual also has clinical symptoms. An individual who has both a positive laboratory serology and presents with clinical symptoms is an acute case. An individual whose laboratory tests show that he or she is positive for hepatitis C, but who has no clinical symptoms, is a chronic case. Since an intervention message can be life-saving for persons with chronic hepatitis C, information regarding the need to practice safe sex and to get vaccinated for hepatitis A and B as well as other information relating to the disease will be given by the Department to each individual reported with hepatitis C.

Comment

The Department should delete hepatitis, viral, including type A and type E, from proposed subsection (a)(1) (now subsection (b)(1)) which requires reporting within 24 hours. All other types of hepatitis are reportable within 5 days. References to type G should be deleted from the proposed subsection (a)(2) (now subsection (b)(2)) listing of diseases reportable within 5 days, since it does not exist. Hepatitis, non-A and non-B should be added to the 5day list in proposed subsection (a)(2). These same comments apply to §27.22(b) (relating to reporting of cases by clinical laboratories).

Response

The Department agrees with the comments, and has revised the references to hepatitis in this section. The Department has deleted all references to hepatitis from what is now subsection (b)(1), which requires reporting within 24 hours. The regulations require that hepatitis, viral, all types, is reportable within 5 days of its identification by symptom, patient appearance, or diagnosis. See subsection (b)(2).

The Department has made similar revisions to §27.22(b).

Comment

The Department should require human immunodeficiency virus (HIV) reporting. The legislature contemplated reporting of HIV infection under section 7(a)(9) of the Confidentiality of HIV-Related Information Act (35 P.S. §7607(a)(9)).

The Department should also explain what type of HIV reporting it favors; most persons appear to favor a unique identifier system of reporting.

Response

The Department has chosen to promulgate regulations relating to HIV separately. The revisions to Chapter 27 included in this final rulemaking have been under consideration by the Department and various stakeholder groups for the past 10 years. The Department was anxious to proceed with the amendments, and did not wish to delay them while important consideration and public discussion was given to the question of when and how HIV should be made reportable. The Department neither wished to rush the process involving the promulgation of regulations relating to HIV reporting, nor to delay this general rulemaking concerning communicable and noncommunicable diseases.

Further, the importance of the promulgation of regulations relating to HIV reporting warranted a separate rulemaking so that attention could be focused on that issue.

Therefore, the Department has proposed separate regulations on that topic. The regulations that would require reporting of certain HIV tests, CD4 T-lymphocyte counts below certain levels, and perinatal exposure of newborns to HIV by name, were published as proposed at 31 Pa. B. 2126 (April 21, 2001). A 30-day public comment period was provided.

Comment

With respect to the requirements for reporting phenylketonuria, maple syrup urine disease

(MSUD), hypothyroidism, and sickle cell hemoglobinopathies, the Department should explain why it is using both the phrase “up to five years” and “up to 60 months” in relation to the age of the child in whom the disease should be reported.

Response

The Department agrees that this language should be changed, and is revising the regulation to state that these diseases are reportable in children under 5 years of age.

Comment

The Department should include smallpox in the list of diseases that must be reported within 24 hours. The threat of bioterrorism requires the reintroduction of smallpox into the list.

Response

The Department agrees with the recommendation, and has added smallpox to subsection (b)(1).

Comment

The statement in the preamble to the proposed regulations that it is not clear that chickenpox can be prevented by vaccination is outdated. This vaccine is now recommended universally for children and other persons not known to be immune.

Response

The Department agrees that the statement is no longer correct. The Department is in the process of promulgating regulations that will include chickenpox (varicella) in the list of diseases for which immunization is required for school entry and attendance. It is anticipated that these regulations will be effective for the 2002-2003 school year.

Comment

Does the Department distinguish between occurrence of the chickenpox disease and post-vaccination cases?

Response

The Department does not distinguish between wild virus chickenpox and post-vaccination cases.

Comment

The Department should remove required reporting of chickenpox (varicella) until it decides that reporting is warranted based on trends in information reported by clinical laboratories. The 3-year time frame presupposes that cases will need to be reported by health care facilities and practitioners. The Department should wait until chickenpox (varicella) immunity is required in schools.

Response

The Department has not changed the proposed regulation in response to this comment. The Department believes that reporting of varicella is warranted now. As stated

previously, the Department's regulations requiring immunity from chickenpox as a condition of school entry and in the seventh grade will be in place for the beginning of the 2002-2003 school year.

Comment

Chickenpox (varicella) should be added to the list of reportable diseases, however, there should not be a 3-year delay for reporting by practitioners. Laboratories will not have data to provide, since a primary care provider rarely, if ever, requires a laboratory test for the disease. School nurses and child care programs could report the disease, since often only the most severe cases are seen by physicians.

Response

The Department has not changed the proposed regulations in response to this comment. Laboratories are already reporting this disease on a voluntary basis. Sentinel surveillance systems are already ongoing in schools and day care centers, and with physicians. Sentinel surveillance for varicella involves polling approximately 2000 sites Statewide on a monthly basis to gather information on ongoing incidence, morbidity and mortality of varicella. As varicella vaccine usage increases, the Department will monitor disease incidence using this system until the numbers of cases of varicella are at a more manageable level for individual case reporting. The Department anticipates that this will be within a 3- year period from the effective date of these regulations, which will coincide with a 3-year period from the effective date of the varicella immunization requirements. The Department, in setting a 3-year delay in reporting for health care

practitioners (which includes school nurses) is attempting to alleviate what could become a burden for health care practitioners, and what could, if reporting were immediately required, cause them to have to report tens of thousands of cases a year. The Department's expectation is that within 3 years of the regulations regarding school immunizations and immunity being in place, this number will drop to less than 1000 annually.

Comment

The Department should add to subsection (c) a requirement that a child care group setting that enrolls more than 12 children is to report to the LMRO any unusual increase in the number of absentees.

Response

The Department agrees that such a requirement would aid it in its responsibilities to prevent and control the spread of disease, and has added the recommended language to subsection (c).

Section 27.22. Reporting of cases by clinical laboratories.

This section addresses reporting requirements for clinical laboratories. It includes the list of diseases, infections and conditions reportable by laboratories, and the timeframes in which laboratories are required to report.

Comment

The Department should delete language from the regulation that limits the reporting of arboviruses to the Eastern, Western and St. Louis arboviruses. The Department should add references to West Nile and Equine as well. Arboviruses can appear in unexpected places, as the West Nile outbreak in New York City shows. Any arboviral case could lead to the need for mosquito control efforts and other public actions.

Response

The Department agrees with the comment. Since the Department's intention is to require the widest reporting possible, it has deleted all references limiting reporting to certain types of arboviral diseases, thereby requiring the reporting of all arboviruses.

Comment

The Department should add language that would permit either the referring laboratory or the laboratory performing the test to report the results. This would ensure that the Department receives a report that contains the most complete information. It will also eliminate duplication. The referral laboratory may not have all the demographic information requested by the Department. If the Department chooses not to revise this section, it should explain why duplicate reports are necessary and how the benefits outweigh the costs.

Response

The Department has not changed the proposed regulation in response to this comment. Because the Department needs all the information on a case it can obtain, both the

“primary” and the “referral” laboratory are required to report. The necessity for reporting from all possible reporters has already been discussed in detail.

Comment

The Department should explain why it has made decisions to delete or add specific diseases.

Response

The Department will respond to this comment in its responses on the specific requests for additions or deletions to the list of cases reportable by clinical laboratories.

Comment

The Department should add CD4 T-lymphocyte counts of 500 cells per microliter or less to the list of reportable diseases in subsection (b).

Response

The Department has not added this requirement to these regulations. The Department, in a separate rulemaking, published at 31 Pa. B. 2126 (April 21, 2001) is proposing to add a requirement for reporting of laboratories, practitioners, and other entities of CD4 T-lymphocyte cell counts of less than 200 cells per microliter or which are 14% or less of total T-lymphocyte cells. Chapter 27 will be amended again when the Department acts to adopt those proposed regulations.

The Department has not proposed the reporting of CD4 T-lymphocyte cell counts of less than 500 cells per microliter because there is not a National consensus on reporting at that level.

Comment

The Department should add the following diseases to the list of diseases reportable by laboratories: cryptosporidiosis; histoplasmosis; meningitis; toxoplasmosis and yellow fever. Arboviruses should be listed in the same manner as in §27.21a (relating to reporting of cases by health care practitioners and health care facilities).

Response

The Department agrees and has amended this section to require reporting of cryptosporidiosis, histoplasmosis, and toxoplasmosis by laboratories. This comports with the National standard for reporting.

The Department has revised the reference to arboviruses in this section to require reporting of all arboviruses, as it has in §27.21a(b)(1). Since yellow fever is a mosquito-borne disease, and is covered by the term “arbovirus,” there is no need to add it specifically to the list. Similarly, the regulation requires the reporting of meningococcal infections by laboratories, rather than meningitis. Meningitis is a clinical diagnosis, and is required to be reported by health care practitioners and health care facilities in §27.21a.

Comment

The Department should delete syncytial virus from the list of diseases required to be reported by clinical laboratories. Local health authorities will be inundated with reports, and the Department did not provide a reason in its preamble to proposed rulemaking for including this disease.

Response

The Department has not changed the proposed regulation in response to this comment. Since this section requires reporting of syncytial virus by laboratories, and not by health care practitioners and facilities, the Department does not expect to be inundated by reports. This requirement will allow the Department to identify outbreaks of disease once the use of the new vaccine for this virus is widespread.

Comment

The Department should remove references to unusual clusters of isolates from subsection (b) since the term “unusual” may mean something different depending on the disease.

Response

The Department has not changed the proposed regulation in response to this comment. The term “unusual” may mean different things depending on different diseases. For example, a laboratory may notice that it has positive results for E. coli 0157:H7 from tests on several different specimens, and this does not usually occur. This unusual grouping of test results could be indicative of an outbreak. The Department does not want to lose an opportunity to intervene to prevent and control the spread of disease.

Comment

The Department should add the following language to subsection (c): “the report shall include the source of the specimen (e.g., serum, CSF, stool, wound); the results; the range of normal values for the specific tests.”

Response

The Department agrees that this additional information would be valuable to it in its disease prevention and control function. It has added the recommended language to subsection (c), with the exception of the test results, since that data element is already included in the regulation.

Comment

The Department should adopt a unique identifier system for all reporting. There is a concern with respect to the confidentiality of information reported to the Department, particularly with cancer information and lead test results. A unique identifier system would permit the Department to carry out its responsibilities while protecting the information.

Response

The Department has not changed the proposed regulation to address this comment. The Department cannot fulfill its disease prevention and control functions, which include follow up with individuals to ensure that medication is being taken, treatment being

followed and contacts being notified, without obtaining the name and identifying information of the individual about whom the report is made. The Department has had information reported to it under the act since 1955 by name of the individual without major issues surrounding confidentiality.

The act requires the Department and local health departments to keep confidential the information they collect under the act. The act prohibits the Department from releasing information secured pursuant to the statute, even in the face of a subpoena, with few exceptions. Section 15 of the Act provides as follows:

State and local health authorities may not disclose reports of diseases, any records maintained as a result of any action taken in consequence of such reports, or any other records maintained pursuant to this act or any regulations, to any person who is not a member of the department or a local board or department of health, except where necessary to carry out the purpose of the act. (35 P.S. §521.15).

The Supreme Court of this Commonwealth has stated that the purpose of the act is to aid the Department and local health departments to prevent and control the spread of disease. See Commonwealth v. Moore, 526 Pa. 152, 159, 584 A.2d 936, 940 (1991). In Moore, the Supreme Court held that release of information collected under the act to aid a criminal prosecution did not carry out the purpose of the act. The Department may disclose aggregate information on disease cases for research purposes, but will only do so without including case-identifying information. The Department will disclose identifying information with a valid consent from the individual whose information is being requested.

Because the Department and local health departments take the responsibility to protect all information reported under the act very seriously; they have, on several occasions, engaged in litigation in State and federal court to prevent the release of information reported under the act. The Department has no reason to abdicate this responsibility to maintain the confidentiality of this information.

With respect to cancer reporting, this type and level of cancer reporting is required by the federal Cancer Registries Amendment Act of 1992.

Comment

Subsections (d), (e) and (k), which require reporting of diseases and conditions of the newborn, sexually transmitted diseases (STDs), lead levels and tuberculosis test results to separate places within the Department (and in the case of tuberculosis, to Allegheny and Philadelphia Counties when the patient resides there), should be deleted. All reports should be made to a single location within the Department.

Response

The Department agrees that a single reporting location should be developed for electronic laboratory reporting, but is unwilling to do so for paper reporting at this time. The Department is, therefore requiring that all laboratory reports that are made electronically ~~this occur~~ be made to the Department's Division of Infectious Disease Epidemiology, with the exception of newborn screening, lead and cancer. The Department intends to phase in electronic reporting by all reporters as has already been discussed.

The Department is addressing paper reporting by changing the requirement in subsection (e) that laboratories making paper reports send the report to the county or municipal department of health where the patient resides. Section subsection (d) now requires the laboratory to send paper reports to the LMRO where the case was diagnosed or identified. This is in keeping with the Department's revisions to requirements for health care providers and practitioners who report on paper. The Department has, therefore, deleted proposed subsection (k), which would have required laboratories to report tuberculosis to either Philadelphia or Allegheny County, depending upon where the case resided, or as a default, to the Division of Tuberculosis and Sexually Transmitted Diseases.

The Department has also made changes to §27.33 (relating to reporting cases of sexually transmitted diseases). The Department has revised that section to delete special reporting requirements for syphilis, and to require paper reports of sexually transmitted diseases to be sent to the LMRO where the case is diagnosed or identified (see §27.33(b)) and electronic reports to be sent to the Division of Infectious Disease Epidemiology, Bureau of Epidemiology (see §27.33(c)). The Department has deleted the reference to §27.33 from subsection (e).

Comment

The Department should add language that would require laboratories that cannot perform serotyping to mail isolates of salmonella (subsection (f)), *Neisseria meningitidis*

(subsection (g)), E. coli isolates (subsection (h)), and H. influenzae isolates (subsection (i)) to the Department. All other laboratories should be exempted from that requirement as they can conduct the serotyping themselves. This would eliminate the need to send a potentially biohazardous specimen through the mail.

Response

The Department has not changed the proposed regulation in response to this comment. The only laboratories that can perform the level of serotyping required by the Department for its disease investigation and surveillance are National reference laboratories, which obtain the necessary reagents from the CDC to perform this testing. However, a commercial National reference laboratory may not be able to perform all the required tests on the specimen. The only laboratory within Pennsylvania that can perform the level of serotyping needed by the Department to conduct its disease surveillance and investigation is the Department's State laboratory operated by its Bureau of Laboratories. The Bureau also maintains the isolates so that the Department can match up disease strains and pinpoint outbreak sources. This enables the Department to control the spread of the disease. Further, the Department does not charge the person submitting the specimen; it does this testing as a public health service.

Section 27.23. Reporting of cases by persons other than health care practitioners, health care facilities, veterinarians or laboratories.

This section requires individuals in charge of certain types of group facilities to report diseases, infections and conditions.

Comment

The language of this section appears to require the same level of reporting for persons in charge of group facilities as is required of health care practitioners and health care facilities. Individuals in charge of group facilities do not diagnose, or treat or examine patients. Does this section intend schools and child care providers to become mini health clinics? What does the Department expect from laymen's reports? Can reports be based on symptoms and suspicions, rather than identification?

Response

As the Department has explained in response to comments on §27.21a (relating to reporting of cases by health care practitioners and health care facilities), the Department does not intend to require diagnosis of a disease, infection or condition by those individuals who are not, by training and experience, capable of performing diagnoses, or who are not, by the scope of their licensure, permitted to diagnose. The act and regulations require reporting, not only of a diagnosed case, but also of a suspected case, based on symptoms, appearance, and the circumstances surrounding the suspected case. The Department does not expect a layperson to be as aware of diseases, infections and conditions as a health care practitioner or facility, and has changed the language of this section to clarify that. The Department has explained how reports from laypersons are handled in its response to comments on the definition of the term "health care practitioner" in §27.1 (relating to definitions).

Comment

Why is the phrase, “except as otherwise set forth in this section” needed here?

Response

The phrase was included because the section, as proposed, would have required individuals in charge of certain group facilities to report in the same manner as health care practitioners are required to report under §27.21a (relating to reporting of cases by health care practitioners and health care facilities). Some of the diseases listed in §27.21a are reported in a unique manner, however. Lead poisoning, for example, is reported directly to the Division of Maternal and Child Health, rather than to an LMRO. Because the Department has revised this section by deleting the statement that reports are to be made in accordance with §27.21a, the phrase is no longer necessary. The Department has deleted it from the regulation.

Section 27.25. [Reports by other licensed health practitioners] (Reserved).

This section, which is being repealed by the Department, required licensed health care practitioners other than physicians, including nurses, chiropractors, and optometrists, to report the knowledge or suspicion of a communicable disease.

Comment

The Department states that it is repealing this section because it is including the requirements of the section in §27.21a. The regulations do not say who is to report. This should be clarified.

Response

Section 27.21a clearly states that health care practitioners and health care facilities are to report the listed diseases, infections and conditions. The Department has defined “health care practitioner” broadly to include the individuals listed in repealed §27.25. The Department believes that no further clarification is necessary, and has repealed the regulation, as proposed.

Section 27.30. Reporting cases of certain diseases in the newborn child.

This section requires that reports of MSUD, PKU, primary congenital hypothyroidism, and sickle cell hemoglobinopathies be made to the Department’s Division of Maternal and Child Health.

Comment

This section should be deleted, since all reports should be made to one central location within the Department.

Response

The Department has discussed the issue of reporting to a central location in its response to general comments on the reporting of cases. However, when electronic reporting for practitioners and facilities as well as laboratories is instituted, §27.30 is unlikely to be repealed. There are additional considerations with respect to reporting results of metabolic disease testing in the newborn that necessitate continued reporting of these

diseases directly to the Division of Maternal and Child Health. If these diseases were reported to a central location within the Department, that location would have to sort these reports out of reports of each of the 52 reportable diseases, infections and conditions, and route them to the Division of Maternal and Child Health. The delay in time that this would cause could be dangerous for the children involved. There is a need for speed in reporting these diseases to the Division, which is responsible for follow-up and referral of children with these conditions. MSUD, for example, within the space of 7 days, can cause severe mental retardation or death.

Comment

Expanding reporting to the four diseases included in the regulations, MSUD, PKU, sickle cell hemoglobinopathies and congenital hypothyroidism is supported, however the regulation should be expanded to include all diseases for which tests are conducted by Neogen, Inc., a company offering an expanded testing panel which is currently used by most birthing hospitals. It is in the epidemiological interest of the Department to monitor the frequency of these diseases for their possible addition to the newborn screening program.

Response

The Department has not changed the proposed regulation in response to this comment. The expansion of diseases and disorders reported to the Department's newborn screening program is cautiously and carefully considered on a condition-by-condition basis, based on criteria adopted by the Department and recommended by the Council of Regional

Networks for Genetic Services. Before adding diseases and conditions to the list, the Department considers demographic information, the genetic composition of the population, available methodologies, outcomes and economics. The Department will screen for only those conditions for which effective intervention and treatment is available and accessible to all affected newborns. The Department also considers the impact of the required reporting on the program's capacity for follow-up and treatment. A follow-up system must be in place, or able to be put in place, that will ensure that any positive or potentially positive result for a newborn is pursued through to resolution.

The Department does continually review the newborn screening program and the list of diseases and conditions included in that program, and evaluates the need for expansion. At 31 Pa. B. 2271 (April 28, 2001), the Department published proposed rulemaking in which it proposed to add two conditions to the list-- galactosemia and congenital adrenal hyperplasia. That rulemaking, upon becoming final, will amend these regulations relating to communicable and noncommunicable diseases as well, to add the two conditions to the list of reportable diseases, infections and conditions. Questions concerning the appropriateness of including diseases and conditions on the list of diseases and conditions for which newborn screening is done are more appropriately addressed through discussion on that rulemaking.

Section 27.32. [Reporting AIDS] Reserved.

This section, which is being repealed, required reporting of AIDS by hospitals and physicians.

Comment

The Department should not delete the section, which includes the requirement that AIDS be reported by hospitals, health care facilities, and institutions. Hospitals as well as health care practitioners should be required to report AIDS.

Response

As the Department has stated earlier in its response to comments on proposed §27.21 (relating to reporting of AIDS cases by physicians and hospitals), the deletion of a requirement that hospitals report cases of AIDS was an oversight, and the Department has reinstated that requirement in §27.21. The Department's regulations never required that institutions report AIDS.

§27.33. Reporting cases of sexually transmitted disease.

This section specifies how health care practitioners and health care facilities are to report cases of cancer.

This section has been revised in response to general comments that all diseases, infections and conditions should be reported in the location where the individual is, rather than where the individual resides. The Department has changed this section to require that all reports of sexually transmitted diseases be made to the LMRO where the case is diagnosed or identified. This will simplify disease reporting.

Section 27.34. Reporting cases of lead poisoning.

This section includes specific requirements for reporting cases of lead poisoning. The Department has changed the language of the section to clarify its intent that clinical laboratories report elevated blood lead levels (not lead poisoning) as defined by the National Institute for Occupational Safety and Health (NIOSH), in persons 16 years of age or older. Currently, that definition is a venous blood lead level of 25 micrograms per deciliter (ug/dl) or higher. The Department will publish updates of this definition in the *Pennsylvania Bulletin* within 30 days of its notification by NIOSH. See §27.34(a)(3) (relating to reporting cases of lead poisoning).

Comment

Reporting of all childhood lead testing analyzed by a clinical laboratory, regardless of the result, is supported. This will give the Department sufficient information to develop appropriate lead testing protocols for the Commonwealth. Reporting by the laboratory is also supported, since all venous and capillary lead testing is done by laboratories.

Response

The Department agrees.

Comment

The requirement that a clinical laboratory report blood lead tests performed on pregnant women should be deleted from subsection (a). A laboratory has no way of knowing

whether a specimen for testing is from a pregnant woman. This information is more appropriately reported by health care practitioners, who have access to it.

Response

The Department agrees, and has changed subsection (a) to remove the proposed requirement that clinical laboratories report blood lead results on pregnant women. The Department has included in subsection (a) all requirements for clinical laboratories, and has revised subsection (b) to require health care practitioners and health care facilities to make reports on blood lead levels in pregnant women, since these entities would have access to that information. Subsection (b) also requires that health care practitioners and health care facilities report all blood lead levels, both venous and capillary, on persons under the age of 16 years.

Comment

As with newborn screening reporting, all reports of lead poisoning should be sent to one clearinghouse within the Department. This would make it easier for persons and facilities required to report.

Response

The Department has not changed the proposed regulation to address this comment. The Department has addressed the issue of reporting to a central location in its response to general comments on these regulations. Further, the Department currently has in place, and is refining, an electronic system for reporting blood lead levels. When, in the

development of its electronic disease surveillance system, the Department finds that it is more efficient and cost effective to include lead reporting within that system, the Department will do so upon 6 months notice to reporters. See 27.4(b).

Comment

In subsection (a), the Department uses the term “persons under 16 years of age” rather than the term “child,” which includes anyone 15 years of age and under. The Department should use the term “child” in this regulation.

Response

The Department has not changed the proposed regulation to address this comment. Because the Department has revised the definition of the word “child” to include persons under the age of 18, use of the word “child” in this section, without any qualifying language, would not be accurate. According to CDC protocols, reportable lead levels for persons under the age of 16, and for pregnant women, differ from those reportable for persons 16 and older. This is because the susceptibility to lead poisoning is different in persons of different ages, and lead poisoning is an extreme hazard for pregnant women.

Comments

Subsection (e) provides for referral of a physician under whose authorization blood is collected for a blood lead test to the appropriate licensing board for disciplinary action if the physician fails to provide the necessary demographic information to the laboratory along with the specimen. This subsection is a cause for concern, and should be deleted.

Subsection (h) should be deleted. Subsection (h) requires that a clinical laboratory follow certain procedures to attempt to obtain information necessary for the laboratory's report to the Department when certain information is not included with the specimen. The laboratory has the responsibility to provide a submission form to the person ordering the test that solicits certain information. The responsibility for providing that information belongs to the person ordering the test. Because there are criminal penalties associated with failure to properly report information, as well as the possibility of licensure sanctions, including revocation of a license, a laboratory should not be required to follow the burdensome procedures included in this subsection.

Response

The Department has reconsidered proposed subsections (h) and (i) of this section, and has decided that, as proposed, they would place too great a burden upon the clinical laboratory to obtain information from the specimen submitter. It has deleted those proposed subsections. Proposed subsection (e) would have been redundant since, if a physician fails to comply with the regulations on an ongoing basis, the Department may choose to refer the physician for disciplinary action under §27.6 (relating to disciplinary consequences for violating reporting responsibilities). The Department has deleted proposed subsection (e) as well.

Comment

Subsection (i) requires the laboratory to notify the Department of its inability to obtain information from the specimen submitter as required in subsection (h), and includes in paragraphs (1) through (5) the information the laboratory must provide to the Department with this notice. Paragraph (5) requires the laboratory to provide any other information requested by the Department. This paragraph should be limited to any other information necessary to complete the reporting form.

Response

Since the Department has deleted proposed subsections (h) and (i), no further response to this comment is necessary.

Comment

Subsection (j) provides that a laboratory may be subject to revocation of its license for failure to comply with the subsection, or may be subject to other disciplinary action. To what other disciplinary action does this refer?

Response

Because §27.6 (relating to disciplinary consequences for violating reporting responsibilities) adequately addresses these issues, the Department has deleted proposed subsection (j) as redundant. Under §27.6, a clinical laboratory that fails to comply with these regulations may be subject to restrictions being placed upon its permit to operate, or revocation of its license under the Clinical Laboratory Act (35 P.S. §§2151-2165).

Further, a laboratory that fails to comply with the act and regulations may be subject to penalties in accordance with section 20 of the act (35 P.S. §521.20) (relating to penalties, prosecutions and disposition of fines) and §27.8 (relating to criminal penalties for violating the act or this chapter)).

§27.41a. **Reporting by local morbidity reporting offices of case reports received.**

§27.42a. **Reporting by local morbidity reporting offices of completed case investigations.**

These sections explain how LMROs are to report.

The Department has revised the proposed sections to reflect its changes to the proposed definition of “LMRO.”

Section 27.43a. **Reporting by local morbidity reporting offices of outbreaks and selected diseases.**

This section explains how LMROs are to report. The Department has also revised this section to reflect its changes to the proposed definition of “LMRO.”

Comment

The Department should review this section, and explain why various diseases have and have not been included in the section.

Response

The Department will address this comment in its response to comments on particular diseases.

Comment

There is no subsection (a) in this section, therefore, the Department should label subsection (b) as subsection (a).

Response

The commentator misread the proposed regulation. The section, as proposed, does include a subsection (a). There is no need to relabel subsection (b) as subsection (a).

Comment

Proposed subsection (b)(2) requires that the LMRO report cases of certain diseases, infections and conditions to the Department on the same day any of the listed diseases are reported to it or it finds out about those diseases. The Department should delete hepatitis A and meningitis from subsection (b)(2) and should add the words "food borne" before the word "botulism" in that subsection.

Response

The Department agrees with this comment, and has made the recommended changes. An urgent response to reports of hepatitis A and meningitis is not necessary due to the manner in which these diseases are transmitted.

Comment

The Department should add the following diseases, infections and conditions to subsection (b)(2): arbovirus disease, haemophilus influenzae invasive disease in a child under the age of 15 years, and Legionnaire's disease. Because of the serious nature of these diseases, action to intervene must be taken to prevent and control their spread in less than 5 days.

Response

The Department agrees with this comment, and has revised subsection (b)(2) to include the recommended changes.

Comment

The Department should add smallpox to subsection (b)(2) due to the possibility of its use in a terrorist attack.

Response

The Department agrees with this comment, and has revised subsection (b)(2) to include smallpox.

SUBCHAPTER C. QUARANTINE AND ISOLATION

Comment

The Department should clarify in the preamble how this subchapter applies to hospitals, or state in its regulations the circumstances under which health care facilities are required

to contact local health officials to confer about matters relating to quarantine and isolation. Hospitals routinely adhere to standards relating to isolation of patients and transporting them without notifying the Department or local health authorities. The Department does not need to have routine matters reported to it by health care facilities.

Response

Subchapter C has been in place in the form now being amended since 1979. Section 27.67 (relating to movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department) has, over the last 20 or more years, required a health care facility to secure the permission of a local health authority or the Department before moving a person under isolation or quarantine. The only substantive change to this section is to include movement of animals under isolation or quarantine to its requirements, which should have little impact on hospitals. The remainder of the amendments to this section are intended to update the terms used in the section, for example, changing “local health officer” to “local health authority.”

There is no need to clarify this subchapter. By law, the Department and local health departments are given broad authority by the General Assembly through the act to prevent and control the spread of disease. (See 35 P.S. §521.3 (relating to responsibility for disease prevention and control)). This includes the imposition of disease control measures, including isolation and quarantine, and the ability to set requirements for those control measures, necessary to prevent and control the spread of disease. (See 35 P.S. §§521.5, 521.7, 521.11, 521.16(a)(3)(4) and (5) (relating to control measures;

examination and diagnosis of persons suspected of being infected with venereal disease, tuberculosis, or any other communicable disease, or being a carrier; persons refusing to submit to treatment for venereal diseases, tuberculosis or any other communicable disease; and rules and regulations); see also 71 P.S. §536(b) (providing the Department authority to establish and enforce quarantines to prevent the spread of disease) and 71 P.S. §541(b) (providing the Department through the Board the ability to promulgate regulations for the health and protection of the people of the Commonwealth)).

While the Department recognizes that a health care facility has the responsibility for the individual patient, the Department has the responsibility for the safety and welfare of the entire public. It is necessary for the Department to be involved in matters relating to isolation and quarantine of persons with reportable diseases, regardless of whether these persons are currently in a health care facility, to ensure that the public's safety is considered as well as the patient's. Further, the Department has expertise in these matters which could benefit the health care facility.

If a disease, infection or condition is reportable under these regulations, the health care facility must report it as required under the regulations. The health care facility has no discretion in the matter. This requirement has also not changed over the years, although the list of diseases and the method of reporting may have changed somewhat. If the disease is one which requires isolation of the case or quarantine of the contacts, and the Department or a local health authority orders the isolation or quarantine, the health care facility must comply with the regulations and the Department or local health authority's

orders regarding control measures, if any are issued, or be in violation of the law. The Department will, of course, be cognizant of the expertise of the hospital's infectious disease staff, and will work with them to ensure that proper control measures are taken, as it currently does.

Section 27.60. Disease control measures.

This section lists the disease control measures that the Department or a local health authority may take, including any disease control measure that the Department or a local health authority considers to be appropriate for the surveillance of disease, when it is necessary to protect the public health. Actions of local health authorities that are not LMROs are conditioned upon the approval of the Department.

Comment

There is considerable controversy over the appropriateness and need for isolation of some infections. Many reports and articles provide a different approach for different facilities. There is concern that a long term care facility may find itself in conflict with the regulations, and be forced to accept the Department's interpretation of whether isolation was indicated, where and how much. Specifically the concern is with Methicillin resistant staphylococcus aureus (MRSA) and Vancomycin resistant enterococci (VRE), which are not often seen. It should be assumed that the requirements for disease control measures with respect to these diseases do not apply, since they are not reportable diseases and conditions. Also, a long-term care facility may isolate a salmonella case, but not always with the practice of universal standard precautions.

The Department's statement that it has the discretion to implement the most appropriate disease control measures for the situation is not accurate. This statement gives all the authority to the Department to determine the isolation requirements without any recognition of a facility's systems. The long-term care industry is currently burdened with Department-imposed two-step tuberculin skin testing for all employees. Neither the CDC nor the Occupational Safety and Health Administration (OSHA) imposes this requirement. Since the Department is not reasonable with respect to these requirements, long term care facilities have no confidence that the Department will be reasonable with respect to control requirements. The Department must give some recognition in this section for a health care facility's existing and regulatorily required infection control systems to prevent the future imposition of arbitrary and capricious measures.

Response

As discussed in response to general comments on this subchapter, the Department has statutory authority, regardless of existing systems within a health care facility, to require specific disease prevention and control measures as the Department's disease control experts find necessary to protect the fragile population resident in long term care facilities. The Department and local health departments will work first within a facility's existing infection control systems, which should be adequate for most outbreaks and cases. If, however, additional precautions are necessary, the facility must comply with the Department's orders in order to remain compliant with the law.

With respect to MRSA and VRE mentioned by the commentator, although these diseases are not specifically listed as reportable within 28 Pa. Code Ch. 27, if there is an outbreak of either, the outbreak is reportable. Upon being informed of the outbreak, the Department may take the steps it deems necessary to prevent and control the spread of disease. Further, these diseases are reportable under the Department's regulations relating to long-term care nursing facilities. See 28 Pa. Code §211.1(c) (relating to reportable diseases).

With respect to the issue regarding tuberculosis, the regulations of the Division of Nursing Care Facilities are not in conflict with the recommendations of the CDC. The regulations require a two-step PPD testing procedure, as the CDC recommends. In interpreting its regulations, the Department requires that long-term care facilities have policies and procedures in place to address individual situations, which may satisfy the two-step PPD test requirement. If a long-term care facility has implemented appropriate policies and procedures and the facility's Medical Director is willing to document that a complete two-step PPD test is not required for an individual employee, the Department will consider that when determining if the facility has met the regulatory requirements. Accordingly, the Department is not in conflict with CDC recommendations, but merely requires that each situation be addressed individually by a medical professional to assure the health and safety of the residents in a long-term care facility.

Comment

The last sentence of this section requires an LMRO to receive approval from the Department before taking disease prevention and control measures. The Department should explain how this is to occur, and whether the requirement needs to be in writing.

Response

This section requires only a local health authority that is not an LMRO to obtain approval from the Department. This is intended to ensure that those local health authorities without experience in dealing with disease control measures have the benefit of the Department's expertise before taking action. The Department has changed the last sentence of the proposed regulation to use the term "LMRO" rather than "local health department" since that is consistent with the remainder of the Department's regulations on disease control. The Department will contact the local health authority by telephone, facsimile, or in writing, depending upon the circumstances of the case and the urgency for action to be taken to control and prevent the spread of disease.

Section 27.67. Movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department.

This section requires certain actions to occur before persons or animals subject to quarantine or isolation by action of the Department or a local health authority can be moved from one place to another.

Comment

The Department should add the word “person” in front of the word “animal” in subsection (d) of this section.

Response

The Department agrees, and has revised the regulation.

**COMMUNICABLE DISEASES IN CHILDREN AND STAFF ATTENDING
SCHOOLS AND CHILD CARE GROUP SETTINGS**

This part of Subchapter C includes criteria for exclusion and readmission of children and staff in schools and in child care group settings, and lists the diseases and symptoms for which exclusion may occur. It also includes a section that requires exclusion from child care group settings if a child does not have the listed immunizations or immunities. The Department received several comments on the sections in this part of the subchapter. Several comments were directed at the substance of this part of the subchapter, rather than to a particular regulation.

Comment

The title of this part of the regulations uses terms like “children” and “staff” while the sections in this part use the term “pupils.” The Department should review this part for consistency, and use terms consistently.

Response

The Department agrees with the comment. It has amended the proposed regulations to use the terms “child and children” rather than “pupil,” and the phrase “staff having contact with children” rather than “staff.”

Comment

A physician or school nurse should not have to verify that criteria for readmission have been satisfied unless there is a question on the part of the school or child care group setting regarding whether the criteria have been satisfied. The criteria specified by the Department for readmission are very clear for most conditions, and to require a doctor or nurse to verify them would be a waste of time and resources. For example, physicians can do no more to ascertain the status of the child than a caregiver, who would ask the parents about whether the first crop of vesicles of chickenpox developed, and whether all the lesions have dried and crusted. Physicians and parents do not have to interact to confirm this status.

The times when a health professional needs to be included are clearly stated in the readmission criteria for conditions where such involvement is appropriate. Where negative culture tests are required, such tests require involvement of a health professional as stipulated in the exclusion criteria.

Response

The Department has not changed the proposed regulations in response to this comment. The disease situations listed in this portion of the regulations that require verification for readmission to a school or group child care setting by a physician or a school nurse are situations that pose serious medical consequences to the individual with the disease, and to those exposed to the disease, if the individual remains communicable. Where the regulations require verification by physicians or school nurses for readmission, that verification is necessary to prevent and control the spread of disease.

Comment

Nonpublic schools do not have full-time school nurses. There are no school nurses functioning in many nonpublic schools. If no other type of personnel is assigned to perform this function, how can children be readmitted?

Response

The Department has not changed the proposed regulations in response to this comment. Whether a school is public or nonpublic does not change the risk to children exposed to a communicable disease. Further, although a school nurse may not be stationed daily at a nonpublic school, school nurses are available from the district. If one is not due for a visit at the time readmission criteria must be verified, the private school may request that one come to the private school for that purpose. The law requires that the school district make health services available to public and private school children. (See 24 P.S. §14-1402(a)). School nurses are made available to nonpublic schools by the school district

(id. at (a.1); 28 Pa. Code §23.51) (relating to children to be provided school nursing services)). The number of school nurses to be provided within a school district is calculated based on the number of private and public school children within that district. (See 24 P.S. §14-1402(a.1)). Therefore, by law, there must be access to school nurse services by children of private schools. Further, as the regulations state, in the absence of a school nurse, a physician's certificate is acceptable.

Comments

To require verification by a school nurse is a problem, because public schools do not have school nurses in every building every day. Further, the function of a school nurse is to focus on children, not the employees of the school.

Given the concern over lack of school nurses, why is verification of the criteria for readmission limited to a school nurse or a physician? Would verification from other medical personnel meet the requirements?

Response

The Department has not changed the proposed regulations in response to these comments. As is the case with private schools, if a school nurse is not present in a particular building, he or she may be sent for to verify readmission criteria. Again, a physician's verification need not be re-verified by a school nurse. Lastly, Article XIV of the Public School Code of 1949 (24 P.S. §§14-1401-14-1422), which addresses school health services, includes requirements for the health of school staff. (See 24 P.S. §14-

1418). If the staff in contact with children have a communicable disease of the type listed in the regulations, the health of the children with whom that staff are in contact could be compromised. To prevent and control the spread of disease within the school community, the health of all members of that community must be monitored. Infected staff can infect children.

Comment

The Department should reconcile the exclusionary language in this part of the regulations with the CDC's Personnel Health Guidelines which were published on September 8, 1997.

Response

The Department has not changed the proposed regulations in response to this comment. The guidelines to which the commentator refers are guidelines for hospital-based infection control. The Department's requirements are broader in this particular part of the regulations, in that they are directed toward prevention and control of the spread of disease in schools and child care group settings. The difference in setting requires a different approach. Individuals in a hospital setting are exposed to more virulent and different types of infections and are more likely to be in a fragile state susceptible to transmission of disease.

Comment

The Department should change the language of §§27.71 through 27.75 to read “children in child care and pupils in schools,” and add the words “child care group settings” and “care giver” to the sections. The reference to §§27.71 through 27.75 in §27.76 (relating to exclusion and readmission of children, and staff having contact with children, in child care group settings) would then be unnecessary.

Response

The Department has not changed the proposed regulations in response to this comment. The Department is satisfied with the language in §27.76 that expressly applies §§27.71 through 27.75 to child care group settings, with appropriate modifications.

Comment

The Department should make immunization delivery a reportable event, as the City of Philadelphia has done. This would allow future implementation of a Statewide immunization system, or registry. The language allowing for this should permit all health care providers or insurers to report, and should include immunity for violations of privacy and confidentiality of medical records.

Response

The Department is taking this comment into consideration. However, given the many serious issues surrounding the actual development and implementation of a registry process, more time is needed to consider the possibility of a registry, and how it would be

implemented. For example, issues concerning whether persons other than the Department would have access to the registry, how that access would occur, whether or not patient consent to be a part of the registry must be obtained, and how registration would occur, must be taken into account. More public comment should be invited than is possible at this stage in this rulemaking process. Further, the Department could not create immunity for providers and insurers from privacy and confidentiality laws, without having the statutory authority to do so. If the Department decides to pursue implementation of reporting of immunization delivery, the most appropriate way to do so is through separate rulemaking.

Section 27.71. Exclusion of children, and staff having contact with children, for specified disease and infections conditions.

This section requires exclusion of children, and staff persons who have contact with children, from school when a physician or school nurse suspects that individual of having any of the communicable diseases, infections or conditions listed in the section.

The Department has made a revision in paragraph (5), with respect to the exclusionary requirements for rubella. The proposed regulations had changed the number of days from the onset of rash from 4 to 7. The number should have remained 4.

Comment

The Department should add *Neisseria meningitidis* to the list of diseases for which children and staff having contact with children are excluded. The exclusion should last

until the person is made noninfective by a course of rifampin or other drug which is effective against the nasopharyngeal carriage state of this disease, or until otherwise shown to be noninfective. This requirement is included in child care group settings, but is missing from this regulation relating to schools.

Response

The Department agrees with this comment, and has added the disease to the regulation.

Comment

The Department should clearly define what adults are affected by these sections. What does contact with pupils mean? Does a staff person who has contact with pupils mean only teachers and administrators, or does it also include custodians, cafeteria workers, and bus drivers? The Department should develop a definition of school employee that indicates who is to be excluded from the definition, and who included in it. The Department could define a "school employee" as an individual employed by a school. This definition would include an independent contractor or employee, and would exclude an individual with no direct or routine interaction with students.

Response

The Department's use of the phrase, "staff having contact with children," is meant to include all persons present in the school to perform duties for the school -- volunteers, employees, and independent contractors -- who come into contact with children. To clarify this for the public, the Department has added language to the regulations

referencing volunteers, along with a general definition of "volunteer" in §27.1 (relating to definitions).

Further, the Department has intentionally used the phrase "having contact with children" and has not qualified the contact as routine or indirect. The regulations include every person performing duties for the school, paid or unpaid, who has any contact with children. Even a nonroutine or indirect contact of an infected person with a very young child, depending upon the circumstances of that contact, can and has caused severe illness in the child. If the school has knowledge of or a suspicion that the person has one of the diseases, infections or conditions included in the regulations, that person is to be excluded. This is necessary to prevent transmission of illness between staff, including volunteers, and the children, illness which, in some cases, may result in death or serious disability.

Comment

It is not clear if volunteers are meant by the Department's use of the phrase "staff having contact with children," although the preamble to proposed rulemaking did say that they were. The regulations do not include the word "volunteer." Volunteers should not be included in these regulations, since these people are present at the school at different times throughout the school year. It would be difficult for school personnel to medically monitor these persons and comply with exclusion and readmission requirements that are more appropriately directed to students and to school employees. The Department should eliminate any requirement that volunteers be covered, but should include language that

emphasizes the ability of the school staff to exclude these volunteers if a health risk is present.

Response

The Department has explained why volunteers are covered in prior responses to comments. The requirement under the regulations is, as the commentator has suggested, to exclude these persons if the school believes there is a health risk present. Once excluded, the individual cannot be readmitted unless the requirements of the regulation are followed.

Comment

Specific time frames for readmission are not mentioned under these diseases. If a specific time frame is satisfied, is it necessary to incur the expense of an additional doctor's visit? Wouldn't verification by a nurse or physician's assistant be satisfactory? This is more easily obtained and less expensive.

Response

The Department has not changed the proposed regulation in response to this comment. The text following most of the diseases listed in this section does include specific time frames for readmission running from a specific event in the course of the disease. The Department has provided a time frame for readmission for the remainder of the listed diseases predicated upon a specific event readily ascertainable which occurs in the course of the disease.

With respect to the comment asking whether verification of readmission criteria by a nurse or physician's assistant would be sufficient, the Department has already explained its reasons for requiring verification by a school nurse or physician in its response to general comments on this portion of the regulations relating to requirements for schools and child care group settings.

Section 27.72. Exclusion of children, and staff having contact with children, for showing symptoms.

This section requires exclusion of children and of staff having contact with children who are showing the symptoms listed.

Comments

The Department is to be commended for including language that is consistent with currently published National standards.

The Department should include diarrhea as a symptom permitting temporary exclusion of a pupil or staff person from a school or college to the extent the person may represent a communicable disease risk. The language would then be consistent with §§27.76(a)(3), 27.154(6) and 27.155(6) (relating to exclusion and readmission of children, and staff having contact with children, in child care group settings; restrictions on caregivers in a child care group setting; and restrictions on health care practitioners).

Response

The Department agrees with the latter comment and has added persistent diarrhea as a symptom for which exclusion is required.

Comment

A child who has a fever or is vomiting would have to be excluded under this section. This would require a child to be seen by a physician or school nurse whenever they have an upset stomach in order to be readmitted.

Response

The symptoms chosen by the Department to require exclusion were intended to be those that could be associated with a serious communicable illness of a child. For example, the Department requires exclusion of a child for a fever when the fever is equal to or greater than 102 degrees Fahrenheit. The Department has changed the regulation to require exclusion for persistent vomiting rather than a single incident of vomiting for the reason raised by the commentator.

Comments

It is not practical to expect schools to keep abreast of what constitutes an unusual rate of absenteeism as published in the *Pennsylvania Bulletin*.

The term “periodically” in subsection (b), which states that the Department will periodically determine and publish what increase constitutes an unusual rate of

absenteeism, is unclear. Will this be quarterly, annually or monthly? The Department should establish a time frame and say where the information will be published.

Response

The Department has deleted this statement from the regulation. A school may determine itself what constitutes an unusual rate of absenteeism, by a review of its records relating to absenteeism.

Comment

Subsection (b) requires schools to maintain records of exclusion of staff and students. This language is broad. Does a school have the authority to determine what an unusual rate of absenteeism is, and how often would it review its records to determine this rate? Development of guidelines and forms by the Department would be helpful to assist in these new record keeping duties. Will school districts be required to submit reports to the Department? The language implies this, but does not require it. The Department should clearly state that schools must submit the information, and specify the reporting process

Response

The regulation neither requires a school to submit records of exclusion or rates of absenteeism to the Department, nor specifies regular review periods for the records. The Department does not want this information reported on a regular basis. The Department expects that when a school notices something unusual occurring with respect to the number of children being excluded or absent, the school will review its records, and

notify the Department through the disease reporting process. There are no special forms for this report.

As stated previously, the Department, through this chapter, intends to obtain the widest variety of information available on possible outbreaks of disease. One possible avenue for this information is through absenteeism rates at schools. If the school fails to notice something unusual, it is possible that the Department could locate the outbreak through other reporting sources. It is also possible, however, that information from a school could provide the Department with early warning of a problem in the community.

Section 27.73. Readmission of excluded children, and staff having contact with children.

This section sets standards for readmission into a school of children, and staff having contact with children, who were excluded under §§27.71 and 27.72 (relating to exclusion of children, and staff having contact with children, for specified diseases and infectious conditions; and exclusion of children, and staff having contact with children, for showing symptoms).

Comment

The first part of subsection (a) should be deleted, since the exclusion criteria that require health professional decisionmaking are already included in the criteria for the specific conditions and symptoms.

Response

The Department has not changed the proposed regulation based on this comment. The Department believes the language is necessary for the clarity of the section.

Section 27.74. Readmission of exposed or isolated children, and staff having contact with children.

Section 27.75. Exclusion of children, and staff having contact with children, during a measles outbreak.

The Department received no comments on §§27.74 and 27.75. The Department has, however, revised these sections consistent with revisions it has made to other sections in Subchapter C. The Department has added language to both of these sections to ensure that volunteers are covered by their provisions, and has clarified that the Department is concerned with all staff having contact with children, as it has in the other sections in this part of Subchapter C.

Section 27.76. Exclusion and readmission of children, and staff having contact with children, in child care group settings.

This section includes exclusion and readmission criteria for children and staff in child care group settings.

Comment

How will staff and management in a child care group setting be able to screen and diagnose children for exclusion? How will they be able to report at the same level as a health care facility?

Response

The regulations do not require management and staff to diagnose diseases, infections and conditions. If management or staff suspect that a child in the child care setting has one of the diseases, infections or conditions listed in the regulations for which a child or staff person must be excluded, or is showing signs and symptoms of that disease, infection or condition, or if the parent or guardian makes the child care group setting aware that the child has a disease, infection or condition for which the child must be excluded, then the child should be excluded. The same reasoning should be applied to staff. Readmission is contingent upon verification from a physician that the criteria for readmission have been satisfied.

The Department has revised subsection (b)(3) to clarify that the child care group setting must ensure that the condition which required exclusion has been resolved before the child may be readmitted.

Comment

Diarrhea should be deleted from the list of conditions that require physician approval for readmission to the child care group setting. A physician will determine whether there has

been resolution of the condition by asking the patient if the symptoms have subsided. A child care operator can do this as well as a physician. The requirement for readmission should be retained, but physician approval should not be required.

Response

The Department has changed the wording of subsection (a)(3) to require physician approval only if persistent diarrhea occurs. Since persistent diarrhea is most likely an indication of disease, unlike the incidence of sporadic diarrhea, the Department believes that a physician's approval is necessary to determine the nature of the disease and its resolution. Further, physician verification is required under this subsection when diarrhea is coupled with other symptoms or circumstances. Both together are evidence of serious illness, rather than a minor stomach condition.

Comment

The requirement in subsection (a)(3) that a person be excluded for diarrhea when associated with an identified bacterial or parasitic pathogen is too broad. Children and staff who are carriers of *Giardia lamblia* do not need to be excluded from child care. Similarly, asymptomatic children with salmonella other than *s. typhi* in their stools do not need to be excluded.

Response

The Department has not changed the proposed regulation in response to this comment. The presence of a bacterial or parasitic pathogen is only cause for exclusion under

subsection (a) when it is coupled with persistent diarrhea. (The Department has changed the term “diarrhea” to “persistent diarrhea” to evidence a serious illness, as has been discussed.) Therefore, asymptomatic children would not be excluded under this provision; the only children who would be excluded would be children who had a persistent symptom. The persistent symptom, diarrhea, particularly when it occurs among very young children, can easily transfer infection by hand-to-mouth contact.

Comment

Subsection (a)(8) should say “influenzae” rather than “influenza.” However, there is no reason to exclude children or staff members from a child care group setting for H. influenzae disease.

Response

The Department agrees, and has deleted the text of proposed subsection (a)(8). Cases are no longer infectious 24 hours after antimicrobial treatment begins. At that time, the child would pose no threat of infection to other children. Prior to treatment, the child will be obviously ill, and will either be kept home by parents or guardians, or will fall under another exclusionary provision of the regulations..

Comments

Subsection (b)(3) requires a caregiver to screen every child for the presence of a condition that requires exclusion. This would require the caregiver, or a school perhaps, to screen for all diseases listed as well as symptoms. This is unreasonable, burdensome,

costly and time consuming. This would require a child to be subjected to a daily medical examination. How would this be administered?

Does this mean a caregiver would have to screen a child every day for the presence of an exclusionary disease, or only if the child is suspected of having a disease?

The Department should clarify whether the caregiver is required to make an accurate diagnosis of the child's condition, or is to screen for symptoms of the child's condition.

Response

This subsection does not apply to schools. This subsection applies when children are returned to a child care group setting following an exclusion under the regulations. The Department realizes that the proposed paragraph reads otherwise, and has revised it so that it clearly applies only when a child is returned to a group care setting following an exclusion.

Comment

How will the caregiver report the presence of an exclusionary disease to the Department? Is there a form required by the Department? The Department must fully explain how to report.

Response

This section deals with exclusion and readmission of children and staff having contact with children in a child care group setting. Child care group settings are required to report diseases, infections and conditions under §27.23 (relating to reporting of cases by persons other than health care practitioners, health care facilities, veterinarians or laboratories). Reporting is done in accordance with §27.4 (relating to reporting of cases). The time frames in which reports must occur are included in §27.21a (relating to reporting of cases by health care practitioners, health care facilities and laboratories). Further discussion concerning case reporting is included in the Department's responses to comments on §27.4 (relating to reporting of cases).

A person who has a question concerning the appropriate reporting requirements may call the Department's district office or the local health department in the area in which the person is located.

Section 27.77. Immunization requirements for children in child care group settings.

This section requires children in child care group settings to have certain immunizations, and sets standards for excluding those children from the setting for failure to obtain those immunizations.

Comment

DPW governs the development, implementation and enforcement of regulations in this area. Operators of child care group settings will take the information provided by the Department relating to disease control and prevention in an effort to improve quality of care. The Department's regulations, however, conflict with standards being followed by home-based providers in the area of procedures involving such matters as communicable diseases.

Response

The Department has not changed the proposed regulation in response to this comment. Although DPW may be licensing agency for child care homes, the Department is the agency with the authority, delegated by the General Assembly, to prevent and control the spread of disease throughout this Commonwealth. The Department has the broad authority to take the necessary steps to prevent and control the spread of disease. The Department has worked and will continue to work with DPW to ensure that entities licensed by that agency are aware of reporting requirements.

Comment

There is no separate definition for schools or child care providers, rather, there is a single definition for child care group setting. Since the exemption provision in subsection (d) references schools, this implies that a child care group setting includes a school, unless specific exemptions are included in the language.

Response

Section 27.77 does not apply to schools. This is made clear under subsection (d). Regulations relating to exclusion of children from schools for failure to obtain immunizations already exist. See 28 Pa. Code §23.85 (relating to responsibilities of schools and school administrators) and 22 Pa. Code §§11.20 and 51.13 (relating to nonimmunized children; and immunization). There is no need to promulgate regulations twice on the same topic.

Comment

The documentation of vaccination status under subsection (a) would impose a heavy administrative burden on the child care group setting, and would require a level of expertise that cannot be met with the resources currently available to child care group settings. These settings do not have health professionals available to help with immunization record checks.

Response

The Department has not changed the proposed regulation in response to this comment. The Department must monitor to ensure that child care group settings are complying with the regulations, so that children within those settings are adequately protected from disease. The burden should be small on many child care group settings, since group child day care facilities licensed by DPW already are required to do health screening under the DPW regulations, and report to DPW concerning vaccination status. (55 Pa. Code §§3280.1-3280.221). These regulations require that a facility licensed by DPW conduct a

health assessment of each child according to guidelines set by the American Academy of Pediatrics (AAP), and that a report be written that includes, among other things, a review of the child's immunization status according to AAP standards. 55 Pa. Code §3280.131(b), (c), and (d)(5). Therefore, child care group settings should have little difficulty in complying with the Department's regulations requiring documentation of a child's vaccination status.

Comment

The Department should consider using our software product to gather and track immunization information to other child care group settings not now under surveillance, as DPW does for its purposes.

Contrary to the Department's assessment in the preamble to proposed rulemaking of additional resources needed to implement the regulations, it will require additional resources to run immunization reviews in child care settings. We are moving with DPW to require the full set of DPW's required forms from facilities. DPW has been working on this for years. Interfering with this careful groundwork and already operational system would be wasteful and regressive.

We recommend that the Department and DPW work together collaboratively to develop, support and internalize existing systems of medical record checking that includes all recommended preventive health services (vaccinations and screening tests) as is now done by the commentator's software package.

Further, the child care facilities that must report under these regulations do not have resources available to perform these recording and reporting functions. Implementing the regulations will require the use of software that can apply complex decision rules about when vaccine should be received at varying ages, and that can track this information. We have developed tools to help accomplish this.

Response

The Department declines to discuss the appropriateness of a particular software product in the context of its regulations. Any comment made by the Department could be viewed as circumventing the established bidding process for products and services, should one be instituted. The Department is currently incorporating a Statewide immunization information system into public clinic sites, and the information gathered through this regulation will be part of that system. This system will enable certain approved health care providers to easily access a child's immunization history, hopefully preventing unnecessary vaccinations, and facilitating the updating of a child's immunizations. For the present time, however, this immunization record will continue to be a paper record.

Comment

Subsection (a)(4) requires the caregiver to update certificates of immunization periodically. The term "periodically" is unclear. The Department should include a time frame.

Response

The Department is requiring certificates of immunization to be updated when new information regarding immunization is obtained. The Department has revised subsection (a)(4) to state that.

Comment

The Advisory Committee on Immunization Practices (ACIP) standards cited by the Department were superceded on January 1, 2000. New recommendations are made each January. The existing DPW section references the existing standard, and therefore requires no revision.

Response

The Department has not changed the proposed regulation in response to this comment. The Department has accepted the standards in place on January 1, 2000, not the recommendations for immunization based upon those standards. Subsection (b)(2) states that the Department will deem an ACIP recommendation pertaining to the immunization of children to satisfy the standards of the subsection unless ACIP eliminates a standard and the recommendation is issued under the altered standards. This means that if ACIP recommends a new immunization in January of 2002, as long as that immunization meets the standards set in subsection (b)(1), children in child care group settings are required to have that immunization.

**SUBCHAPTER D. SEXUALLY TRANSMITTED DISEASES, TUBERCULOSIS
AND OTHER COMMUNICABLE DISEASES.**

Section 27.84. Examination for a sexually transmitted disease of persons detained by police authorities.

This section tracks section 8(a) of the act (35 P.S. §521.8(a)) and sets standards for requiring persons detained by police authorities to be tested for sexually transmitted diseases.

Comment

Subsections (a) and (b) state that if a person refuses to undergo an examination or submit a specimen, the Department or a local health authority may take judicial action to secure an appropriate remedy. What does the phrase “appropriate remedy” mean?

Response

The phrase, when taken in conjunction with the previous phrase, means that the Department or a local health authority may ask a court of competent jurisdiction for a variety of relief. It may petition, as provided for in sections 7 and 11 of the act (35 P.S. §§521.7 and 521.11), for an order requiring examination, and, if necessary, treatment. It may prosecute the individual under section 20 of the act (35 P.S. §521.20). It may petition the court for any appropriate remedy to allow it to enforce the requirements of the act, which require an individual taken into custody and charged with a crime involving lewd conduct or a sex offense, or any person to whom the jurisdiction of a juvenile court attaches, to be examined for a sexually transmitted disease. (See 35 P.S. §521.8). The Department will determine the appropriate remedy to pursue, if any,

depending upon the case. Since the matter would be before a court, the individual against whom the petition is filed would have the opportunity to challenge the Department's requested relief. The relief granted will ultimately be up to the court.

Section 27.87. Refusal to submit to treatment for communicable diseases.

This section sets out the actions the Department may take if a person refuses to submit to treatment for a communicable disease. It is based on section 11 of the act (35 P.S. §521.11).

Comment

The Department should revise the second sentence of subsection (b), as it is long and complex.

Response

The second sentence of subsection (b) reads as follows: "Upon the filing of a petition, the court shall, within 24 hours after service of a copy upon the respondent, hold a hearing without a jury to ascertain whether the person named in the petition has refused to submit to treatment." The Department believes that this sentence is clear as it is written.

Comment

Subsection (b) states that the Department or a local health authority may file a petition in the court of common pleas of the county in which the person resides asking the court to commit the person to “an appropriate institution.” What is “an appropriate institution?”

Response

The type of institution appropriate for quarantining an individual will depend upon the person, the type of disease in question, and the availability of places to which the person may be committed. For example, for one case of multi-drug resistant tuberculosis, where the individual involved was known to have drug and alcohol problems, the Department recommended to the court that the individual be sent to a drug and alcohol abuse treatment facility. The Department could recommend that the individual be placed in a hospital, or the individual’s home, or some other type of institution, depending upon the circumstances and the available resources. The Department, or a local health authority, may recommend a type of institution for commitment, however, the court must approve that placement. The individual does have the opportunity before that court to object to the Department’s or local health authority’s recommendation. A copy of the petition must be served on the individual who is the subject of the petition. 35 P.S. §521.11(a.2).

Section 27.89. Examinations for syphilis.

This section includes standards for examinations for syphilis. Subsection (a) requires testing in the third trimester of pregnancy when the woman resides in a county where the annual rate of infectious syphilis is at a rate of syphilis occurring in a given population

for which the CDC has determined it is cost-effective to require special precautions.

Subsections (b) and (c) require testing of a woman who has had a live or stillbirth under the same circumstances.

The Department has added language to subsection (a)(1) to clarify that it is the person attending the pregnant woman who is to explain the importance of the syphilis test, and not the laboratory technician seeking to draw her blood.

Comment

In subsections (a), (b) and (c) the Department has stated that it will publish in the *Pennsylvania Bulletin*, as necessary, the rate of syphilis at which the CDC determines it is cost-effective to require special precautions. What is the purpose of publishing the rate of syphilis? What criteria will be used to determine when it is necessary to publish the rate of syphilis?

Response

The purpose of publishing this rate in the *Pennsylvania Bulletin* is to alert health care providers that a syphilis test is required to be done in their county based on the rates at which the CDC has determined that it is cost-effective to require special precautions.

To make it easier for physicians, the Department has stated in the section that, rather than publishing the rate determined by the CDC, the Department will publish a list of the counties in which that rate occurs. Reporting is only required in those counties where the

annual rate of infectious syphilis is equal to or greater than the rate determined by the CDC.

At the present time, only Philadelphia has a rate of syphilis above the CDC-established rate. Therefore, these specific requirements will only apply to Philadelphia at the present time. This standard enables the Department to broaden surveillance to prevent congenital syphilis in the event the established CDC rate is exceeded elsewhere.

Section 27.96. Diagnostic tests for sexually transmitted diseases.

This section sets standards for tests used to determine the presence of a sexually transmitted disease.

Comment

This section should be deleted, since a separate section for standards is not required. Diagnostic tests for all diseases should be done following standard or approved test procedure, including using FDA approved tests where applicable.

Response

The Department has not changed the proposed regulation in response to this comment. The act requires that the standard or approved test procedures for each of the sexually transmitted diseases be a test approved by the Department, and that if a laboratory test is part of the approved procedure, it be done in a laboratory approved by the Department to make such tests. (See 35 P.S. §531.12).

Section 27.97. Treatment of minors.

This section includes language from section 14.1 of the act (35 P.S. §521.14a) and 35 P.S. §10103, both of which provide for a minor to give effective consent for certain medical and health services without the consent of any other person. Section 14.1 and 35 P.S. §10105 also state that a physician who provides treatment under the given circumstances is not liable for properly administering appropriate treatment to the minor.

Comment

The Department should add language to this section defining health services to include venipuncture and clinical laboratory testing. The section should also state that a laboratory may not be sued or held liable for venipuncture or testing services if the minor consents.

Response

The Department has not changed the proposed regulation in response to this comment. Pursuant to statute, a minor can give consent for “medical and health services to determine the presence of or to treat pregnancy, and venereal disease and other diseases reportable under the [act]” (35 P.S. §10103). Since neither the Department nor local health authorities enforce this statutory provision, it is up to the individual health care provider to determine whether the phrase, “to determine the presence of” would include venipuncture and laboratory testing, so that consent of a minor would be sufficient. The Department cannot provide clinical laboratories with immunity through

regulation. Only the General Assembly can grant immunity, which it has done in this case to physicians who act appropriately under the statute, and provide appropriate treatment. (See 35 P.S. §§521.14a and 10105). The legislature has not seen fit to extend that immunity to clinical laboratories.

Comment

This section raises serious concerns. The regulations the Department is amending allow for consent for treatment for venereal disease, however, these regulations broaden it to all communicable diseases. A minor could give consent to a cancer workup without parental consent. The Department must be cognizant of parental rights. There should be further legal review of this section.

Response

Further legal review is unnecessary. The General Assembly has already directed through 35 P.S. §§10101 – 10105 that a minor may consent to medical and health services for pregnancy, sexually transmitted diseases, and other diseases reportable under the act (35 P.S. §10103), or when an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's health (35 P.S. §10104). The regulation tracks these statutes. The Department has not changed the proposed regulation.

Section 27.98. Prophylactic treatment of newborns.

This section requires the application of certain medications to the eyes of a newborn child, unless the parent or guardian objects for religious reasons.

Comment

The Department should add “or if in the opinion of the attending physician treatment is not advisable,” before the phrase “prophylactic treatment shall be withheld.”

Response

The Department agrees with the comment. The addition of the language is necessary to take into account the health and safety of the newborn. The Department has added the language to the regulation.

Section 27.99. Prenatal examination for hepatitis B.

Subsection (a) requires a pregnant woman to undergo immunologic testing for the presence of hepatitis B antibodies, but permits her to object to the testing on religious grounds. Subsection (b) requires that, if the mother tests positive for hepatitis B surface antigens, the baby receive prophylactic treatment, and again provides a religious exemption.

Comment

The Department should delete the religious exemption from subsection (b). No parent has ever expressed a religious objection to treating the infant for exposure to its mother’s hepatitis B in order to prevent chronic disease in the infant. It seems unlikely that this could be challenged in court.

Response

The Department has not changed the proposed regulation in response to this comment. The fact that the commentator is not aware of the challenge of any parent or guardian to this treatment of the newborn does not mean that a parent or guardian does not have the right to reject medical care for the child. The Department must take that right into account in writing its regulations, and cannot mandate the treatment of the infant in this instance. The regulation does not prevent the hospital or attending physician from challenging the objection of the parent or guardian in a court of law, if they feel it is necessary to do so.

SUBCHAPTER E. SELECTED PROCEDURES FOR PREVENTING DISEASE TRANSMISSION.

Section 27.151. Restrictions on the donation of blood, blood products, tissue, sperm and ova.

This section sets standards for the donation of certain materials from the human body.

Comment

In subsection (a), the Department should add the words “or suspected” to the phrase “a person known to be infected with the causative agent of a reportable disease”

Response

The Department agrees with this recommendation, and has added the words “or suspected of being” to the regulation.

Comment

In subsection (b), the Department should add “from a person known or suspected of being infected with the causative agent of a reportable disease” before “for donation” and “and” before “without obtaining.” If the donor who has the infection is prohibited from donating, the receiving agency should also be prohibited from accepting the donation. Screening tests will prevent donations from persons with HIV, hepatitis B and C, but from none of the other diseases.

Response

The Department agrees with the comment, and has added the recommended language “from a person known or suspected of being infected with the causative agent of a reportable disease.”

Section 27.152. Investigation of cases and outbreaks.

This section states that the Department or a local health authority may investigate any case or outbreak that either believes is a potential threat to the public health. It also requires cooperation with the investigator from health care practitioners, facilities, other institutions and the public, provided that the representative presents documentation establishing that he or she is an authorized representative.

Comment

What type of documentation is required to establish that the person is an authorized representative of the Department or a local health authority? Is a name tag sufficient to meet this requirement?

Response

An official form of Department or local health authority identification would be sufficient. Department staff have photo identification cards, but do not wear name tags. A letter bearing official signatures would also be sufficient. For example, Department staff will often carry a letter from the Secretary of Health on Department stationary when attempting to require compliance with a drug treatment regimen for tuberculosis. Any method which clearly establishes that the person performing the investigation is a representative of the Department or a local health authority is acceptable.

Section 27.153. Restrictions on food handlers.

This section limits the ability of persons with the listed diseases or conditions to work as food handlers.

Comment

The Department should reconcile the requirements of this section and of §27.154 (relating to restriction on caregivers in a childcare group setting) with the CDC's Personnel Health Guidelines that specifically deal with the prevention of nonsocomial

transmissions of selected infections. In particular, the Department should reconcile the differences with respect to hepatitis A and diarrhea.

Response

The Department has not changed the proposed regulations to address this comment. The guidelines referred to by the commentator were crafted for hospital settings and are concerned with nosocomial transmissions of disease. The Department sees no conflict between its regulations, drafted to meet more general public health requirements, and those guidelines. The Department is available to provide guidance on these issues as is necessary.

Comment

The use of the term “diarrhea” in this section and §27.154 is outdated. That term should be replaced with the term “gastroenteritis.”

Response

The Department has not changed the proposed regulation in response to this comment. The term “diarrhea” most accurately describes the symptom with which the Department is concerned. The term “gastroenteritis” is a general description of a variety of illnesses, and does not convey the need for a demonstrative symptom which may be measured.

Comment

The Department should add “or paratyphi” after “typhi” in paragraph (4) of this section. The same revision should be made to §§27.154 and 27.155 (relating to restrictions on caregivers in a childcare group setting; and restrictions on health care practitioners).

Response

The Department agrees that paratyphi should be added to paragraph (4) of each of these three sections. The Department has revised all three sections accordingly.

Section 27.154. Restrictions on caregivers in a child care group setting.

This section limits the ability of persons with the listed diseases or conditions to work as caregivers in a child care group setting.

Comment

Diarrhea should be deleted from the list of conditions that require physician approval for readmission to the child care group setting. A physician will determine whether there has been resolution of the condition by asking the patient if the symptoms have subsided. A child care operator can do this as well as a physician. The requirement for readmission should be retained, but physician approval should not be required.

Response

The Department has not changed the proposed regulation to address this comment. The Department has addressed the comment in its response to a similar comment on §27.76

(relating to exclusion and readmission of children, and staff having contact with children, in child care group settings).

Section 27.155. Restrictions on health care practitioners.

This section limits the ability of persons with the listed diseases or conditions to work as health care practitioners.

Comment

The Department should provide education sessions regarding disease reporting across the Commonwealth. There are differences in how various local health authorities and other health departments work with health care practitioners and health care facilities in disease reporting, the presence or absence of a county health department dictates the way diseases are reported, and special requirements for certain diseases exist. It would be beneficial for the Department to discuss its plans regarding electronic reporting, to review the forms required, and to provide contacts and telephone numbers for each county as appropriate.

Response

The Department agrees that education regarding disease reporting would be beneficial, to acquaint practitioners and facilities with disease reporting requirements. The Department will provide a list of LMROs, which will include the county/municipal health departments, upon request. A more detailed discussion of the Department's plans

regarding electronic reporting is included in its response to the general comments on these regulations.

Comment

The Department should include a hospital-based infection control practitioner on the Department's task forces or on the Advisory Health Board to ensure that the perspective of health care facilities are considered and addressed.

Response

The members of the Advisory Health Board are appointed by the Governor, and, by statute, must fall within certain specified categories. The Board is to be comprised of 13 members, including the Secretary of Health, 5 of whom must be physicians, 1 a dentist, 1 a pharmacist, 1 a registered nurse, and 1 an engineer. (71 P.S. §158). The Department agrees that an individual with experience in facility-based infection control could be an asset to the Board, and will consider recommending such an individual to the Governor for appointment once an appropriate vacancy occurs.

The Department does, however, have doctorate level staff, including physicians, with expertise in infectious disease control. These persons do discuss issues with hospitals and their infectious disease staff.

Comment

Is there a more comprehensive way to describe a potentially infectious case of diarrhea versus a one day condition due to a known strain of influenza than the language in paragraph (6)? Paragraph (6) also suggests that an evaluation by a physician is necessary for readmission to work as a health care practitioner. The Department may wish to consider defining the term “resolved.”

Response

The Department’s intent was to address only potentially infectious diarrhea in this section, and in §§27.153 and 27.154. Therefore, the Department has changed the listed condition to “persistent diarrhea” to clarify this intent.

Section 27.158. Special requirements for shigellosis.

This section prohibits household contacts of persons with shigellosis who have certain employment that could expose others to the disease from performing that work until the requirements of the section are met.

Comment

The Department should define the term “household contact” or provide examples.

Response

The Department has added a definition of “household contact” to the definition section of the regulations. The term is intended to apply to any person living in the same residence as a case, whether or not the individual is related.

Section 27.161. Special requirements for tuberculosis.

This section includes standards for the isolation of persons with tuberculosis, and requirements for testing close human contacts of that person.

Comment

Subsection (b) defines a close human contact as a person who spends a substantial amount of time with the person who has infectious tuberculosis. The term “substantial” should be deleted, and a specific time frame included.

Response

There are no definite guidelines published by the CDC on time frames for determining who is a “close contact.” Further, what constitutes “substantial” could differ depending upon who the other individuals are and the circumstances surrounding the case. For example, a young child is more susceptible to contracting tuberculosis than an older person, and less time in contact with the infected individual could be necessary for a child to contract the disease. Therefore, it would be impossible to specify a definite time frame in the regulations. “Substantial,” as used in this section, means anything more than casual contact. However, the Department must be able to determine who are close human contacts and who are casual contacts on a case-by-case basis, based on the characteristics of the individuals and the circumstances surrounding the contact.

SUBCHAPTER F. MISCELLANEOUS PROVISIONS

Section 27.183. Occurrence of psittacosis.

This section requires certain disease prevention and control measures to occur when a case of psittacosis is found in humans or in birds.

Comment

The Department should add a subsection (c) that states:

“A bird with psittacosis that has been placed under quarantine may not be sold or removed from its isolation quarters until it has been treated for at least 7 days. After 7 days, it may be sold, but the buyer must be made aware in writing with a signed receipt of the significance of psittacosis and the signs and symptoms for which to look. The signed receipt paperwork will include a copy of any documents provided to the new owner, and will be maintained at the place of sale for 6 months after the sale of the quarantined bird. The duration of additional treatment necessary must be established at the time of sale, and a supply of medicated feed sufficient for the duration of the treatment must be provided to the new owner.”

Response

The Department agrees with this recommendation, and has added the language. This requirement is a National practice standard relating to psittacosis, and has been added to the CDC’s compendium on psittacosis.

Section 27.201. Disposition of articles exposed to contamination.

This section includes requirements for the disposition of bedding, clothing, or other articles that have been exposed to contamination from specific communicable diseases.

Comments

The Department should explain why it has deleted certain diseases and added others to this section.

The Department should retain references to smallpox (variola, varioloid) in this section, since there is the possibility of a bioterrorist attack using this infectious agent.

Response

The Department agrees with the latter comment, and has reinstated references to smallpox (variola, varioloid) into this section. Because the Department is not deleting any diseases from the section, no further response to the first comment is necessary.

Comment

The Department should explain or reference what a proper precaution to be taken is when there is a transmission of articles that have been contaminated.

Response

Appropriate precautions to be taken to decontaminate articles exposed to smallpox, plague, or anthrax so that they may be safely transmitted from one person to another depend upon the circumstances of the case, including the type of disease involved and the manner in which it is spread. The Department and local health authorities do not expect individuals to determine what these appropriate precautions are. The Department will make recommendations concerning what type of precautions are necessary on a case by case basis.

Section 27.202. Lease of premises occupied by a person with a communicable disease.

This section includes requirements for renting out a room, house or part of a house in which a person with a communicable disease has been.

Comment

The Department has deleted from this section language that requires these places to be cleaned to the Department's satisfaction. What is the standard of cleanliness that must now be met?

Response

The Department agrees that the original standard provided more guidance than the proposed regulation, and has retained the language it had proposed to delete from this section.

Section 27.203. Preparation for burial or transportation of deceased human bodies.

This section requires persons handling deceased human bodies to take appropriate precautions to prevent the spread of communicable diseases.

Comment

The statement that appropriate precautions should be taken is vague. The Department should give examples of appropriate precautions in the final form regulations.

Response

The Department agrees that there is a need for more explicit standards in this section, and has retained the language it had proposed to delete.

CHAPTER 211. PROGRAM STANDARDS FOR LONG-TERM CARE NURSING FACILITIES

Section 211.1. Reportable diseases.

This section lists communicable diseases that long-term care nursing facilities are required to report. The Department is amending this section as has been previously discussed in commentary on §27.21a (relating to reporting of cases by health care practitioners and health care facilities).

C. AFFECTED PERSONS

The amendments impact on health care providers, health care practitioners, clinical laboratories, health care facilities and child care group settings in this Commonwealth.

The amendments also impact on local health authorities, including the 10 county/municipal health departments. These entities must comply with the updated disease reporting procedures, which are not, however, significantly different from current reporting requirements.

Additionally, every citizen in this Commonwealth is affected by the amendments as each will benefit from a reduced risk of exposure to, and resulting morbidity and mortality from, infection with the more than 50 reportable diseases, infections and conditions.

All reporters will be affected by the Department's phasing in of an electronic reporting system. Reporting electronically will make reporting easier and more efficient, and, since reporting software and training will be provided at no cost to the Department, will not increase reporting costs for providers.

D. COST AND PAPERWORK ESTIMATE

The amendments will have no measurable fiscal impact on the Commonwealth, local government, the private sector or the general public because the disease reporting system already exists in the Commonwealth. In fact, the application of nationally accepted state-of-the-art public health practices and communicable disease prevention and control strategies within Pennsylvania should create savings in related health care costs each year. The regulated community and local governments will see a benefit directly proportional to the numbers and types of disease cases prevented, thereby reducing community health care costs. The Commonwealth will also benefit in an amount directly proportional to the numbers and types of disease cases and disease outbreaks prevented, thereby greatly reducing State government health care costs.

The amendments fine-tune an already existing disease reporting system in the Commonwealth and will not result in additional paperwork. Newly listed reportable

diseases, infections and conditions will be reported and investigated in a manner similar to the reporting and investigation of currently listed diseases, infections and conditions, using National case-definitions and investigation forms provided by the CDC.

E. STATUTORY AUTHORITY

The Department's overarching authority to promulgate these regulations is found in the act. Section 16(a) of the act (35 P.S. §521.16(a)) gives the Board the authority to issue rules and regulations on a variety of matters relating to communicable and non-communicable diseases, including the following: the diseases that are to be reported; the methods of reporting diseases; the contents of reports; the health authorities to whom diseases are to be reported; the control measures that are to be taken with respect to different diseases; the enforcement of control measures; the immunization and vaccination of persons and animals; the prevention and control of disease in public and private schools; the treatment of sexually transmitted diseases, including patient counseling; and any other matters the Board may deem advisable to address for the prevention and control of disease and for carrying out the provisions and purposes of the act. Section 16(b) of the act (35 P.S. §521.16(b)) gives the Secretary of Health the authority to review existing regulations and make recommendations to the Board for changes the Secretary considers to be desirable.

There is also legislative authority for specific provisions of the regulations in other statutes. The Administrative Code of 1929 (71 P.S. §51 et seq.) (Code), contains several

pertinent provisions. First, section 2102(g) of the Code (71 P.S. §532(g)) provides general authority for the Department to promulgate its regulations.

Section 2106(a) of the Code (71 P.S. §536(a)) provides the Department with additional authority to declare diseases to be communicable, and to establish regulations for the prevention and control of disease. Section 2106(b) of the Code (71 P.S. §536(b)) provides the Department with the authority to establish and enforce quarantines to prevent the spread of disease, and section 2106(c) of the Code (71 P.S. §536(c)) gives the Department the authority to administer and enforce the laws of the Commonwealth with respect to vaccination and other means of preventing the spread of communicable disease.

Section 2111(b) of the Code (71 P.S. §541(b)) provides the Board with additional authority to promulgate regulations deemed by the Board to be necessary for the prevention of disease, and for the protection of the lives and the health of the people of the Commonwealth. That section further provides that the regulations of the Board shall become the regulations of the Department.

Section 2111(c.1) of the Code (71 P.S. §541(c.1)) also provides the Board with the authority to make and revise a list of communicable diseases against which children are required to be immunized as a condition of attendance at any public, private, or parochial school, including kindergarten. The section requires the Secretary to promulgate the list, along with any rules and regulations necessary to ensure the immunizations are timely,

effective, and properly verified. The regulations that primarily carry out this responsibility are set forth in Subchapter C of Chapter 23 (relating to school health) (§§23.81-23.87).

Other statutes speak to the Department's authority to promulgate regulations in relation to specific diseases, infections, or conditions. The Newborn Child Testing Act of 1992 (35 P.S. §§621-625) provides the Department with the authority to promulgate regulations listing reportable diseases and conditions in the newborn child, and setting out the operation of a program of screening, follow-up, assessment and diagnosis of newborn children for those reportable diseases and conditions. (35 P.S. §§621.23 and 621.25). The Pennsylvania Cancer Control, Prevention, and Research Act (35 P.S. §§5631-5637) authorizes the Department to create a cancer registry to which persons in charge of hospitals and laboratories must report cases of cancer in accordance with rules and regulations adopted by the Department with the advice of the Pennsylvania Cancer Control, Prevention and Research Advisory Board. (35 P.S. §5636(b)). This legislation has been impacted by federal legislation which was enacted in 1992, and which requires complete reporting of cancer cases to be made by all health care practitioners, and all hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer. (42 U.S.C. §§280e and 280e-1 - 280e-4). Statutory provisions known as the "Turtle Law" (35 P.S. §§1071-1077), provide the Department with the authority to prohibit a person from bringing, causing to be brought, or transporting any live turtle into the Commonwealth, unless the turtle or lot of turtles is accompanied by a permit issued by the Department or another agency authorized by the

Department to issue a permit. The permit may only be issued if there is adequate biological proof that the turtles are free from salmonella. The same permit is required when the turtles originate within the Commonwealth.

Several statutes provide the Department with authority to command disease prevention and control measures within certain institutions. Section 803 of the Health Care Facilities Act (35 P.S. §448.803) provides the Department with the authority to promulgate regulations relating to the licensure of health care facilities, and allows the Department to require certain actions relating to disease control and prevention to occur within health care facilities. Articles IX and X of the Public Welfare Code (62 P.S. §§901-1059), which provide the Department with the authority to license inpatient drug and alcohol abuse treatment facilities, play the same role with respect to the Department's ability to require certain disease prevention and control methods in those facilities.

The Public School Code of 1949 (24 P.S. §1-101 et seq.), provides the Department with additional authority for disease prevention and control actions taken within schools. Section 1421(c)(2) of the Public School Code of 1949 (24 P.S. §14-1421(c)(2)), provides the Secretary of Health, in consultation with the Secretary of Education, with the authority to promulgate regulations implementing the school health program. The requirements of the school health program are set out in Article XIV of the Public School Code, and provide, among other things, that pupils are released from compulsory attendance when they are prevented from attending by the health laws of the Commonwealth (24 P.S. §14-1417), and that no persons having any form of tuberculosis

in a transmissible stage shall be a pupil, teacher, janitor, or any other employee in a school, unless it is a special school. (24 P.S. §14-1418). Section 1303a of the Public School Code (24 P.S. §1303a) provides that the Board will make and review a list of diseases against which children must be immunized, as the Secretary may direct, before being admitted to school for the first time. The section provides that the school directors, superintendents, principals, or other persons in charge of any public, private, parochial, or other school including kindergarten, must ascertain whether the immunization has occurred, and certificates of immunization will be issued in accordance with rules and regulations promulgated by the Secretary with the sanction and advice of the Board. Most of the regulations carrying out these responsibilities are set forth in Chapter 23.

F. EFFECTIVENESS/SUNSET DATES

The regulations will become effective upon final publication in the Pennsylvania Bulletin. No sunset date has been established. The Department will continually review and monitor the effectiveness of these regulations.

G. REGULATORY REVIEW

Under Section 5(a) of the Regulatory Review Act of June 30, 1989 (P.L. 73, No. 19) (71 P.S. §§745.1-745.14), on December 8, 1999, the Department submitted a copy of Notice of Proposed Rulemaking published at 30 Pa. B. 2715 (May 27, 2000) to IRRC and the Chairpersons of the House Health and Human Services Committee and the Senate Public Health and Welfare Committee for review and comment. In compliance with section 5(c)

of the Act, the Department also provided IRRC and the Committees with copies of all comments received, as well as other documentation.

In compliance with section 5.1(a) of the Act, the Department submitted a copy of the final-form regulations to IRRC and the Committees on November 26, 2001. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed regulatory analysis form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

In preparing this final form regulation, the Department has considered all comments received from IRRC, the Committees and the public.

These final-form regulations were approved by the House Health and Human Services Committee on _____ and approved by the Senate Public Health and Human Services Committee on _____. IRRC met on _____ and approved the regulations in accordance with Section 5.1(e) of the Act. The Attorney General approved the regulations on _____.

H. CONTACT PERSON

Questions regarding these regulations may be submitted to: James T. Rankin, Jr., D.V.M., M.P.H., Ph.D., Director, Division of Communicable Disease Epidemiology, Department of Health, P.O. Box 90, Harrisburg, PA 17108, (717) 787-3350. Persons

with disabilities may submit questions in alternative formats such as audio tape, Braille or by using V/TT (717) 783-6514 for speech and/or hearing impaired persons or the Pennsylvania AT&T Relay Service at (800-654-5984[TT]). Persons who require an alternative format of this document may contact Dr. Rankin at the above address or telephone numbers so that necessary arrangements may be made.

I. FINDINGS

The Department and the Board find that:

(1) Public notice of the intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. §§1201 and 1202), and the regulations thereunder, 1 Pa. Code §§7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The adoption of the regulation in the manner provided by this order is necessary and appropriate for the administration of the authorizing statutes.

J. ORDER

The Department and the Board, acting under the authorizing statutes, order that:

(a) The regulations of the Department, 28 Pa. Code Chapter 27, are hereby amended by adding §§27.5a, 27.6, 27.7, 27.8, 27.21a, 27.24a, 27.33, 27.34, 27.35,

27.41a, 27.42a, 27.43a, 27.60, 27.76, 27.77, 27.99 and 27.151-27.164; by amending §§27.1, 27.2, 27.3, 27.4, 27.21, 27.22, 27.23, 27.29, 27.30, 27.31, 27.61, 27.65, 27.66, 27.67, 27.68, 27.69, 27.71, 27.72, 27.73, 27.74, 27.75, 27.81, 27.82, 27.83, 27.84, 27.85, 27.87, 27.88, 27.89, 27.95-27.98, 27.181, 27.183, 27.191, 27.192, 27.201, 27.202, 27.203, 27.204 and 211.1; and by repealing §§27.5, 27.24, 27.25, 27.26, 27.27, 27.28, 27.32, 27.41, 27.42, 27.43, 27.44, 27.45, 27.46, 27.47, 27.51, 27.62, 27.63, 27.64, 27.86, 27.90, 27.91, 27.92, 27.93, 27.94, 27.101-27.146, 27.184 and 27.205 as set forth in Annex A.

(b) The Secretary of Health shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as required by law.

(c) The Secretary of Health shall submit this order, Annex A, and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law.

(d) The Secretary of Health shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(e) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

ANNEX A
TITLE 28, HEALTH AND SAFETY
PART III. PREVENTION OF DISEASES
CHAPTER 27. COMMUNICABLE AND NONCOMMUNICABLE DISEASES

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Subchapter A. GENERAL PROVISIONS

Sec.		
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§27.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ACIP - The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

* * *

Caregiver - The entity or individual responsible for the safe and healthful care or education of a child in a child care group setting.

* * *

Case - A person or animal that is determined to have or suspected of having a disease, infection or condition.

Case report form - The form designated by the Department for reporting a case or a carrier.

Central office - Department headquarters located in Harrisburg.

Child - A person ~~15~~ UNDER THE AGE OF 18 years of age or younger.

Child care group setting - The premises in which care is provided at any one time to four or more children, unrelated to the operator.

Clinical laboratory - A laboratory for which a permit has been issued to operate as a clinical laboratory under the Clinical Laboratory Act (35 P.S. §§2151-2165).

Communicable disease - An illness [due to an infectious agent or its toxic products which is transmitted, directly or indirectly, to a susceptible host from]which is capable of being spread to a susceptible host through the direct or indirect transmission of an infectious agent or its toxic product by an infected person, animal or arthropod, [or through the agency of an intermediate host, or a vector] or through the inanimate environment.

Communicable period - The time during which [the] an etiologic agent may be

transferred directly or indirectly from an infected person to another person, or from an infected animal to a person.

Contact - A person or animal known to have [been in] had an association with an infected person or animal [as to have had an opportunity of] which presented an opportunity for acquiring the infection.

[*County morbidity reporting area* - A county so designated by the Board wherein initial reports for communicable and noncommunicable diseases are to be reported to the State health center of the Department.]

* * *

District office - One of the district headquarters of the Department located within this Commonwealth of Pennsylvania.

Health care facility -

(i) A facility providing clinically related health services, including a general, chronic disease, or other type of hospital, a home health care agency, A HOSPICE, a long-term care nursing facility, a cancer treatment center using radiation therapy on an ambulatory basis, an ambulatory surgical facility, a birth center, and an inpatient drug and alcohol treatment facility, regardless of whether such health care facility is operated for profit, nonprofit or by an agency of the Commonwealth or local government.

(ii) The term does not include:

(A) An office used primarily for the private practice of a health care practitioner where no clinically related health service is offered.

(B) A facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination.

(C) A facility conducted by a religious organization for the purpose of providing health care services exclusively to clergy or other persons in a religious profession who are members of a religious denomination.

Health care practitioner - An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board.

Health care provider - An individual, a trust or estate, a partnership, a corporation

(including associations, joint stock companies and insurance companies), the Commonwealth, or a political subdivision, or instrumentality (including a municipal corporation or authority) thereof, that operates a health care facility.

HOUSEHOLD CONTACT -- A PERSON LIVING IN THE SAME RESIDENCE AS A CASE, INCLUDING A SPOUSE, CHILD, PARENT, RELATION OR OTHER PERSON, WHETHER OR NOT RELATED TO THE CASE.

Infectious agent - Any organism, such as a virus, bacterium, fungus or parasite, that is capable of being communicated by invasion and multiplication in body tissues and capable of causing disease.

Isolation - The separation for the [period of communicability] communicable period of an infected [persons] person or [animals] animal from other persons or animals, in [places and under conditions that prevents] such a manner as to prevent the direct or indirect transmission of the infectious agent from infected persons or animals to other persons or animals who are susceptible or who may spread the disease to others.

LMRO - Local morbidity reporting office - An office designated by the Department to receive initial case reports on a local basis, including the primary office of a local health department, any other local health authority designated by the Department as an LMRO, and a State health center in the absence of a local health department. A DISTRICT OFFICE OF THE DEPARTMENT OR A LOCAL HEALTH DEPARTMENT.

[*Local board* - The board of health or the department of public health of a municipality of the first class, a county department of health or a joint county or joint municipal department of health.]

Local health authority - [The appropriate local health officer, local board or district director of the area] A county or municipal department of health, or board of health of a municipality that does not have a department of health. The term does not include INCLUDES a sanitary board.

Local health department - Each county department of health under the Local Health Administration Law (16 P.S. §§12001-12028), and each department of health in a municipality approved for a Commonwealth grant to provide local health services pursuant to section 25 of the Local Health Administration Law (16 P.S. §12025). The Department will maintain a list of local health departments and revise the list when new local health departments are established.

Local health officer - [The head of a local board] The person appointed by a local health authority to head the daily administration of duties imposed upon or permitted of local health authorities by State laws and regulations.

Medical record - An account compiled by physicians and other health professionals including a patient's medical history; present illness; findings on physical examination; details of treatment; reports of diagnostic tests; findings and conclusions from special examinations; findings and diagnoses of consultants; diagnoses of the responsible physician; notes on treatment, including medication, surgical operations, radiation, and physical therapy; and progress notes by physicians, nurses and other health professionals.

Modified quarantine - A selected, partial limitation of freedom of movement determined on the basis of differences in susceptibility or danger of disease transmission which is designated to meet particular situations. The term includes the exclusion of children from school and the prohibition, or the restriction, of those exposed to a communicable disease from engaging in particular activities.

MONITORING OF CONTACTS - THE CLOSE SUPERVISION OF PERSONS AND ANIMALS EXPOSED TO A COMMUNICABLE DISEASE WITHOUT RESTRICTING THEIR MOVEMENT.

* * *

Operator - The legal entity that operates a child care group setting or a person designated by the legal entity to serve as the primary staff person at a child care group setting.

Outbreak - An unusual increase in the number of cases of a disease, infection, or condition, whether reportable or not as a single case, above the number of cases that a person required to report would expect to see in a particular geographic area or among a subset of persons (defined by a specific demographic or other features).

Physician - An individual licensed to practice medicine or osteopathic medicine within this Commonwealth.

Placarding - The posting on a home or other building of a sign or notice warning of the presence of communicable disease within the structure and the danger of infection therefrom.

Quarantine - The limitation of freedom of movement of [persons] a person or [animals who have] an animal that has been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease, or until judged noninfectious by a physician, in [such] a manner [as] designed to prevent [effective contact with those not exposed] the direct or indirect transmission of the infectious agent from the infected person or animal to other persons or animals. This term does not exclude the movement of a person or animal from one location to another when approved by the Department or a local health authority under §27.67 (relating to the movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department). [A quarantine may be complete or one of

the following types:

(i) *Segregation* - The separation for special control or observation of one or more persons or animals from other persons or animals to facilitate the control of a communicable disease.

(ii) *Modified quarantine* - A selected, partial limitation of freedom of movement determined on the basis of differences in susceptibility or danger of disease transmission which is designed to meet particular situations. Modified quarantine includes, but is not limited to, the exclusion of children from school and the prohibition, or the restriction, of those exposed to a communicable disease from engaging in particular occupations.

(iii) *Surveillance* - The close supervision of persons and animals exposed to a communicable disease without restricting their movement.

Regulation - A rule or regulation issued by the Board or an ordinance, rule or regulation enacted or issued by a local board.]

Reportable disease, infection, or condition - A [communicable] disease, [declared] infection, or condition, made reportable by [regulation; an unusual or group expression of illness which, in the opinion of the Department, may be a public health emergency; noncommunicable diseases and conditions for which the Department may authorize reporting to provide data and information which, in the opinion of the Board, are needed in order to effectively carry out those programs of the Department designed to protect and promote the health of the people of this Commonwealth, or to determine the need for the establishment of the programs.] §27.2 (relating to specific identified reportable diseases, infections and conditions).

* * *

Segregation - The separation for special control or observation of one or more persons or animals from other persons or animals to facilitate the control of a communicable disease.

Sexually transmitted disease - A disease which, except when transmitted perinatally, is transmitted almost exclusively through sexual contact.

State health center (SHC) - The official headquarters of the Department in [each] a county, other than [those organized as county departments of health] a district office.

~~*Surveillance of contacts* - The close supervision of persons and animals exposed to a communicable disease without restricting their movement.~~

Surveillance of disease - The continuing scrutiny of all aspects of occurrence and spread of disease that are pertinent to effective control.

VOLUNTEER – A PERSON WHO PROVIDES SERVICES TO A SCHOOL OR CHILD CARE GROUP SETTING WITHOUT RECEIVING REMUNERATION.

§27.2. [Reportable] Specific identified reportable diseases, infections, and conditions.

[The Board declares the following communicable diseases, unusual outbreaks of illness, noncommunicable diseases and conditions to be reportable:

AIDS (Acquired Immune Deficiency Syndrome).
Amebiasis.
Animal bite.
Anthrax.
Botulism.
Brucellosis.
Campylobacteriosis.
Cancer.
Chlamydia trachomatis infections.
Cholera.
Diphtheria.
Encephalitis.
Food poisoning.
Giardiasis.
Gonococcal infections.
Guillain-Barre syndrome.
Haemophilus influenzae type b disease.
Hepatitis non-A non-B.
Hepatitis, viral, including Type A and Type B
Histoplasmosis.
Kawasaki disease.
Legionnaires' disease.
Leptospirosis.
Lyme Disease.
Lymphogranuloma venereum.
Malaria.
Measles.
Meningitis--all types.
Meningococcal disease.
Mumps.
Pertussis (whooping cough).
Plague.
Poliomyelitis.

Psittacosis (Ornithosis).
Rabies.
Reye's syndrome.
Rickettsial diseases including Rocky Mountain Spotted Fever.
Rubella (German Measles) and congenital rubella syndrome.
Salmonellosis.
Shigellosis.
Syphilis--all stages.
Tetanus.
Toxic shock syndrome.
Toxoplasmosis.
Trichinosis.
Tuberculosis--all forms.
Tularemia.
Typhoid.
Yellow Fever.]

The diseases, infections, and conditions set out in Subchapter B (relating to the reporting of diseases, infections and conditions) are reportable to the Department or the appropriate local health authority by the persons or entities in the manner and within the time frames set out in this chapter.

§27.3. [Unusual or ill-defined diseases, illnesses or outbreaks] Reporting outbreaks and unusual diseases, infections and conditions.

[The occurrence of outbreaks or clusters of an illness which may be of public concern, whether or not it is known to be communicable in nature, shall be reported to the local health officer of the municipality in which it occurs. In areas which have no local health officer, reports shall be made to the representative of the Secretary.]

(a) A person required to report under this chapter shall report an outbreak within 24 hours, and in accordance with the requirements of §27.4 (relating to reporting cases).

(b) A person required to report under this chapter who suspects a public health emergency, shall report an unusual occurrence of a disease, infection, or condition not listed as reportable in Subchapter B (relating to reporting of diseases, infections and conditions) or defined as an outbreak, within 24 hours, and in accordance with the requirements of §27.4.

(c) Any unusual or group expression of illness which the Department designates as a public health emergency shall be reported within 24 hours, and in accordance with the requirements of §27.4.

§27.4. [Noncommunicable diseases and conditions] Reporting cases.

[(a) Diseases and conditions shall be reported where the reports are needed to enable the Secretary to determine and employ the most efficient and practical means to protect and promote the health of residents of this Commonwealth. Reporting of these diseases and conditions shall be requested to include statistical data needed for specific studies and research projects approved by the Board.

(b) The following diseases and conditions shall be reported as follows:

(1) Lead poisoning or lead toxicity in children up to age 6 and in pregnant women, as evidenced by a confirmed blood lead level of 25 micrograms per deciliter (ug/dL) or higher and by an erythrocyte protoporphyrin level of 35 micrograms per deciliter (ug/dL) or higher shall be reported to the Division of Environmental Health, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108-9990.

(2) Increased lead absorption in persons age 6 and above, as evidenced by a confirmed blood lead level of 40 micrograms per deciliter (ug/dL) or higher, shall be reported to the Division of Environmental Health, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108-9990.]

(a) Except for reporting by a clinical laboratory, a case is to be reported to the LMRO serving the area in which a case resides IS DIAGNOSED OR IDENTIFIED unless another provision of this chapter directs that a particular type of case is to be reported elsewhere. If the residence of the case is unknown, the case is to be reported to the LMRO serving the area in which the case is identified. A clinical laboratory shall make reports to the appropriate office of the Department unless otherwise specified.

(B) UPON THE DEPARTMENT'S IMPLEMENTATION OF ITS ELECTRONIC DISEASE SURVEILLANCE SYSTEM FOR CERTAIN TYPES OF CASE REPORTS, PERSONS WHO MAKE THOSE REPORTS SHALL DO SO ELECTRONICALLY USING AN APPLICATION AND REPORTING FORMAT PROVIDED BY THE DEPARTMENT. AT LEAST 6 MONTHS IN ADVANCE OF REQUIRING A TYPE OF CASE REPORT TO BE REPORTED ELECTRONICALLY, THE DEPARTMENT WILL PUBLISH A NOTICE IN THE *PENNSYLVANIA BULLETIN* ANNOUNCING WHEN ELECTRONIC REPORTING IS TO BEGIN.

(C) NOTHING IN THIS SECTION SHALL PROHIBIT A REPORTER FROM MAKING AN INITIAL REPORT OF A CASE TO THE DEPARTMENT OR AN LMRO BY TELEPHONE. THE REPORTER WILL BE INSTRUCTED ON HOW TO MAKE A COMPLETE CASE REPORT AT THE TIME OF THE TELEPHONE CALL.

(b)(D) Department offices to which this chapter requires specified case reports to be filed are as follows:

- (1) Cancer Registry, Division of Health Statistics, Bureau of Health Statistics and Research.
- (2) Division of ~~Communicable~~ INFECTIOUS Disease Epidemiology, Bureau of Epidemiology.
- (3) ~~Division of Immunizations, Bureau of Communicable Diseases.~~
- (4) ~~Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases.~~
- (5) ~~Division of Environmental Health Assessment, Bureau of Epidemiology.~~
- (6) HIV/AIDS Epidemiology Section, DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY, Bureau of Epidemiology.
- (7)(4) Division of Maternal and Child Health, Bureau of Family Health.

(e)(E) A case shall be reported using the appropriate case report format. Information solicited by the case report form shall be provided by the reporter, irrespective of whether the report is made by submitting the form directly in hard copy or by telecommunication or electronic submission. An appropriate case report form or format may be procured from the office to which the type of case is reportable.

§27.5. [Cancer Registry] (Reserved).

[A hospital and laboratory where cancer is diagnosed or treated or both shall report their finding to the Cancer Registry, Department of Health, State Health Data Center, Health and Welfare Building, Post Office Box 90, Harrisburg, Pennsylvania 17108.]

§27.5a. Confidentiality of case reports.

Case reports submitted to the Department or to an LMRO are confidential. Neither the reports, nor any information contained in them which identifies or is perceived by the Department or the LMRO as capable of being used to identify a person named in a report, will be disclosed to any person who is not an authorized employe or agent of the Department or the LMRO, AND WHO HAS A LEGITIMATE PURPOSE TO ACCESS CASE INFORMATION, except for any of the following reasons:

(1) When disclosure is necessary to carry out a purpose of the act, as determined by the Department or LMRO, and disclosure would not violate another act or regulation.

(2) When disclosure is made for a research purpose for which access to the information has been granted by the Department or an LMRO. Access shall be granted only when disclosure would not violate another act or regulation. The research shall be subject to strict supervision by the LMRO to ensure that the use of information disclosed is limited to the specific research purpose and will not involve the further disclosure of information which identifies or is perceived as being able to be used to identify a person named in a report.

§27.6. Disciplinary consequences for violating reporting responsibilities.

(a) Failure of a clinical laboratory to comply with the reporting provisions of this chapter may result in restrictions being placed upon or revocation of the laboratory's permit to operate as a clinical laboratory, as provided for in the Clinical Laboratory Act (35 P.S. §§2151-2165) UNLESS FAILURE TO REPORT IS DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE CLINICAL LABORATORY.

(b) Failure of a Department licensed health care facility to comply with the reporting provisions of this chapter may result in restrictions being placed upon or revocation of the health care facility's license, as provided for in the Health Care Facilities Act (35 P.S. §§448.101-448.904b).

(c) Failure of a health care practitioner to comply with the reporting provisions of this chapter may result in referral of that matter to the appropriate licensure board for disciplinary action.

(D) FAILURE OF A CHILD CARE GROUP SETTING TO COMPLY WITH THE REPORTING PROVISIONS OF THIS CHAPTER MAY RESULT IN REFERRAL OF THAT MATTER TO THE APPROPRIATE LICENSING AGENCY FOR APPROPRIATE ACTION.

§27.7. Cooperation between clinical laboratories and persons who order laboratory tests.

To facilitate the reporting of cases by clinical laboratories, the following is required:

(1) When a clinical laboratory is requested to conduct a test which, depending upon the results, would impose a reporting duty upon the clinical laboratory, the clinical laboratory shall provide to the person who requests ORDERS the testing, a form that solicits all information which is required for completion of the applicable case report form.

(2) A person who orders testing subject to paragraph (1) shall, at the time of ordering the test, provide the clinical laboratory with the information solicited by the form which that person either possesses or may readily obtain.

§27.8. Criminal penalties for violating the act or this chapter.

(a) A person who violates any provision of the act or this chapter shall, for each offense, upon conviction thereof in a summary proceeding before a district justice in the county wherein the offense was committed, be sentenced to pay a fine of not less than \$25 and not more than \$300, together with costs, and in default of payment of the fine and costs, shall be imprisoned in the county jail for a period not to exceed 30 days.

(b) A person afflicted with communicable tuberculosis, ordered to be quarantined or isolated in an institution, who leaves without consent of the medical director of the institution, is guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine of not less than \$100 nor more than \$500, or undergo imprisonment for not less than 30 days nor more than 6 months, or both.

(c) Prosecutions may be instituted by the Department, by a local health authority, or by any person having knowledge of a violation of the act or this chapter.

§27.9. Authorized departures from the regulations.

The Department may authorize an exception to any regulation in this chapter, which does not repeat a statutory requirement, if the regulation becomes outdated due to medical or public health developments and the exception is determined by the Department to be necessary to protect the health of the people of this Commonwealth. The exception shall not remain in effect for more than 90 days unless the Board acts to affirm the exception within that 90-day period.

Subchapter B. REPORTING OF DISEASES, INFECTIONS, AND CONDITIONS

GENERAL

Sec.

27.21. [Physicians who treat patients with reportable diseases including tuberculosis]
Reporting of AIDS cases by physicians AND HOSPITALS.

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DISEASES AND CONDITIONS REQUIRING SPECIAL REPORTING

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**[REPORTS BY LOCAL HEALTH OFFICERS]
REPORTING BY LOCAL MORBIDITY REPORTING OFFICE**

- 27.41. [Individual case reports] (Reserved).
- 27.41a. Reporting by local morbidity reporting offices of case reports received.

- 27.42. [Summary reports] (Reserved).
- 27.42a. Reporting by local morbidity reporting offices of completed case investigations.
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- 27.43a. Reporting by local morbidity reporting offices of outbreaks and selected diseases.
- 27.44. [Destinations of reports] (Reserved).
- 27.45. [Reports to the Department] (Reserved).
- 27.46. [Records of local health officers] (Reserved).
- 27.47. [Reports by the Department] (Reserved).

[REPORTING VIRAL HEPATITIS TO BLOOD BANKS]

- 27.51. [Time and information reported] (Reserved).

GENERAL

§27.21. [Physicians who treat patients with reportable diseases including tuberculosis] Reporting of AIDS cases by physicians AND HOSPITALS.

(a) A physician who treats or examines a person who is suffering from or who is suspected of having a reportable disease or a person who is suspected of being a carrier or who is infected asymptotically shall make a prompt report of the disease or condition to the local board. Physicians are not required to report cases of cancer.

(b) In a municipality not served by a local board, reports shall be made to the State health center of the Department. In a county designated by the Board as a county morbidity reporting area, reports shall be made to the State health center.

(c) The report shall be on a standard type Suspected Case Notification form, or cases may be reported by telephone. The report shall state the name of the patient or carrier, the address at which the patient or carrier may be located, the date of onset of the disease and the name, address and telephone number of the attending physician.

(d) Reports of venereal diseases shall include the stage of the disease. These reports shall be mailed in an enclosed and sealed standard type Suspected Case Notification form to the health authorities of Philadelphia, Allegheny County and other county departments of health

authorized by the Department to receive reports when the patients are residents of the city or counties. Other cases shall be reported directly to the Division of Communicable Disease Control and Surveillance, Bureau of Epidemiology and Disease Prevention, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108. Physicians shall report only laboratory confirmed cases of chlamydia trachomatic infections.

(e) Physicians shall report cases of AIDS under 27.32 (relating to reporting AIDS).] A physician OR A HOSPITAL is required to report a case of AIDS within 5 work days after it is identified to the local health department if the case resides within the jurisdiction of that local health department. In all other cases, the physician OR HOSPITAL shall report the case to the HIV/AIDS Epidemiology Section, DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY, Bureau of Epidemiology.

§27.21a. Reporting of cases by health care practitioners and health care facilities.

(A) EXCEPT AS SET FORTH HEREIN OR AS OTHERWISE SET FORTH IN THIS CHAPTER, A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY IS REQUIRED TO REPORT A CASE OF A DISEASE, INFECTION OR CONDITION LISTED IN SUBSECTION (B) AS SPECIFIED IN §27.4 (RELATING TO REPORTING CASES), IF THE HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY TREATS OR EXAMINES A PERSON WHO IS SUFFERING FROM, OR WHO THE HEALTH CARE PRACTITIONER SUSPECTS, BECAUSE OF SYMPTOMS OR THE APPEARANCE OF THE INDIVIDUAL, OF HAVING A REPORTABLE DISEASE, INFECTION OR CONDITION:

- (1) A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT A CASE IF THAT HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY HAS REPORTED THE CASE PREVIOUSLY.
- (2) A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT A CASE OF INFLUENZA UNLESS THE DISEASE IS CONFIRMED BY LABORATORY EVIDENCE OF THE CAUSATIVE AGENT.
- (3) A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT A CASE OF CHLAMYDIA TRACHOMATIS INFECTION UNLESS THE DISEASE IS CONFIRMED BY LABORATORY EVIDENCE OF THE INFECTIOUS AGENT.
- (4) A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT A CASE OF CANCER UNLESS THE

HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY PROVIDES SCREENING, THERAPY OR DIAGNOSTIC SERVICES TO CANCER PATIENTS.

(5) ONLY PHYSICIANS AND HOSPITALS ARE REQUIRED TO REPORT CASES OF AIDS.

(a)(B) The following diseases, infections and conditions in humans are reportable by health care practitioners and health care facilities within the specified time periods AND AS OTHERWISE REQUIRED BY THIS CHAPTER:

(1) The following diseases, infections and conditions are reportable within 24 hours after being identified BY SYMPTOMS, APPEARANCE OR DIAGNOSIS:

ANIMAL BITE.

ANTHRAX.

ARBOVIRUSES.

Botulism.

Cholera.

Diphtheria.

ENTEROHEMORRHAGIC E. COLI.

Food poisoning outbreak.

Haemophilus influenzae type B-invasive disease.

Hantavirus pulmonary syndrome.

Hemorrhagic fever.

Hepatitis, viral, including type A and type E.

Lead poisoning.

LEGIONELLOSIS.

Measles (rubeola).

Meningococcal invasive disease.

Plague.

Poliomyelitis.

Rabies.

SMALLPOX

Typhoid fever.

(2) The following diseases, infections and conditions are reportable within 5 work days after being identified BY SYMPTOMS, APPEARANCE OR DIAGNOSIS:

AIDS

Amebiasis.

Animal bite.

Anthrax.
Arbovirus disease.
Brucellosis.
Campylobacteriosis.
Cancer.
Chancroid.
Chickenpox (varicella) (effective 3 years from the date of publication of these regulations as final in the *Pennsylvania Bulletin*).
Chlamydia trachomatis infections.
CREUTZFELDT-JAKOB DISEASE.
Cryptosporidiosis.
Encephalitis.
Enterohemorrhagic E. coli.
Giardiasis.
Gonococcal infections.
Granuloma inguinale.
Guillain-Barre syndrome
Hepatitis, viral, ACUTE AND CHRONIC CASES ~~including type B, type C, type D, type G.~~
Histoplasmosis.
Influenza.
Legionnaires' disease.
Leprosy (Hansen's disease).
Leptospirosis.
Listeriosis.
Lyme disease.
Lymphogranuloma venereum.
Malaria.
Maple syrup urine disease (MSUD) in children ~~up to~~ UNDER 5 years/~~60 months~~ of age.
Meningitis (All types not caused by invasive Haemophilus influenza or Neisseria meningitis).
Mumps.
Pertussis (whooping cough).
Phenylketonuria (PKU) in children ~~up to~~ UNDER 5 years ~~or 60 months~~ of age.
Primary congenital hypothyroidism in children ~~up to~~ UNDER 5 years ~~or 60 months~~ of age.
Psittacosis (ornithosis).
Rickettsial diseases.
Rubella (German measles) and congenital rubella syndrome.
Salmonellosis.
Shigellosis.
Sickle cell hemoglobinopathies in children ~~up to~~ UNDER 5 years ~~or 60 months~~ of age.

STAPHYLOCOCCUS AUREUS, VANCOMYCIN-RESISTANT (OR INTERMEDIATE) INVASIVE DISEASE.

Streptococcal invasive disease (group A).

STREPTOCOCCUS PNEUMONIAE, DRUG-RESISTANT INVASIVE DISEASE.

Syphilis (all stages).

Tetanus.

Toxic shock syndrome.

Toxoplasmosis.

Trichinosis.

Tuberculosis, SUSPECTED OR CONFIRMED ACTIVE DISEASE (all sites).

Tularemia.

Yellow fever.

~~(b) — Except as otherwise set forth in this section, a health care practitioner or health care facility is required to report a case, as specified in §27.4 (relating to reporting cases), if the health care practitioner or health care facility treats or examines a person who is suffering from, or who the health care practitioner suspects of having, a reportable disease, infection or condition.~~

~~(1) — A health care practitioner or health care facility is not required to report a case if that health care practitioner or health care facility has reported the case previously.~~

~~(2) — A health care practitioner or health care facility is not required to report a case of influenza unless the disease is confirmed by laboratory evidence of the causative agent.~~

~~(3) — A health care practitioner or health care facility is not required to report a case of chlamydia trachomatis infection unless the disease is confirmed by laboratory evidence of the infectious agent.~~

(c) A school nurse shall report to the LMRO any unusual increase in the number of absentees among school children. A CAREGIVER AT A CHILD CARE GROUP SETTING SHALL REPORT TO THE LMRO ANY UNUSUAL INCREASE IN THE NUMBER OF ABSENTEES AMONG CHILDREN ATTENDING THE CHILD CARE GROUP SETTING.

(d) A health care facility OR HEALTH CARE PRACTITIONER providing screening, diagnostic or therapeutic services to patients with respect to cancer shall also report cases of cancer as specified in §27.31 (relating to reporting cases of cancer).

**§27.22. [Reporting laboratory results indicative of certain infections or conditions]
Reporting of cases by clinical laboratories.**

(a) A person who is in charge of a clinical laboratory in which a laboratory examination of a specimen derived from [the] a human body yields [microscopical, cultural, immunological, serological, chemical or other] evidence significant from a public health standpoint of the presence of a disease, infection or condition listed in subsection (b) shall promptly report [promptly] the findings, [not] no later than the next [working] work day after the close of business on the day on which the examination was completed, except as [noted] otherwise noted in this chapter.

(b) The [conditions or] diseases, infections and conditions [or diseases] to be reported include the following:

Amebiasis.

Anthrax.

An unusual cluster of isolates.

Arboviruses (~~limited to Eastern, Western, and St. Louis~~
~~encephalitis.~~

Botulism - all forms.

Brucellosis.

Campylobacteriosis.

Cancer.

Chancroid.

Chickenpox (varicella).

Chlamydia trachomatis infections.

Cholera.

CREUTZFELDT-JAKOB DISEASE.

CRYPTOSPORIDIOSIS.

Diphtheria infections.

Enterohemorrhagic E. coli 0157 infections, or infections caused by
other sub-types producing shiga-like toxin.

Giardiasis.

Gonococcal infections.

Granuloma inguinale.

Haemophilus influenzae type [b disease] ~~B~~ infections - invasive
from sterile sites.

Hantavirus.

Hepatitis, viral, including types A [and], B, C, D, E, and G ACUTE AND
CHRONIC CASES.

HISTOPLASMOSIS.

Influenza.

[Hypothyroidism in infants up to 24 months old.

Histoplasmosis.]

Lead poisoning[or toxicity].

Legionnaires' disease LEGIONELLOSIS.

Leprosy (Hansen's disease).
 Leptospirosis.
Listeriosis.
 Lyme disease.
 Lymphogranuloma venereum.
 Malaria.
Maple syrup urine disease (MSUD) in children up to UNDER 5 years or 60 months of age.
Measles (rubeola).
 Meningococcal [isolations] infections - invasive from sterile sites.
Mumps.
Pertussis.
Phenylketonuria (PKU) in children up to UNDER 5 years or 60 months of age.
Primary congenital hypothyroidism in children up to UNDER 5 years or 60 months of age.
 Plague.
Poliomyelitis.
 Psittacosis (ornithosis).
 Rabies.
Respiratory syncytial virus.
 Rickettsial infections[including Rocky Mountain Spotted Fever].
Rubella.
 Salmonella[isolations].
 Shigella[isolations].
Sickle cell hemoglobinopathies in children up to UNDER 5 years or 60 months of age.
 STAPHYLOCOCCUS AUREUS VANCOMYCIN-RESISTANT (OR INTERMEDIATE) INVASIVE DISEASE.
 STREPTOCOCCUS PNEUMONIAE, DRUG-RESISTANT INVASIVE DISEASE.
 Syphilis.
Tetanus.
 TOXOPLASMOSIS.
 Trichinosis.
 Tuberculosis, CONFIRMATION OF POSITIVE SMEARS OR CULTURES, including results of drug susceptibility testing.
 Tularemia.
 Typhoid[isolations].
 [Viral infections.

- (i) Vaccine-preventable diseases.
- (ii) Arboviruses.

(iii) Respiratory viruses.]

(c) The report shall [give] include the following: the name, age[and], address, and telephone number of the person from whom the specimen was obtained; the date the specimen was collected; THE SOURCE OF THE SPECIMEN (E.G., SERUM, STOOL, CSF, WOUND); the name of the test or examination performed and the date it was performed; the results; THE RANGE OF NORMAL VALUES FOR THE SPECIFIC TEST PERFORMED; [and] the name [and], address, and telephone number of the physician for whom the examination or test was [made] performed; and all other information requested in case reports or formats specified by the Department.

(d) The report shall be submitted by the person in charge of a laboratory [as follows:

(1) *Reports except for venereal disease, hypothyroidism in infants up to 24 months old, phenylketonuria and lead poisoning or lead toxicity.* Reports shall be made to the appropriate health authority of Philadelphia or the county department of health if the patient resides in such an area. Other reports shall be sent to the Division of Epidemiology, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108.

(2) *Venereal disease (including positive dark fields).* Reports shall be made to the appropriate health authority of Philadelphia when the patient resides in Philadelphia and to the health authority in Allegheny County when the patient resides in Allegheny County. Other reports shall be sent to the Division of Communicable Disease Control and Surveillance, Bureau of Epidemiology and Disease Prevention, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108, unless otherwise directed by the Secretary.

(3) *Phenylketonuria and hypothyroidism in infants up to 24 months old.* Reports shall be made to the Division of Maternal/Child Health, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108.

(4) *Lead poisoning or lead toxicity.* Reports shall be made to the Division of Environmental Health, Department of Health, Post Office Box 90, Harrisburg, Pennsylvania 17108-9990 on forms developed and supplied by the Division of Environmental Health.], in either a hard copy format or an electronic transmission format specified by the Department.

(e) Reports MADE ON PAPER shall be made to the appropriate health authority of the county or municipal department of health if it can be determined that the patient resides in one of those cities or counties. LMRO WHERE THE CASE IS DIAGNOSED OR IDENTIFIED. Other reports REPORTS MADE ELECTRONICALLY shall be submitted to the Division of Communicable INFECTIOUS Disease Epidemiology, Bureau of Epidemiology. Reports of maple syrup urine disease, phenylketonuria, primary congenital hypothyroidism, sickle cell

hemoglobinopathies, cancer, sexually transmitted diseases and lead poisoning shall be reported to the location specifically designated in this subchapter. See §§27.30, 27.31, 27.33 and 27.34.

(f) A clinical laboratory shall submit isolates of salmonella and shigella to the Department's Bureau of Laboratories for serotyping within 5 work days of isolation.

(g) A clinical laboratory shall submit isolates of Neisseria meningitidis obtained from a normally sterile site to the Department's Bureau of Laboratories for serogrouping within 5 work days of isolation.

(h) A clinical laboratory shall send isolates of enterohemorrhagic E. coli to the Department's Bureau of Laboratories for appropriate further testing within 5 work days of isolation.

(i) A clinical laboratory shall send isolates of Haemophilus influenzae obtained from a normally sterile site to the Department's Bureau of Laboratories for serotyping within 5 work days of isolation.

(j) The Department, upon publication of a notice in the *Pennsylvania Bulletin*, may authorize changes in the requirements for submission of isolates based upon medical or public health developments when such departure is determined by the Department to be necessary to protect the health of the people of this Commonwealth. The change shall not remain in effect for more than 90 days after publication unless the Board acts to affirm the change within that 90-day period.

(k) — A clinical laboratory shall make case reports of tuberculosis to the Philadelphia Department of Health when the patient resides in Philadelphia County and to the Allegheny County Health Department when the patient resides in Allegheny County. The clinical laboratory shall send all other reports of tuberculosis to the Department's Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases unless otherwise directed by the Department.

§27.23. [School reports of communicable diseases] Reporting of cases by persons other than health care practitioners, health care facilities, veterinarians or laboratories.

[(a) School nurses shall report the presence of suspected reportable disease to the local health authority in accordance with existing requirements of the local health authority. A copy of this report shall be sent to the school administration.]

(b) An unusual increase in the number of absentees among school children shall be reported to the local health authority by the school nurse.]

Except as otherwise set forth in this section, and except with respect to reporting cancer, individuals in charge of the following types of group facilities IDENTIFYING A DISEASE, INFECTION OR CONDITION LISTED IN §27.21A (RELATING TO REPORTING OF CASES BY HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES) BY SYMPTOM, APPEARANCE OR DIAGNOSIS shall have the same reporting responsibilities as health care practitioners have under §27.21a (relating to reporting of cases by health care practitioners and health care facilities) MAKE A REPORT WITHIN THE TIMEFRAMES REQUIRED IN §27.21A:

- (1) Institutions maintaining dormitories and living rooms.
- (2) Orphanages.
- (3) Child care group settings.

§27.24. [Reports by heads of institution] (Reserved).

(a) Superintendents of hospitals or other persons in charge of an institution for the treatment of disease or of an institution maintaining dormitories and living rooms or of an orphanage shall notify the local health authorities having jurisdiction over the area in which the institution is located and the district director or county health officer upon the occurrence in or admission to the institution of a patient with a reportable disease and shall thereafter follow the advice and instructions of the health authorities for controlling the disease, but the notification may not relieve physicians of their duty to report in the manner set forth in §27.21 (relating to physicians who treat patients with reportable diseases including tuberculosis), cases which they may treat or examine in any such institution.

(b) Persons in charge of hospitals shall report cases of AIDS under §27.32 (relating to reporting AIDS).]

§27.24a. Reporting of cases by veterinarians.

A veterinarian is required to report a case, as specified in §27.4 (relating to reporting cases), only if the veterinarian treats or examines an animal which the veterinarian suspects of having a disease set forth in §27.35(a) (relating to reporting cases of disease in animals).

§27.25. [Reports by other licensed health practitioners] (Reserved).

[A chiropractor, dentist, nurse, optometrist, podiatrist or other licensed health practitioner having knowledge or suspicion of a reportable disease or condition, except cancer and AIDS, shall report promptly to the local board.]

§27.26. [Reporting by householders and others] (Reserved).

[A householder; proprietor of a hotel, rooming, lodging or boarding house; or other person having knowledge or suspicion of a reportable disease or condition, except cancer and AIDS, shall report this knowledge or suspicion promptly to the local board.]

§27.27. [Revision of diagnosis by attending physician] (Reserved).

[No diagnosis of a disease for which isolation or quarantine is required may be revised without the concurrence of the county health officer or the designated representative of the Department or the medical member of the local board.]

§27.28. [Reporting unusual or ill-defined diseases or illnesses] (Reserved).

[A person having knowledge of the occurrence of an unusual disease or group expression of illness which may be of public concern, whether or not it is known to be of a communicable nature, shall report it promptly to the local health officer; reports shall be made to the representative of the Department district director.]

§27.29. Reporting [nonreportable diseases] for special research projects.

A person in charge of [an] a hospital or other institution for the treatment of disease shall [be authorized], upon request of the Department, [to] make [a report] reports of [diseases and conditions other than reportable diseases,] a disease or condition for which the Board has approved a specific study to enable the Department to determine and employ the most efficient and practical means to protect and to promote the health of the people by the prevention and control of the [diseases and conditions] disease or condition. The reports shall be made on forms prescribed by the Department and shall be transmitted to the Department or to local [boards] health authorities as directed by the Department.

DISEASES AND CONDITIONS REQUIRING SPECIAL REPORTING

§27.30. Reporting ~~results~~ CASES of metabolic disease testing CERTAIN DISEASES in the newborn child.

[In addition to the requirements that may be applicable under this chapter, testing conducted on newborn children shall be reported in accordance with Chapter 28 (relating to metabolic diseases of the newborn).]

Reports of maple syrup urine disease, phenylketonuria, primary congenital hypothyroidism and sickle cell hemoglobinopathies shall be made to the Division of Maternal and Child Health, Bureau of Family Health, as specified in Chapter 28 (relating to metabolic diseases of the newborn) and those provisions of §27.4 (relating to reporting cases) consistent with the provisions of Chapter 28 and this section.

§27.31. Reporting cases of cancer.

(a) A hospital [or], clinical laboratory [within this Commonwealth which is designated by the Department], or other health care facility ~~diagnosing or providing treatment~~ PROVIDING SCREENING, DIAGNOSTIC OR THERAPEUTIC SERVICES FOR CANCER to cancer patients shall report [cases] each case of cancer [which are diagnosed or treated, or both, at the hospital or the laboratory] to the Department[. These reports shall be submitted [on forms] in a format prescribed by the Cancer Registry, Bureau of Health Statistics and Research, within [90] 180 days of the patient's discharge, if an inpatient or, if an outpatient, within [90] 180 days following diagnosis or initiation of treatment. [Hospitals and laboratories shall report, in addition to other information, the patient's name, address, sex, race, date of birth, cancer site and histology. Copies of laboratory reports shall be attached by the hospital or laboratory to the prescribed form.]

(b) A health care practitioner ~~diagnosing or providing treatment~~ PROVIDING SCREENING, DIAGNOSTIC OR THERAPEUTIC SERVICES to cancer patients FOR CANCER shall report each cancer case to the Department in a format prescribed by the Cancer Registry, Bureau of Health Statistics and Research, within 5 work days of diagnosis. Cases directly referred to or previously admitted to a hospital or other health care facility providing screening, diagnostic or therapeutic services to cancer patients in this Commonwealth, and reported by those facilities, are exceptions and do not need to be reported by the health care practitioner.

(c) The Department or its authorized representative shall be afforded physical access to all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes and all other facilities, individuals or agencies providing services to patients which would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer or medical status of any identified cancer patient.

[(b)](d) [The reports] Reports submitted [to the Cancer Registry] under this section are confidential and may not be open to public inspection or dissemination. Information for specific research purposes may be released in accordance with procedures established by the Department with the advice of the [Cancer Advisory Board] Pennsylvania Cancer Control, Prevention and Research Advisory Board.

(e) Case reports of cancer shall be sent to the Cancer Registry, DIVISION OF HEALTH STATISTICS, Bureau of Health Statistics and Research, unless otherwise directed by

the Department.

§27.32. [Reporting AIDS] (Reserved).

[(a) Physicians and hospitals shall report cases of AIDS promptly to the Department of Health, Division of Acute Infectious Disease Epidemiology, Post Office Box 90, Harrisburg, Pennsylvania 17108, or to the local health department in the counties of Allegheny, Bucks, Chester, Erie and Philadelphia and in the cities of Allentown, Bethlehem and York when the individual who is the subject of the report is a resident of the county or city.

(b) Local health authorities receiving reports of AIDS cases shall forward completed case report forms to the Department of Health in a timely manner. Completed forms shall provide identifying information, including but not limited to, the name of the case, the individual's address and telephone number, the name of the individual's medical provider and the reporting source.]

§27.33. Reporting cases of sexually transmitted disease.

(a) Reportable sexually transmitted diseases and infections are as follows:

- (i) Chancroid.
- (ii) Chlamydia trachomatis infections.
- (iii) Gonococcal infections.
- (iv) Granuloma inguinale.
- (v) Lymphogranuloma venereum.
- (vi) Syphilis.

(b) Case HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES SHALL MAKE CASE reports of these diseases and infections, except for cases of syphilis to be reported by a clinical laboratory, shall be made to the appropriate health authority of the county or municipal health department when the patient resides in a city or county that has its own health department. All other reports of sexually transmitted diseases shall be submitted to the Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases, unless otherwise directed by the Department LMRO WHERE THE CASE IS DIAGNOSED OR IDENTIFIED.

(c) A clinical laboratory making a case report of syphilis BY PAPER shall make the report to the Philadelphia Department of Health when the patient resides in Philadelphia County and to the Allegheny County Health Department when the patient resides in Allegheny County LMRO WHERE THE CASE IS DIAGNOSED OR IDENTIFIED. A clinical laboratory shall make all other reports to the Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases, unless otherwise directed by the Department MAKING A

CASE REPORT ELECTRONICALLY SHALL MAKE THE REPORT TO THE DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY, BUREAU OF EPIDEMIOLOGY.

§27.34. Reporting cases of lead poisoning.

(a) *REPORTING BY CLINICAL LABORATORIES.*

(1) A clinical laboratory shall report all blood lead test results on both venous and capillary specimens for persons under 16 years of age and pregnant women to the Childhood Lead Poisoning Prevention Program, Division of Maternal and Child Health, Bureau of Family Health TO THE CHILDHOOD LEAD POISONING PREVENTION PROGRAM, DIVISION OF MATERNAL AND CHILD HEALTH, BUREAU OF FAMILY HEALTH.

(2) A CLINICAL LABORATORY SHALL REPORT AN ELEVATED BLOOD LEAD LEVEL IN A PERSON 16 YEARS OF AGE OR OLDER TO THE DIVISION OF ENVIRONMENTAL HEALTH EPIDEMIOLOGY, BUREAU OF EPIDEMIOLOGY OR TO OTHER LOCATIONS AS DESIGNATED BY THE DEPARTMENT. AN ELEVATED BLOOD LEAD LEVEL IS DEFINED BY THE NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (NIOSH). AS OF _____ (EFFECTIVE DATE OF RULEMAKING), NIOSH DEFINES AN ELEVATED BLOOD LEAD LEVEL AS A VENOUS BLOOD LEAD LEVEL OF 25 MICROGRAMS PER DECILITER (UG/DL) OR HIGHER. THE DEPARTMENT WILL PUBLISH IN THE *PENNSYLVANIA BULLETIN* ANY NIOSH UPDATE OF THE DEFINITION WITHIN 30 DAYS OF NIOSH'S NOTIFICATION TO THE DEPARTMENT.

(1)(3) A clinical laboratory which conducts blood lead tests of 100 or more specimens per month shall submit results electronically in a format specified by the Department.

(2)(4) A clinical laboratory which conducts blood lead tests of less than 100 blood lead specimens per month shall submit results either electronically or by hard copy in the format specified by the Department.

(b) A clinical laboratory shall report cases of lead poisoning in persons 16 years of age or older as evidenced by a venous blood lead level of 25 micrograms per deciliter (ug/dL) or higher, to the Division of Environmental Health Assessment, Bureau of Epidemiology, or to other locations as designated by the Department.

(1) The Department may change this reporting level to comply with regulatory requirements or guidelines of Federal environmental or occupational

health agencies by publishing a notice in the *Pennsylvania Bulletin* to this effect no later than 60 days before the change is implemented.

(2) — The change will not remain in effect for more than 90 days after publication unless the Board acts to affirm the change within that 90-day period.

(e) (5) A laboratory which performs blood lead tests on blood specimens collected in this Commonwealth shall be licensed as a clinical laboratory and shall be specifically approved by the Department to conduct those tests.

(d)(6) Blood lead analyses requested for occupational health purposes on blood specimens collected in this Commonwealth shall be performed only by laboratories which are licensed and approved as specified in subsection (e) PARAGRAPH (5), and which are also approved by the Occupational Safety and Health Administration of the United States Department of Labor under 29 C.F.R. 1910.1025(j)(2)(iii) (relating to lead).

(e) — A physician under whose authorization blood is collected for a blood lead test is responsible for assuring that all of the information requested on the case report form is forwarded to the clinical laboratory along with the specimen. Failure of the physician to provide the requested information to the clinical laboratory may result in disciplinary consequences as specified in §27.6(e) (relating to disciplinary consequences for violating reporting responsibilities).

(f) (7) A clinical laboratory shall complete a blood lead test within 5 work days of the receipt of the blood specimen and shall submit the case report to the Department no later than the close of business of the next work day after the day on which the test was performed. The clinical laboratory shall submit a report of lead poisoning using either the hard-copy form or electronic transmission format specified by the Department.

(g) (8) When a clinical laboratory receives a blood specimen without all of the information required for reporting purposes, the clinical laboratory shall test the specimen and shall submit the incomplete report to the Department as described in subsection (f).

(h) — A clinical laboratory shall proceed as follows when a blood specimen is received with missing information:

(1) — Within 5 days after the receipt of the blood specimen, the clinical laboratory shall return the incomplete report form to the person who submitted the specimen. The clinical laboratory shall include with the form a letter instructing the submitter to complete all missing information on the form and return the form to the laboratory within 14 days of the date of the letter.

(2) — Within 1 day after receipt of the completed form from the person who submitted the specimen, the clinical laboratory shall forward a report containing

all requested information to the Department.

(i) If the person who submitted the specimen does not enter the missing items of information and return the completed form to the clinical laboratory within the time period specified in subsection (h)(1), the clinical laboratory shall notify the Department using either the hard-copy form or electronic reporting format specified by the Department. The clinical laboratory shall submit this information to the Department within 2 weeks of the due date for return of completed forms by the person who submitted the specimen. This information shall include:

(1) The name and address of the person who submitted the specimen.

(2) The name of the patient.

(3) The date of specimen collection.

(4) The date of specimen analysis.

(5) Other information as requested by the Department.

(i) — A clinical laboratory that fails to report applicable results or to notify the Department of a person who submits a specimen without providing complete information shall be subject to revocation of approval to perform blood lead tests or other disciplinary action.

(B) REPORTING BY HEALTH CARE PRACTITIONERS OR HEALTH CARE FACILITIES.

A HEALTH CARE PRACTITIONER OR HEALTH CARE FACILITY SHALL REPORT ALL CASES OF LEAD POISONING FOR PERSONS UNDER 16 YEARS OF AGE AND PREGNANT WOMEN TO THE LEAD POISONING PREVENTION PROGRAM, CHILD AND ADULT HEALTH SERVICES DIVISION, BUREAU OF FAMILY HEALTH. A CASE OF LEAD POISONING SHALL BE A LEAD LEVEL OF 20 UG/DL OR GREATER OR A PERSISTENT ELEVATED BLOOD LEAD LEVEL (2 OR MORE VENOUS BLOOD LEAD LEVELS OF 15 TO 19 UG/DL (INCLUSIVE) AT LEAST THREE MONTHS APART).

§27.35. Reporting cases of disease in animals.

(a) The following diseases, infections, and conditions in animals are reportable to the Division of Communicable INFECTIONOUS Disease Epidemiology, Bureau of Epidemiology, as specified in §27.4 (relating to reporting cases) within 5 work days after being identified:

Anthrax.
Arboviruses.
Brucellosis.
Plague.
Psittacosis.
Rabies.
Transmissible Spongiform Encephalopathies
Tuberculosis.
Tularemia.
Any disease, infection or condition covered by §27.3(b) (relating to reporting outbreaks and unusual diseases, infections and conditions.)

(b) This chapter applies ONLY to only animals having or suspected of having one of the diseases, infections or conditions listed in subsection (a).

[REPORTS BY LOCAL HEALTH OFFICERS]

REPORTING BY LOCAL MORBIDITY REPORTING OFFICES

§27.41. [Individual case reports] (Reserved).

[A health officer of a municipality shall report weekly to the appropriate county health authorities on the prescribed form each individual case of reportable disease or condition which as been reported to him during the week.]

§27.41a. Reporting by local morbidity reporting offices of case reports received.

When an AN LMRO is an office of a county or municipal health authority, it THAT IS NOT ONE OF THE DEPARTMENT'S DISTRICT OFFICES shall report a case that has been reported to it to the district office for the State health district in which it is located, or to the central office when this chapter directs that reports are to be filed with that office.

§27.42. [Summary reports] (Reserved).

[For cases of influenza, the local health officer of a municipality shall prepare and send to the appropriate county health authorities once each week a report on the prescribed form showing the number of cases reported during that week.]

§27.42a. Reporting by local morbidity reporting offices of completed case investigations.

(a) When an LMRO is an office of a local health authority other than a local health department, it shall complete a case investigation report in a format and within the length of time set forth in this chapter for each case reported to it.

(b) — When an AN LMRO THAT IS NOT ONE OF THE DEPARTMENT'S DISTRICT OFFICES is an office of a local health department, it shall submit, on a weekly basis, a case investigation report of the information from each case investigation which has resulted in confirmation of the incidence of a reportable disease, infection or condition. The report shall be submitted to the appropriate Department office as follows in a format and within the length of time set forth in this chapter:

(1) AIDS. To the HIV/AIDS Epidemiology Section, DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY, Bureau of Epidemiology.

(2) Chickenpox, diphtheria, measles, mumps, pertussis, polio, rubella, and tetanus. To the Division of Immunizations, Bureau of Communicable Diseases.

(3) Chancroid, Chlamydia trachomatis infections, gonococcal infections, granuloma inguinale, Lymphogranuloma venereum, syphilis, and tuberculosis. To the Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases.

(4) Other reportable diseases and conditions. To the Division of Communicable INFECTIOUS Disease Epidemiology, Bureau of Epidemiology.

§27.43. [Immediate reports by telephone or telegraph] (Reserved).

[A local health officer of a municipality shall report immediately by telephone or telegraph to the appropriate county health authorities a case or suspected case of the following:

- (1) Anthrax.
- (2) Botulism.
- (3) Cholera.
- (4) Diphtheria.
- (5) Food poisoning.
- (6) Measles.
- (7) Plague.
- (8) Poliomyelitis.
- (9) Psittacosis (Ornithosis).
- (10) Rabies in man.
- (11) Smallpox.
- (12) Yellow fever.]

§27.43a. Reporting by local morbidity reporting offices of outbreaks and selected diseases.

(a) ~~When an~~ AN LMRO THAT IS NOT ONE OF THE DEPARTMENT'S DISTRICT OFFICES is an office of a local health authority, it shall report an outbreak by telephone on the same day that the outbreak is reported or otherwise made known to it, as follows:

(1) *AIDS.* To the HIV/AIDS Epidemiology Section, DIVISION OF INFECTIOUS DISEASE EPIDEMIOLOGY, Bureau of Epidemiology.

(2) *Chancroid, chlamydia trachomatis infections, gonococcal infections, granuloma inguinale, lymphogranuloma venereum, syphilis, and tuberculosis.* To the Division of Tuberculosis and Sexually Transmitted Diseases, Bureau of Communicable Diseases.

(3) *Chickenpox, diphtheria, measles, mumps, pertussis, polio, rubella, and tetanus.* To the Division of Immunizations, Bureau of Communicable Diseases.

(4) *Other reportable diseases and conditions.* To the Division of ~~Communicable~~ INFECTIOUS Disease Epidemiology, Bureau of Epidemiology.

(b) ~~When an~~ AN LMRO THAT IS NOT ONE OF THE DEPARTMENT'S DISTRICT OFFICES is an office of a local health authority, it shall report by telephone on the same day any of the following diseases is reported or otherwise made known to it, as follows:

(1) *Diphtheria, measles, pertussis and polio.* To the Division of Immunizations, Bureau of Communicable Diseases.

(2) *Anthrax, ARBOVIRUS DISEASE, ~~botulism~~, cholera, enterohemorrhagic Escherichia coli, hantavirus pulmonary syndrome, FOOD BORNE BOTULISM, HAEMOPHILUS INFLUENZAE INVASIVE DISEASE IN A CHILD UNDER 15 YEARS OF AGE, hemorrhagic fever, ~~hepatitis A~~, hepatitis E, human rabies, ~~meningitis~~, LEGIONELLOSIS, plague, SMALLPOX, typhoid fever, and yellow fever.* To the Division of ~~Communicable~~ INFECTIOUS Disease Epidemiology, Bureau of Epidemiology.

§27.44. [Destinations of reports] (Reserved).

[Morbidity reports, as outlined in §§27.41-27.43 (relating to individual case reports; summary reports; and immediate reports by telephone or telegraph) shall be submitted by local health

officers of municipalities to the appropriate health authority as follows:

- (1) The local health officer in a municipality situated in a county not organized as a county department of health shall report to the State health center.
- (2) The local health officer of a municipality situated in a county organized as a county department of health shall report to the county health office.]

§27.45. [Reports to the Department] (Reserved).

[Health officers of cities of the first class, of county or joint county, of municipal or joint municipal departments of health and district directors shall transmit to the Harrisburg office of the Department once each week on specific disease case report forms furnished or approved for this purpose by the Department, individual specific disease case report forms and summary reports described in §§27.41-27.43 (relating to individual case reports; summary reports; and immediate reports by telephone or telegraph).]

§27.46. [Records of local health officers] (Reserved).

[A local health officer of a municipality shall maintain records that will permit the efficient function of the local department for the prevention and control of communicable diseases.]

§27.47. [Reports by the Department] (Reserved).

[In a county designated as a county morbidity reporting area, the State health center of the Department shall report at weekly intervals to local boards of health within the morbidity reporting area cases of communicable and noncommunicable diseases reported from the jurisdiction of that board of health.]

[REPORTING VIRAL HEPATITIS TO BLOOD BANKS]

§27.51. [Time and information reported] (Reserved).

[If, in the opinion of the Department, or of the health officer of a county department of health or of the department of health of a city of the first class, it is deemed advisable and is in the interest of public health, the health officer shall report to blood banks serving their areas the name, date of onset and other identifying information of a case of viral hepatitis.]

Subchapter C. QUARANTINE AND ISOLATION

GENERAL PROVISIONS

Sec.

- 27.60. Disease control measures.
- 27.61. [Prompt isolation] Isolation.
- 27.62. [Isolation instructions] (Reserved).
- 27.63. [Modified isolation] (Reserved).
- 27.64. [Isolation within hospitals] (Reserved).
- 27.65. Quarantine [instructions].
- 27.66. Placarding.
- 27.67. Movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department.
- 27.68. Release from isolation [and] or quarantine.
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COMMUNICABLE DISEASES IN [SCHOOL] CHILDREN AND STAFF ATTENDING SCHOOLS AND CHILD CARE GROUP SETTINGS

- 27.71. Exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN, for specified diseases and infectious conditions.
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- 27.73. Readmission of excluded pupils [showing symptoms] CHILDREN, and staff HAVING CONTACT WITH CHILDREN.
- 27.74. ~~Admission~~ Readmission of exposed or isolated pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN.
- 27.75. Exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN during a measles [(rubeola)] outbreak.

27.76. Exclusion and readmission of children, and staff HAVING CONTACT WITH CHILDREN, in child care group settings.

27.77. Immunization requirements for children in child care group settings.

GENERAL PROVISIONS

§27.60. Disease control measures.

The Department or local health authority shall direct isolation of a person or an animal with a communicable disease or infection; surveillance, segregation, quarantine or modified quarantine of contacts of a person or an animal with a communicable disease or infection; and any other disease control measure the Department or the local health authority considers to be appropriate for the surveillance of disease, when the disease control measure is necessary to protect the public from the spread of infectious agents. THE DEPARTMENT AND LOCAL HEALTH AUTHORITY WILL DETERMINE THE APPROPRIATE DISEASE CONTROL MEASURE BASED UPON THE DISEASE OR INFECTION, THE PATIENT'S CIRCUMSTANCES, THE TYPE OF FACILITY AVAILABLE AND ANY OTHER AVAILABLE INFORMATION RELATING TO THE PATIENT AND THE DISEASE OR INFECTION. If a local health authority is not a local health department AN LMRO, it shall consult with and receive approval from the Department prior to taking any disease control measure.

§27.61. [Prompt isolation] Isolation.

When the isolation of [an individual ill with any communicable disease, or the quarantine of susceptible contacts, is required by the provisions of Subchapter E (relating to procedure for treating each reportable disease), the] a person or animal that is suspected of harboring an infectious agent is appropriate, the Department or local health [officer] authority shall cause the isolation [or quarantine] to be done promptly following receipt of the case report.

(1) If the local health authority is not an LMRO, the local health officer shall consult with and receive approval from the Department prior to requiring isolation.

(2) If more than one jurisdiction is involved, the local health officer shall cause a person or animal to be isolated only after consulting with and receiving approval from the Department.

(3) The Department or local health authority shall ensure that instructions are given to the case or persons responsible for the care of the case and to members of the household or appropriate living quarters, defining the area within which the case is to be isolated and identifying the measures to be taken to prevent the spread of disease.

§27.62. [Isolation instructions] (Reserved).

[If the disease is one requiring isolation, the local health authority shall insure that instructions are given to the patient and members of the household defining the area within which the patient is to be isolated and stating the measures to be taken to prevent the spread of the disease.]

§27.63. [Modified isolation.] (Reserved).

[If the disease is one for which only a modified isolation is required the local health authority shall issue appropriate instructions, prescribing the isolation technique to be followed. The isolation technique shall depend upon the disease.]

§27.64. [Isolation within hospitals] (Reserved).

[A case of a communicable disease may be treated in any hospital, if the patient is isolated in a private room, cubicle or ward where none but patients with the same disease are segregated, and if the isolation technique is observed. The requirements of the rule relating to isolation for a specific disease which the patient experienced, as described in Subchapter E (relating to procedure for reporting each reportable disease), shall be observed while the patient is hospitalized; however, the removal of the patient to this home during the period of isolation or quarantine may be permitted if the requirements of §27.67 (relating to the movement of persons subject to isolation or quarantine) are observed.]

§27.65. Quarantine [instructions].

If the disease is one [requiring] which the Department, or a local health authority which is also an LMRO, determines TO REQUIRE the quarantine of [the] contacts in addition to isolation of the case, the Department or local health [authority] officer of the LMRO shall determine [the] which contacts [who are subject to quarantine] shall be quarantined, specify the place to which they shall be quarantined, and issue appropriate instructions.

(1) When any other local health authority is involved, the local health officer shall quarantine contacts only after consulting with and receiving approval from the Department.

(2) The Department or local health [authority] officer shall [insure] ensure that provisions are made for the medical observation of the contacts as frequently as necessary during the quarantine period.

§27.66. Placarding.

Whenever the Department or a local health [authority is unable to enforce] officer has reason to believe that a case, a contact or others will not fully comply with the isolation or quarantine as required for the protection of the public health and [he] the Department or local health officer deems it necessary to use placards, placards may be utilized [in its jurisdiction]. Placards may be utilized by a local health officer of a local health authority that is not an LMRO only if the specific use is approved by the Department.

§27.67. Movement of persons and animals subject to isolation or quarantine by action of a local health authority or the Department.

(a) A person [under] or animal subject to isolation or quarantine by action of a local health authority or the Department may be removed to another [dwelling or a hospital] location only with permission of the local health [officer concerned,] authority or the Department. If the local health authority is not an LMRO, the local health authority shall consult with and receive approval from the Department prior to permitting removal. Permission for removal may be given by the Department if the local health officer is not available.

(b) Removal of a [patient] person or animal under isolation or quarantine by action of the Department or a local health authority, from [one health] the jurisdiction [to another within this Commonwealth] of the Department or a local health authority to the jurisdiction of the Department or another local health authority may [be made] occur only with permission of [the health officers concerned or] the Department, if it is involved, and with the permission of the local health [officer] authorities concerned [is not available]. If both of the local health authorities involved are not LMROs, the local health authorities shall consult with and receive approval from the Department prior to permitting removal. Permission for removal may be given by the Department if a local health officer from whom permission would otherwise be required is not available.

(c) Interstate [removal] transportation to or from this Commonwealth of a person or animal under isolation or quarantine may be made only with permission of the Department.

(d) Transportation of a person or animal under isolation or quarantine shall be made by private conveyance or as otherwise ordered by the local health [officer] authority or the Department. If the local health authority is not an LMRO, it shall consult with the Department prior to issuing an order. [Due] The sender, the receiver and the transporter of the PERSON OR animal shall be responsible to take due care [shall be taken] to prevent the spread of the disease.

(e) [Immediately upon the arrival of the patient at the point of destination, isolation, or quarantine shall be resumed for the period of time required for the specific disease.] When a person or animal under isolation or quarantine is transported, isolation or quarantine shall be

resumed for the period of time required for the specific disease immediately upon arrival of the person or animal at the point of destination.

§27.68. Release from isolation [and] or quarantine.

The Department or [the] a local health [officer] authority may order [release] that a person or animal isolated or quarantined pursuant to the direction of the Department or to the appropriate health authority be released from isolation or quarantine when [the provisions of this title of the Department have been met] the Department or the local health authority determines that the person or animal no longer presents a public health threat. If the local health authority involved is not an LMRO, it shall consult with, and receive approval from, the Department prior to making the order.

§27.69. Laboratory analysis.

Whenever [the regulations of the Department provide for the submission of] a laboratory [specimens] specimen is to be examined for the presence of [micro-] etiologic organisms [in order] to determine the duration of isolation or quarantine or to determine the eligibility of a person or animal for release from isolation or quarantine, the [specimens] specimen shall be examined in a laboratory [of the Department or in one] approved by the Department [for] to conduct that type of examination [of the specimens].

**COMMUNICABLE DISEASES IN [SCHOOL] CHILDREN
AND STAFF ATTENDING SCHOOLS AND CHILD CARE GROUP SETTINGS**

§27.71. Exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN, for specified diseases and infectious conditions.

[Each teacher, principal, superintendent or other] A person in charge of a public, private, parochial, Sunday or other school or college [or preschool] shall exclude [students] from school [who have been diagnosed by a physician or are suspected of having the disease by the school nurse for the indicated period of time for the following diseases:] a pupil CHILD, or a staff person, INCLUDING A VOLUNTEER, who has contact with pupils CHILDREN, who is suspected by a physician or the school nurse of having any of the communicable diseases, infections or conditions. Readmission shall be contingent upon the school nurse or, in the absence of the school nurse, a physician, verifying that the criteria for readmission have been satisfied. The diseases, the periods of exclusion and the criteria for readmission are as follows:

- (1) *Diphtheria* - Two weeks from the onset or until appropriate negative culture tests. [Reference should be made to §27.108 (relating to diphtheria).]

- (2) *Measles* - Four days from the onset of rash. [Reference should be made to §27.121 (relating to measles (rubeola)).] Exclusion may also be ordered by the Department as specified in §27.160 (relating to special requirements for measles).
- (3) *Mumps* - Nine days from the onset or until subsidence of swelling. [Reference should be made to §27.124 (relating to mumps).]
- (4) *Pertussis* - [~~Four~~] Three weeks from the onset or [7] 5 days from institution of appropriate antimicrobial therapy. [Reference should be made to §27.126 (relating to pertussis (whooping cough)).]
- (5) *Rubella* - [~~Four~~] Seven days from the onset of rash. [Reference should be made to §27.134 (relating to Rubella (German measles) and congenital rubella syndrome).]
- (6) *Chickenpox* - [~~Six~~] Five days from the [last crop of vesicles] appearance of the first crop of vesicles, or when all the lesions have dried and crusted, which ever is sooner.
- (7) *Respiratory streptococcal infections including scarlet fever* – [Not less than 7] At least 10 days from the onset if no physician is in attendance or 24 hours [from] after institution of appropriate antimicrobial therapy.
- (8) [*Acute contagious*] *Infectious conjunctivitis (pink eye)* - [Twenty-four hours from institution of appropriate therapy] Until judged not infective; that is, without a discharge.
- (9) *Ringworm* - [all types - Until judged noninfective by the nurse in school, college or preschool, or child's physician.] The person shall be allowed to return to school, child care or other group setting immediately after the first treatment, if body lesions are covered. Neither scalp nor body lesions that are dried need to be covered.
- (10) *Impetigo contagiosa* - [Until judged noninfective by the nurse in school, college or preschool, or by the child's physician] Twenty-four hours after the institution of appropriate treatment.
- (11) *Pediculosis capitis* - [Until judged noninfective by the nurse in school, college or preschool, or by the child's physician.] The person shall be allowed to return to either the school, child care, or other group setting immediately after first treatment. The person shall be reexamined for infestation by the school nurse, or other health care practitioner, 7 days posttreatment.
- (12) *Pediculosis corpora* - [Until judged noninfective by the nurse in school, college or preschool, or child's physician] After completion of appropriate treatment.
- (13) *Scabies* - [Until judged noninfective by the nurse in school, college or preschool,

or by the child's physician] After completion of appropriate treatment.

(14) [*Tonsillitis* - Twenty-four hours from institution of appropriate therapy.

(15)] *Trachoma* - Twenty-four hours [from] after institution of appropriate [therapy] treatment.

(15) *Tuberculosis* - Following a minimum of 2 weeks adequate chemotherapy and three consecutive negative morning sputum smears, if obtainable. In addition, a note from the attending physician that the person is noncommunicable shall be submitted prior to readmission.

(16) *NEISSERIA MENINGITIDIS*. UNTIL JUDGED NONINFECTIVE AFTER A COURSE OF RIFAMPIN OR OTHER DRUG WHICH IS EFFECTIVE AGAINST THE NASOPHARYNGEAL CARRIAGE STATE OF THIS DISEASE, OR UNTIL OTHERWISE SHOWN TO BE NONINFECTIVE.

§27.72. Exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN, FOR showing symptoms.

(a) A [teacher, principal, superintendent, or other] person in charge of a public, private, parochial, Sunday or other school or college shall, following consultation with a physician or school nurse, exclude immediately a [person] pupil CHILD, or staff person, INCLUDING A VOLUNTEER, HAVING CONTACT WITH CHILDREN, showing [an unusual skin eruption, having soreness of the throat or having signs or symptoms of whooping cough or diseases of the eyes. The exclusion and the reasons prompting it shall be reported to the health authority of the municipality or county in which the school is situated, together with the name and address of the person excluded.] any of the following symptoms, unless that person is determined by the school nurse, or a physician, to be noncommunicable:

(1) Mouth sores associated with inability to control saliva.

(2) Rash with fever or behavioral change.

(3) Purulent discharge from the eyes.

(4) Productive cough with fever.

(5) Oral or axillary temperature equal to or greater than 102° F.

(6) Unusual lethargy, irritability, persistent crying, difficulty breathing or other signs of severe illness.

(7) Vomiting PERSISTENT VOMITING.

(8) PERSISTENT DIARRHEA.

(b) The school shall maintain a record of the exclusion and the reasons prompting the exclusion and shall review the record to determine when unusual rates of absenteeism occur. The Department will periodically determine and publish in the Pennsylvania Bulletin what increase in absenteeism constitutes an unusual rate of absenteeism.

§27.73. Readmission of excluded pupils [showing symptoms] CHILDREN, and staff HAVING CONTACT WITH CHILDREN.

(a) [No person] A pupil CHILD or staff person, INCLUDING A VOLUNTEER, HAVING CONTACT WITH CHILDREN, excluded from a public, private, parochial or other school or college under [the provisions of] §27.72 (relating to exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN, FOR showing symptoms) may not be readmitted until the school nurse [in the school, college or preschool] or, in the absence of a school nurse, a physician, is satisfied that the condition for which the [child] person was excluded is not communicable or until the [child] person presents a [certificate of recovery or noninfectiousness] statement from [the] a physician that the person has recovered or is non-infectious.

(b) A pupil CHILD, or staff person, INCLUDING A VOLUNTEER, HAVING CONTACT WITH CHILDREN, excluded for the following reasons shall be readmitted only when a physician has determined the illness to be either resolved, noncommunicable or in a noncommunicable stage:

(1) Rash with fever or behavioral change.

(2) Productive cough with fever.

§27.74. [Admission] Readmission of exposed or isolated pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN.

[No person] A pupil CHILD, or staff person, INCLUDING A VOLUNTEER, HAVING CONTACT WITH CHILDREN, who has been absent from school by reason of having had or because of residing on premises where there has been a disease for which isolation is required, may not be readmitted to school without the permission of the [health authorities] LMRO. [The person shall be required to secure permission whether or not there has been a physician in attendance or whether or not isolation has been established in the household.]

§27.75. Exclusion of pupils CHILDREN, and staff HAVING CONTACT WITH CHILDREN, during a measles [(rubeola)] outbreak.

Pupils [who are presumed susceptible may] CHILDREN, and staff, INCLUDING A VOLUNTEER, HAVING CONTACT WITH CHILDREN, shall be excluded from school during a measles [(rubeola)] outbreak under the procedures described in [§27.121] §27.160 (relating to special requirements for measles [(rubeola)]).

§27.76. Exclusion and readmission of children, and staff HAVING CONTACT WITH CHILDREN, in child care group settings.

(a) Sections 27.71- 27.75 apply to child care group settings, with the exception that readmission of excluded persons as provided in those sections, as well as provided in this subsection, shall be contingent upon a physician verifying that the criteria for readmission have been satisfied. The following conditions and circumstances also govern exclusion from and readmission to a child care group setting of a child, or a staff person, INCLUDING A VOLUNTEER, who has contact with children attending the child care group setting:

- (1) *Meningococcal meningitis or meningococemia. Until made noninfective by a course of rifampin or other drug which is effective against the nasopharyngeal carriage stage of this disease, or otherwise shown to be noninfective.*
- (2) *Haemophilus influenzae (H. flu) meningitis or other invasive H. flu disease. Until made noninfectious by a course of rifampin or other drug which is effective against the nasopharyngeal carriage stage of this disease, or otherwise shown to be noninfective.*
- (3) *Diarrhea PERSISTENT DIARRHEA. Until resolved or judged to be noninfective when associated with any of the following:*
 - (i) *Inability to prevent contamination of the environment with feces.*
 - (ii) *Fever.*
 - (iii) *Identified bacterial or parasitic pathogen.*
- (4) *Fever in children younger than 4 months of greater than 101 ° F. rectally or 100 ° F. axillary; in children 4-24 months of greater than 102 ° F. rectally or 101 ° F. axillary. Until resolved or judged to be noninfective.*
- (5) *Hepatitis A, viral hepatitis unspecified, or jaundice of unspecified etiology. Until 1 week following the onset of jaundice, or 2 weeks following*

symptom onset or IgM antibody positivity if jaundice is not present.

(6) Shigellosis. Until the etiologic organism is eradicated. See §27.158 (relating to special requirements for shigellosis).

(7) Typhoid fever or paratyphoid fever. Until the etiologic organism is eradicated. See §27.159 (relating to special requirements for typhoid fever and paratyphoid fever).

(8) Exposure to an individual with invasive H. influenza disease if children less than 4 years of age attend the child care group setting in the same room as the exposed person. Until the institution of treatment with appropriate antibiotic to eradicate the nasopharyngeal carrier state, or until proven noninfectious with nasopharyngeal cultures, or until 30 days following the exposure. Exclusion shall be postponed, until the second day following notice that exclusion will be required, to give the individual sufficient time to arrange for institution of appropriate antibiotic treatment.

(9) Exposure to an individual with meningococcal disease. Until the institution of treatment with appropriate antibiotic to eradicate the nasopharyngeal carrier state, or until proven noninfectious with nasopharyngeal cultures, or until 30 days following the exposure. Exclusion shall be postponed, until the second day following notice that exclusion will be required, to give the individual sufficient time to arrange for institution of appropriate antibiotic treatment.

(b) To facilitate the proper exclusion of sick children and staff, the caregiver at a child care group setting shall arrange for the following:

(1) Instruction of staff, INCLUDING VOLUNTEERS, regarding exclusion and screening criteria which THAT apply to themselves and attending children.

(2) Instruction of parents and guardians regarding exclusion criteria and that they are to notify the caregiver within 24 hours after it is determined or suspected that a child has an illness or condition for which exclusion is required.

(3) Screening FOLLOWUP AFTER EXCLUSION of each A child by staff at the time the child is brought to the child care group setting for the presence of a TO ENSURE THAT THE condition which requires REQUIRED exclusion HAS BEEN RESOLVED. The screening shall be conducted each day while the parent, guardian, or other person bringing the child to the child care group setting is present.

§27.77.

Immunization requirements for children in child care group settings.

(a) Caregiver responsibilities.

(1) Except as exempted in subsection (d), effective (60 days after final publication of these regulations), the caregiver at a child care group setting may not accept or retain a child 2 months of age or older at the setting, for more than 60 days, unless the caregiver has received a written objection to a child being vaccinated on religious grounds from a parent or guardian, or one of the following:

(i) For all children not exempt under subsection (d) (1) (ii), an initial written verification from a physician, the Department or a local health department of the dates (month, day and year) the child was administered any vaccines recommended by ACIP. The verification shall also specify any vaccination not given due to medical condition of the child and shall state whether the condition is temporary or permanent. The verification shall show compliance with the vaccination requirements in subsection (b).

(ii) For all children for whom vaccinations remain outstanding following the caregiver's receipt of the initial written verification, subsequent written verifications from a physician, the Department or a local health department as additional vaccinations become due. These verifications shall be prepared in the same manner as set forth in subparagraph (i), but need not repeat information contained in a previously submitted verification. The verifications shall demonstrate continuing compliance with the vaccination requirements in subsection (b).

(2) If the caregiver receives a written verification under paragraph (1) explaining that timely vaccination did not occur due to a temporary medical condition, the caregiver shall exclude the child from the child care group setting after an additional 30 days unless the caregiver receives, within that 30-day period, written verification from a physician, the Department or a local health department that the child was vaccinated or that the temporary medical condition still exists. If the caregiver receives a written verification that vaccination has not occurred because the temporary condition persists, the caregiver shall require the presentation of a new verification at 30-day intervals. If a verification is not received as required, the caregiver shall exclude the child from the child care group setting and not readmit the child until the caregiver receives a verification that meets the requirements of this section.

(3) The caregiver shall retain the written verification or objection referenced in paragraphs (1) and (2) for 60 days following the termination of the child's attendance.

(4) The caregiver shall ensure that a certificate of immunization is completed and signed for each child enrolled in the child care group setting. The certificates shall be periodically updated by the caregiver to include the information provided to the caregiver pursuant to subsection (a) WHEN THAT ADDITIONAL INFORMATION IS RECEIVED. The immunization status of each enrolled child shall be summarized and reported on an annual basis to the Department at the time prescribed by the Department and on the form provided by the Department.

(b) *Vaccination requirements.* Each child enrolled in a child care group setting shall be immunized in accordance with ACIP standards in effect on January 1, 1999, governing the issuance of ACIP recommendations for the immunization of children.

(1) The standards are as follows:

(i) The immunization practice is supported by both published and unpublished scientific literature as a means to address the morbidity and mortality of the disease.

(ii) The labeling and packaging inserts for the immunizing agent are considered.

(iii) The immunizing agent is safe and effective.

(iv) The schedule for use of the immunizing agent is administratively feasible.

(2) The Department will deem an ACIP recommendation pertaining to the immunization of children to satisfy the standards in this subsection unless ACIP alters its standards for recommending immunizations for children by eliminating a standard set forth in this subsection and the recommendation is issued under those changed standards.

(c) *Notice.* The Department will place a notice in the *Pennsylvania Bulletin* listing publications containing ACIP recommendations issued pursuant to the standards in subsection (b). The Department will publish the initial notice contemporaneously with the publication of this chapter. The Department will update that list in a notice which it will publish in the *Pennsylvania Bulletin* within 30 days after ACIP issues a recommendation which satisfies the criteria of this section.

(d) *Exemptions.*

(1) This section does not apply to the following:

(i) Kindergarten, elementary school or higher school. These caregivers shall comply with the standards in §§23.81-23.87 (relating to immunization).

(ii) Children who are known by the caregiver to be 6 years of age or older or to attend a kindergarten, elementary school or high school.

(iii) A caregiver who does not serve as a caregiver for at least 40 hours during at least 1 month.

(2) The requirement imposed by subsection (a), to not accept a child into a child care group setting without receiving an initial written verification or objection specified in subsection (a), does not apply during a month the caregiver does not serve as a caregiver for at least 40 hours.

(e) Exclusion when disease is present. Whenever one of the diseases mentioned in §27.76 (relating to exclusion and readmission of children, and staff HAVING CONTACT WITH CHILDREN, in child care-giver CARE GROUP settings) has been identified within a child care group setting, the Department or a local health department may order the exclusion from the child care group setting or any other child care group setting which is determined to be at high-risk of transmission of that disease, of an individual susceptible to that disease in accordance with public health standards as determined by the Department.

Subchapter D. [VENEREAL DISEASES] SEXUALLY TRANSMITTED DISEASES, TUBERCULOSIS AND OTHER COMMUNICABLE DISEASES

Sec.

27.81. Examination of persons suspected of being infected.

27.82. Refusal to submit to examination.

27.83. Court ordered examinations.

27.84. Examination for a sexually transmitted disease of persons detained by police authorities.

27.85. Diagnosis and treatment of [venereal] a sexually transmitted disease.

27.86. [Sale of drugs for venereal disease] (Reserved).

27.87. Refusal to submit to treatment for communicable diseases.

- 27.88. [Quarantine in jails] Isolation and quarantine on appropriate institutions.
- 27.89. [Premarital examination for syphilis.] Examinations for syphilis.
- 27.90. [Appeal from a denial of statement of the physician] (Reserved).
- 27.91. [Form for statement of physician] (Reserved).
- 27.92. [Misrepresentation of facts and release of information] (Reserved).
- 27.93. [Waiver of syphilis examination] (Reserved).
- 27.94. [Prenatal examination for syphilis] (Reserved).
- 27.95. Reporting [birth] syphilis examination information for births and fetal deaths.
- 27.96. Diagnostic tests for [venereal] sexually transmitted diseases.
- 27.97. Treatment of minors.
- 27.98. Prophylactic treatment of newborns.
- 27.99. Prenatal examination for hepatitis B.

§27.81. Examination of persons suspected of being infected.

Whenever the Department or a local [qualified medical] health [officer] authority has reasonable grounds to suspect a person of being infected with an organism causing a [venereal] sexually transmitted disease, tuberculosis or other communicable disease, or of being a carrier, but lacks confirmatory medical or laboratory evidence, the Department or the [officer will] local health authority may require the person to undergo a medical examination and any other approved diagnostic procedure to determine whether or not [he] the person is infected or is a carrier. If the local health authority involved is not an LMRO, the local health authority shall consult with and receive approval from the Department prior to requiring any medical examination or other approved diagnostic procedure.

§27.82. Refusal to submit to examination.

(a) [Section 7 of the act (35 P.S. §521.7) provides that in the event] If a person refuses to submit to the examination required in §27.81 (relating to examination of persons suspected of being infected), the Department or the local [qualified medical] health [officer] authority may [take one of the following actions:

(1) Cause] direct the person to be quarantined until it is determined that [he is not infected with a venereal disease, tuberculosis or other communicable disease, or he is not a carrier] the person does not pose a threat to the public health by reason of being infected with a disease causing organism or being a carrier.

[(2) File] (b) If the person refuses to abide by an order issued under subsection (a), the Department or local health authority may file a petition in the court of common pleas of the county in which the person is present. The petition shall have a statement attached, given under oath by a physician licensed to practice in this Commonwealth, that the person is suspected of being infected with [venereal] an organism causing a sexually transmitted disease, tuberculosis or other communicable disease, or that the person is suspected of being a carrier. Upon the filing of the petition, the court shall, within 24 hours after service of a copy upon the respondent, hold a hearing without a jury to ascertain whether the person named in the petition has refused to submit to an examination to determine whether the person is infected with [venereal disease, tuberculosis or other communicable disease] the suspected disease causing organism, or that the person is a carrier. Upon a finding that the person has refused to submit to an examination and that there is no valid reason for the person to do so, the court may forthwith order the person to submit to the examination. The certificate of the physician attached to the petition shall be received in evidence and shall constitute prima facie evidence that the person named is suspected of being infected with [venereal disease, tuberculosis or other communicable disease] the disease causing organism, or that the person is a carrier.

[(b) Section 7 of the Act (P.S. §521.7) provides that a](c) A person refusing to undergo an examination as [provided in subsection] required under subsections (a) and (b) may be committed by the court to an institution in this Commonwealth determined by the Department to be suitable for the care of [the cases] persons infected with the suspected disease causing organism.

§27.83. Court ordered examinations.

The examination ordered by the court [as provided in] under §27.82 (relating to refusal to submit to examination) may be performed by a physician chosen by the person at [his] the person's own expense. The examination shall include an appropriate physical examination and laboratory tests performed in a clinical laboratory approved by the Department to conduct the tests, and shall be conducted in accordance with accepted professional practices. The results shall be reported to the local health [board or health department] authority or the Department on case report forms furnished by the Department.

§27.84. Examination for a sexually transmitted disease of persons detained by police authorities.

(a) [Section 8(a) of the act (35 P.S. §521.8(a)) provides that a] A person taken into custody and charged with a crime involving lewd conduct or a sex offense, or a person to whom the jurisdiction of a juvenile court attaches may be examined for a [venereal] sexually transmitted disease by a qualified physician appointed by the Department [or], by the local [board or department of health] health authority or [appointed] by the court having jurisdiction over the person so charged. If the person refuses to permit an examination or provide a specimen for laboratory tests as requested by the physician designated by the Department, a local health authority or a court, judicial action may be pursued by the Department or local health authority to secure an appropriate remedy.

(b) [Section 8(b) of the act (35 P.S. §521.8(b)) provides that a] A person convicted of a crime or pending trial, who is confined in or committed to a State or local penal institution, reformatory or other house of correction or detention, may be examined for [venereal] a sexually transmitted disease by a qualified physician appointed by the Department or by the local [board] health authority. If the person refuses to permit an examination or provide a specimen for laboratory tests as requested by the physician, judicial action may be pursued by the Department or local health authority to secure an appropriate remedy.

(c) [Section 8(c) of the act (35 P.S. §521.8(c)) provides that a] A person described in subsections (a) or (b) found, upon examination, to be infected with a [venereal] sexually transmitted disease shall be given appropriate treatment by [constituted] the local health [authorities or their deputies] authority, the Department or [by] the attending physician of the institution[, if any].

§27.85. Diagnosis and treatment of [venereal] a sexually transmitted disease.

(a) [Section 9(a) of the act (35 P.S. §521.9(a)) provides that the] The Department [shall] will provide or designate adequate facilities for the free diagnosis and, where necessary for the preservation of public health, free treatment of persons infected with [venereal diseases] sexually transmitted diseases. [The diagnosis shall include blood tests and other tests.]

(b) [Section 9(b) of the act (35 P.S. §521.9(b)) provides that upon] Upon approval of the Department, a local [board or department of health may] health authority shall undertake to share the expense of furnishing free diagnosis and free treatment of [venereal] a sexually transmitted disease, or [the local board or department of health may take over, entirely or in part, the furnishing of] shall furnish free diagnosis and free treatment of [venereal] the sexually transmitted disease [with or] without financial assistance from the Department.

§27.86. [Sale of drugs for venereal disease] (Reserved).

[Section 10 of the act (35 P.S. §521.10) provides that the sale of drugs or other remedies for the treatment of venereal disease shall be prohibited, except under prescription of physicians licensed to practice in this Commonwealth.]

§27.87. Refusal to submit to treatment for communicable diseases.

(a) If the Department or a local health [officer] authority finds that a person who is infected with [venereal] a sexually transmitted disease, tuberculosis or other communicable disease in a communicable stage refuses to submit to treatment approved by the Department or by a local [board] health authority, the Department or the local health [officer] authority [may take the following action:

(1) Under section 11(a) of the act (35 P.S. §521.11(a)), isolate the person], if it determines the action advances public health interests, shall order the person to be isolated in an appropriate institution designated by the Department or by the local [board] health authority for safekeeping and treatment until the disease has been rendered noncommunicable. If the disease is one which may be significantly reduced in its communicability following short-term therapy, but is likely to significantly increase in its communicability if that therapy is not continued, such as tuberculosis, the Department or local health authority may order the person to complete therapy which is designed to prevent the disease from reverting to a communicable stage, including completion of an inpatient treatment regimen. See, also, §27.161 (relating to special requirements for tuberculosis). If the local health authority involved is not an LMRO, the local health authority shall consult with and receive approval from the Department prior to taking any action under this subsection.

[(2) Under section 11(a) of the act (35 P.S. §521.11(a)),]

(b) If a person refuses to comply with an order issued pursuant to subsection (a), the Department or local health authority shall MAY file a petition in the court of common pleas of the county in which the person is present to commit the person to an appropriate institution designated by the Department or by the local [board] health authority for safekeeping and treatment [until such time as the disease has been rendered noncommunicable] as specified in subsection (a). Upon the filing of a petition, the court shall, within 24 hours after service of a copy upon the respondent, hold a hearing without a jury to ascertain whether the person named in the petition has refused to submit to treatment. Upon a finding that the person has refused to submit to treatment, the court shall [forthwith order him to be committed to an appropriate institution or hospital designated by the Department or by the local board] issue an appropriate order.

[(b)] (c) For the purpose of this section, [it is understood that] treatment approved by the Department or by a local [board shall] health authority may include treatment by an

accredited practitioner of a well recognized church or religious denomination which relies on prayer or spiritual means alone for healing, if requirements relating to sanitation, isolation or quarantine are [complied with] satisfied.

§27.88. [Quarantine in jails] Isolation and quarantine in appropriate institutions.

[Section 11(b) of the act (35 P.S. §521.11(b)), provides that a county jail or other appropriate institution may receive persons who are isolated or quarantined by the Department or by a local board by reason of a venereal disease for the purpose of safekeeping and treatment.]

(a) When the Department or a local health authority orders a person with or suspected of having a sexually transmitted disease to be isolated or quarantined for the purpose of safekeeping and treatment, it may order that the isolation or quarantine take place in an institution where the person's movement is physically restricted.

(b) The Department or the local [board or department of health] health authority shall reimburse an institution which accepts the [persons] person at the rate of maintenance that prevails in the institution, and shall furnish the necessary medical treatment to the [persons committed to] person isolated or quarantined within the institution.

§27.89. [Premarital examination for syphilis] Examinations for syphilis.

[Section 12(a) of the act (35 P.S. §521.12(a)) provides that no license to marry may be issued until there is in the possession of the clerk of the orphans' court a statement signed by a licensed physician of this Commonwealth, or of other state or territory, or a commissioned medical officer in the United States Armed Forces or a physician of the United States Public Health Service that the applicant within 30 days of the issuance of the marriage license has submitted to an examination to determine the existence or nonexistence of syphilis. The examination shall include a standard serological test for syphilis and a statement that, in the opinion of the examining physician, the applicant is not infected with syphilis, or if so infected, is not in a stage of the disease which is likely to become communicable. The statement of the physician shall be accompanied by a statement from the person in charge of the laboratory making the test, or from some other person authorized to make a statement, setting forth the name of the test, the date it was made, the name and address of the physician to whom a report was sent and the exact name and address of the person whose blood was tested, but not setting forth the result of the test.]

(a) Prenatal examination for syphilis.

(1) A physician who attends, treats or examines a pregnant woman for conditions relating to pregnancy during the period of gestation or delivery shall inform the woman that he intends to take or cause to be taken, unless the woman objects, a sample of her blood at the time of the first examination (including the

initial visit when a pregnancy test is positive), or within 15 days after the first examination, and shall submit the sample to a clinical laboratory for an approved test for syphilis. A physician shall similarly collect and have tested a sample of the pregnant woman's blood during the third trimester of her pregnancy, in those counties of this Commonwealth where the annual rate of infectious syphilis is at a rate of syphilis occurring in a given population for which the CDC has determined it is cost-effective to require special precautions. The Department will publish THE LIST OF THOSE COUNTIES IN WHICH this rate IS OCCURRING in the Pennsylvania Bulletin as necessary. Other persons permitted by law to attend pregnant women, but not permitted by law to take blood samples, shall, unless the woman objects, cause a blood sample to be taken and submitted to a clinical laboratory for an approved test for syphilis. If the pregnant woman objects, it shall be the duty of the person ATTENDING THE PREGNANT WOMAN AND seeking to have the woman give a blood sample to explain to her the desirability of the test.

(2) The serological test required by subsection (b)(1) PARAGRAPH (1) will be made without charge, by the Department, upon the request of the physician submitting the blood sample and the submission of a certificate by the physician that the patient is unable to pay.

(b) Examination for syphilis in mother of newborn. A test for syphilis shall be done, unless the mother objects, on the blood of the mother of every newborn delivered in those counties of this Commonwealth where the annual rate of infectious syphilis is at a rate of syphilis occurring in a given population for which the CDC has determined it is cost-effective to require special precautions.

(1) The Department will publish THE LIST OF COUNTIES IN WHICH this rate IS OCCURRING in the Pennsylvania Bulletin as necessary.

(2) The results of the test shall be recorded both in the mother's medical record and in the newborn's medical record prior to discharge.

(c) Examination for syphilis in mother of stillborn. A test for syphilis shall be done, unless the mother objects, on the blood of the mother of every stillborn child delivered in those counties of this Commonwealth where the annual rate of infectious syphilis is at a rate of syphilis occurring in a given population for which the CDC has determined it is cost-effective to require special precautions. The Department will publish THE LIST OF COUNTIES IN WHICH this rate IS OCCURRING in the Pennsylvania Bulletin as necessary. The Department will be responsible for alerting physicians about this standard. The blood shall be collected within 2 hours after delivery and the result entered into the mother's medical record prior to discharge. See also, §27.95 (relating to reporting syphilis examination information for births and fetal deaths).

§27.90. [Appeal from denial of statement of the physician] (Reserved).

[Section 12(b) of the act (35 P.S. §521.12(b)) provides that an applicant for a marriage license who has been denied a statement of the physician as required by §27.89 (relating to premarital examination for syphilis) shall have the right of appeal to the Department for a review of the case and the Department will, after appropriate investigation, issue or refuse to issue a statement in lieu of the required statement of the physician.]

§27.91. [Form for statement of physician] (Reserved).

[Section 12(c) of the act (35 P.S. §521.12(c)) provides that the statements required of the physician who examined the applicant and of the person in charge of the laboratory which made the serological or other test shall be uniform throughout this Commonwealth and shall be upon forms provided by the Department or upon any comparable forms provided by other states. These forms shall be filed by the clerk of the orphan's court separately from the applications for marriage licenses, and shall be regarded as confidential by every person whose duty it may be to obtain, make, transmit or receive the information or report.]

§27.92. [Misrepresentation of facts and release of information] (Reserved).

[Section 12(d) of the act (35 P.S. §521.12(d)) provides that it shall be unlawful for an applicant for a marriage license, physician or representative of a laboratory to misrepresent the facts prescribed by the act. It shall be unlawful for a licensing officer who fails to receive the statements prescribed by the act or who has reason to believe that the facts have been misrepresented to issue a marriage license. It shall also be unlawful for a person to disregard the confidential character of the information or reports required by the act or for a person to otherwise fail to comply with the provisions of §§27.89- 27.91, 27.93 and this section (relating to premarital examination for syphilis; appeal from a denial of statement of the physician; form for statement of physician; and waiver of syphilis examination).]

§27.93. [Waiver of syphilis examination] (Reserved).

[Section 12(e) of the act (35 P.S. §521.12(e)) provides that a judge of an orphans' court within the county in which the license is to be issued is authorized, on joint application by both applicants for a marriage license, to waive the requirements as to medical examination, laboratory tests and certificates, and to authorize the clerk of the orphans' court to issue the license, if other requirements of the marriage laws have been complied with, and the judge is satisfied by affidavit or other proof that the examination or tests are contrary to the tenets or practices of the religious creed to which the applicant is an adherent, and that the public health and welfare will not be injuriously affected by the waiver and authorization.]

§27.94. [Prenatal examination for syphilis] (Reserved).

[(a) Section 13(a) of the act (35 P.S. §521.13(a)) provides that every physician who attends, treats or examines a pregnant woman for conditions relating to pregnancy during the period of gestation or delivery, shall take or cause to be taken, unless the woman objects, a sample of her blood at the time of first examination or within 15 days and shall submit the sample to an approved laboratory for an approved serological test for syphilis. Other persons permitted by law to attend pregnant women, but not permitted by law to take blood samples, shall, unless the woman objects, cause a blood sample to be taken by a physician licensed in this Commonwealth and shall submit it to an approved laboratory for an approved serological test. If the pregnant woman objects it shall be the duty of the physician to explain to her the desirability of the test.

(b) The serological test required by subsection (a) will be made without charge by the Department upon the request of the physician submitting the sample, if he submits a certificate that the patient is unable to pay.]

§27.95. Reporting [birth] syphilis examination information for births and fetal deaths.

[Section 13(b) of the act (35 P.S. §521.13(b)) provides that in] In reporting [every] a birth [and] or fetal death, physicians and others required to make the reports shall state [upon the certificate] in the medical record whether or not the blood [test] tests required by §[27.94] 27.89(b) (relating to [prenatal examination] examinations for syphilis) [was] were made. If [the] a test was made, the date of the test shall be given, and if [the] a test was not made [it may be stated whether it was not made because, in the opinion of the physician, the test was not advisable or because the woman objected], the reason the test was not made shall be given.

§27.96. Diagnostic tests for [venereal] sexually transmitted diseases.

[Section 14 of the act (35 P.S. §521.14) provides that a standard or approved test procedure for each of the venereal diseases]

(a) When testing for a sexually transmitted disease is required by the act or this chapter, the test used shall be a test approved by the [Department] Food and Drug Administration, and if a laboratory test is part of the approved procedure, it shall be [made] conducted in a clinical laboratory approved by the Department to [make] perform the [tests] test.

(b) The diagnostic tests that have been approved to test for each sexually transmitted disease may be ascertained by contacting the Division of Clinical Microbiology, Bureau of

Laboratories.

§27.97. Treatment of minors.

[Section 14a of the act (35 P.S. §521.14a) provides that a] A person under the age of 21 [infected with a venereal disease may be given appropriate treatment by a physician] may give consent for medical and other health services to determine the presence of or to treat a sexually transmitted disease and any other reportable disease, infection or condition. If the minor consents to undergo diagnosis or treatment, approval or consent of [his parents or persons in *loco parentis* may not be] another person is not necessary[, and the]. The physician may not be sued or held liable for [properly] implementing appropriate diagnostic measures or administering appropriate treatment to the minor if the minor has consented to such procedures or treatment.

§27.98. Prophylactic treatment of newborns.

Physicians and midwives attending women in childbirth shall instill in each eye of the newborn child, as soon as practicable after birth, either a 1% silver nitrate solution, [or tetracycline ophthalmic ointment or solution,] or erythromycin ophthalmic ointment or solution as a single application in both conjunctival sacs, or appropriate medication approved by the Department. If the parent or guardian of the newborn child objects on the ground that the prophylactic treatment conflicts with the parent's or guardian's religious beliefs or practices, OR IF IN THE OPINION OF THE ATTENDING PHYSICIAN TREATMENT IS NOT ADVISABLE, prophylactic treatment shall be withheld[; and an]. An entry in the child's hospital record indicating the reason for withholding treatment shall be made and signed by the attending physician and the parent or guardian.

§27.99 Prenatal examination for hepatitis B.

(a) A physician who attends, treats, or examines a pregnant woman for conditions relating to pregnancy during the period of gestation or delivery, shall inform the woman that he intends to take or cause to be taken, unless the woman objects, a sample of her blood at the time of the first examination (including the initial visit when a pregnancy test is positive) or within 15 days thereafter, but no later than the time of delivery, and shall submit the sample to a clinical laboratory approved by the Department to conduct immunologic testing.

(b) When a pregnant woman tests positive for hepatitis B surface antigen, a physician shall provide the appropriate ~~prophylaxis~~ PROPHYLACTIC treatment to the newborn within 12 hours after birth. If the parent or guardian of the newborn child objects on the ground that the prophylactic treatment conflicts with the parent's or guardian's religious beliefs or practices, prophylactic treatment shall be withheld, and an entry in the child's hospital record indicating the reason for withholding treatment shall be made and signed by the attending physician and the

parent or guardian.

**Subchapter E. [PROCEDURE FOR TREATING EACH REPORTABLE
DISEASE] SELECTED PROCEDURES FOR PREVENTING
DISEASE TRANSMISSION**

Sec.

- 27.101. [General] (Reserved).
- 27.101a. [Acquired Immune Deficiency Syndrome (AIDS)] (Reserved).
- 27.102. [Amebiasis (amebic dysentery)] (Reserved).
- 27.103. [Animal bites] (Reserved).
- 27.104. [Anthrax] (Reserved).
- 27.105. [Botulism] (Reserved).
- 27.106. [Brucellosis] (Reserved).
- 27.106a. [Campylobacteriosis] (Reserved).
- 27.107. [Cholera] (Reserved).
- 27.108. [Diphtheria] (Reserved).
- 27.109. [Encephalitis] (Reserved).
- 27.110. [Food poisoning] (Reserved).
- 27.111. [Giardiasis] (Reserved).
- 27.112. [Gonococcal infections] (Reserved).
- 27.113. [Guillain-Barre Syndrome] (Reserved).
- 27.113a. [Haemophilus influenzae Type b Disease] (Reserved).
- 27.114. [Hepatitis A (viral, infections, acute catarrhal jaundice)] (Reserved).
- 27.115. [Hepatitis B (viral, serum homologous serum jaundice)] (Reserved).

- 27.115a. [Hepatitis Non-A Non-B] (Reserved).
- 27.116. [Histoplasmosis] (Reserved).
- 27.116a. [Kawasaki disease] (Reserved).
- 27.117. [Lead poisoning or lead toxicity] (Reserved).
- 27.117a. [Legionnaires' Disease] (Reserved).
- 27.118. [Leptospirosis (Weil's disease)] (Reserved).
- 27.118a. [Lyme disease] (Reserved).
- 27.119. [Lymphogranuloma venereum] (Reserved).
- 27.120. [Malaria] (Reserved).
- 27.121. [Measles (rubeola)] (Reserved).
- 27.121a. [Measles immunization requirements for children in childhood group settings] (Reserved).
- 27.122. [Meningitis-all types] (Reserved).
- 27.123. [Meningococcal disease] (Reserved).
- 27.124. [Mumps] (Reserved).
- 27.125. [Neonatal hyperthyroidism] (Reserved).
- 27.126. [Pertussis (whooping cough)] (Reserved).
- 27.127. [Phenylketonuria] (Reserved).
- 27.128. [Plague] (Reserved).
- 27.129. [Poliomyelitis (paralytic and nonparalytic)] (Reserved).
- 27.130. [Psittacosis (Ornithosis)] (Reserved).
- 27.131. [Rabies] (Reserved).

- 27.132. [Reye's syndrome] (Reserved).
- 27.133. [Rickettsial diseases, including Rocky Mountain Spotted Fever] (Reserved).
- 27.134. [Rubella (German measles) and congenital rubella syndrome] (Reserved).
- 27.135. [Salmonellosis] (Reserved).
- 27.136. [Shigellosis (bacillary dysentery)] (Reserved).
- 27.137. [Smallpox] (Reserved).
- 27.138. [Syphilis] (Reserved).
- 27.139. [Tetanus] (Reserved).
- 27.139a. [Toxic shock syndrome] (Reserved).
- 27.140. [Toxoplasmosis] (Reserved).
- 27.141. [Trichinosis] (Reserved).
- 27.142. [Tuberculosis] (Reserved).
- 27.143. [Tularemia] (Reserved).
- 27.144. [Typhoid and paratyphoid] (Reserved).
- 27.145. (Reserved).
- 27.146. [Yellow fever] (Reserved).
- 27.151. Restrictions on the donation of blood, blood products, tissue, sperm and ova.
- 27.152. Investigation of cases and outbreaks.
- 27.153. Restrictions on food handlers.
- 27.154. Restrictions on caregivers in a child care group setting.
- 27.155. Restrictions on health care practitioners.
- 27.156. Special requirements for amebiasis.

- 27.157. Special requirements for enterohemorrhagic E. coli.
- 27.158. Special requirements for shigellosis.
- 27.159. Special requirements for typhoid and paratyphoid fever.
- 27.160. Special requirements for measles.
- 27.161. Special requirements for tuberculosis.
- 27.162. Special requirements for animal bites.
- 27.163. Special requirements for psittacosis.
- 27.164. Special requirements for plague, pharyngitis or pneumonia.

§27.101. [General] (Reserved).

[This subchapter contains the names of reportable diseases in alphabetical order and prescribes, in each case, the general requirements for the control of the infected individual, his contacts and his environment. Detailed requirements for reporting diseases are prescribed in Subchapter B (relating to reporting of diseases) and requirements for isolation and quarantine are prescribed in Subchapter C (relating to quarantine and isolation).]

§27.101a. [Acquired Immune Deficiency Syndrome (AIDS)] (Reserved).

(a) *Reporting.* Reports of AIDS cases shall be made to the Division of Acute Infectious Disease Epidemiology, Department of Health, or to the local health department, as specified in §27.32 (relating to reporting AIDS).

(b) *Isolation.* Observe blood/body fluid precautions. Observe precautions appropriate for other specific infections that occur in AIDS patients.

(c) *Concurrent disinfection.* Equipment contaminated with blood or semen shall be disinfected.

(d) *Terminal disinfection.* Thorough cleaning of the patient's environment is required upon the patient's discharge from a hospital room.

(e) *Quarantine.* No quarantine is required.

(f) *Restrictions on infectious individuals.* Restrictions on body fluid and organ

donations shall conform to the following:

(1) AIDS cases, human immunodeficiency virus (HIV) infected persons and HIV antibody positive persons may not donate blood, plasma, semen, organs or other body tissues.

(2) Blood banks, sperm banks and hospitals may not accept for human use blood, plasma, semen, organs or other body tissues without obtaining prior evidence that the donor is HIV antibody negative. Transplants may be performed prior to receiving HIV test results if delay, due to performance of the test, would threaten the recipient's survival.]

§27.102. [Amebiasis (amebic dysentery)] (Reserved).

[(a) *Reporting.* Report to the local health authority.

(b) *Isolation.* No isolation may be required. Infected persons shall be excluded from an occupation that prepares or serves food for public consumption until they have had three negative successive stool specimens collected on the last day of therapy and at intervals of not less than 48 hours.

(c) *Concurrent disinfection.* Feces shall be disposed of in a sanitary manner, and hands shall be washed after defecation.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

(e) *Quarantine.* No quarantine of carriers or contacts is required.]

§27.103. [Animal bites] (Reserved).

[(a) *Reporting.* A bite or other trauma likely to result in rabies inflicted by an animal capable of being a reservoir for rabies shall be reported by telephone or other prompt means to the local health authority.

(b) *Isolation.* No isolation is required.

(c) *Concurrent disinfection.* No concurrent disinfection is required.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine of contacts is required.

(f) *Quarantine of biting animals.* Quarantine of biting animals shall conform with

the following:

- (1) A dog, cat or other domestic mammal that bites or otherwise potentially exposes a human to rabies shall be quarantined in a place and manner approved by the Secretary or his representative or the local health officer for at least 10 days after the date of the bite.
- (2) A wild animal that bites or otherwise potentially exposes a human to rabies shall be immediately destroyed and its head submitted to one of the state or county diagnostic laboratories for a rabies examination. Exceptions to the requirement of this paragraph may be granted by the Secretary or his representative.
- (3) Notwithstanding the paragraphs (1) and (2), the Secretary or his representative or the local health officer may order in writing the killing in a humane manner of a biting animal for the purpose of a laboratory examination for rabies if it has been determined that it is necessary to preserve human health.
- (4) The Secretary or his representative or the local health officer may order the owner of a biting animal to have the animal examined for rabies by a Commonwealth licensed veterinarian during the quarantine period. The cost of the examinations and other associated costs shall be borne by the owner or custodian of the biting animal.
- (5) No animal under quarantine may be moved from the place of quarantine without the written permission of the Secretary or his representative or the local health officer.
- (6) No individual may fail or refuse to surrender an animal for quarantine or destruction as required in this subsection when demand is made by the written order of the local health officer.]

§27.104. [Anthrax] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.
- (b) *Isolation.* The patient shall be isolated until lesions are healed.
- (c) *Concurrent disinfection.* Discharges from lesions and articles soiled from the discharge shall require sterilization by an appropriate method of sterilization such as incineration or steam sterilization under pressure.
- (d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

- (e) *Quarantine.* No quarantine of contacts is required.]

§27.105. [Botulism] (Reserved).

[(a) *Reporting.* Report case or suspected cases to the local health authority by telephone or other equally prompt means.

- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.106. [Brucellosis] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authorities.
- (b) *Isolation.* No isolation may be required.
- (c) *Concurrent disinfection.* Purulent discharges shall require disinfection.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.106a. [Campylobacteriosis] (Reserved).

- [(a) *Reporting.* Reports shall be made to the local health authority.
- (b) *Isolation.* Hospitalized patients shall be isolated according to the recommended standard enteric disease isolation procedures. Cases shall be excluded from any occupation that prepares or serves food for public consumption until diarrhea has ended.
- (c) *Concurrent disinfection.* Feces and articles soiled therewith shall be disinfected. In communities with modern and adequate sewage disposal systems, feces may be discharged directly into the sewage without preliminary disinfection.
- (d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

- (e) *Quarantine.* No quarantine is required.
- (f) *Restrictions on infectious individuals.*
 - (1) Symptomatic household contacts who prepare or serve food for public consumption are not permitted to work until diarrhea has ended.
 - (2) Pregnant women in the household shall be referred to their private physician.
- (g) *Outbreaks of Campylobacteriosis.*
 - (1) *Food or waterborne.* Suspected outbreaks shall be investigated to identify the implicated food, water or raw milk to which others may have been exposed. The Department has the authority to require stool cultures on individuals involved in the outbreak. Suspect food handlers may be excluded from work until results of one stool culture is negative.
 - (2) *Institutional outbreaks.* The Department has the authority to conduct an epidemiologic investigation to require stool specimens on patients and employees and, to exclude from work an individual who is a threat to the health of others in that institution.]

§27.107. [Cholera] (Reserved).

- [(a) *Reporting.* Report to the local health authority by telephone or other equally prompt means.
- (b) *Isolation.* The patient shall be isolated in a hospital or a fly proof room or its equivalent.
- (c) *Concurrent disinfection.* Prompt and thorough disinfection of articles contaminated with feces, vomitus and urine shall be required. Urine and feces shall be directly flushed down the toilet. Attendants shall practice scrupulous cleanliness, and hands shall be washed with an antiseptic soap or disinfectant after handling or touching articles contaminated by feces.
- (d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning. Urinals and bedpans shall be decontaminated and sterilized.
- (e) *Quarantine.* A surveillance of the contacts shall be maintained for 5 days from the last exposure and until two negative specimens have been collected 3 days apart.]

§27.108. [Diphtheria] (Reserved).

[(a) *Reporting.* Report to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* The infected person shall be isolated until cultures from the nose and throat taken on two occasions not less than 24 hours apart and 24 hours after cessation of antimicrobial therapy fail to show diphtheria bacilli. Where termination of isolation by culture is impracticable, isolation may end with fair safety 14 days after onset. Where practicable, a virulence test or a toxigenicity test shall be made if throat cultures are reported to be positive three weeks or more after onset. Isolation may be terminated if the microorganism reported present is proved avirulent or nontoxigenic.

(c) *Concurrent disinfection.* Articles in contact with patient and articles soiled by discharges of patient shall require disinfection.

(d) *Terminal disinfection.* Terminal disinfection shall consist of a thorough airing, sunning and cleaning of the sick room.

(e) *Quarantine.* Intimate contacts shall be isolated until the results of the bacteriologic examinations are known. Persons with positive cultures shall be treated. Contacts shall be isolated until appropriate measures exist or have been taken to insure the public health.

(f) *Diphtheria carriers.* A chronic diphtheria carrier is a person who has been free from the symptoms of diphtheria for 4 weeks or longer and who harbors virulent or toxigenic diphtheria bacilli. A chronic carrier of diphtheria bacilli may be placed under quarantine until cultures from the nose and throat on four successive occasions not less than 24 hours apart are negative, or until the cultures are found to be avirulent or nontoxigenic. When appropriate medical and surgical measures to eliminate the carrier state fail, the health authorities may release the carrier from quarantine when the release is not detrimental to the public health.]

§27.109. [Encephalitis] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* Appropriate for confirmed or suspected agent.

(c) *Concurrent disinfection.* Appropriate for confirmed or suspected etiologic agent.

(d) *Terminal disinfection.* Appropriate for confirmed or suspected etiologic agent.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.110. [Food poisoning] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

- (b) *Isolation.* Appropriate for confirmed or suspected etiologic agent.
- (c) *Concurrent disinfection.* Appropriate for confirmed or suspected etiologic agent.
- (d) *Terminal disinfection.* Appropriate for confirmed or suspected etiologic agent.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.111. [Giardiasis] (Reserved).

- [(a) *Reporting.* Report to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.112. [Gonococcal infection] (Reserved).

[(a) *Reporting.* A physician who treats a patient with a reportable communicable disease which is classed as a venereal disease shall report the case in the manner prescribed in 27.21 (relating to physicians who treat patients with reportable diseases including tuberculosis).

- (b) *Isolation.* No isolation is required except for newborns with gonococcal ophthalmia neonatorum for whom isolation may be terminated after 24 hours of adequate and effective therapy under medical supervision.
- (c) *Concurrent disinfection.* Care shall be taken in the disposal of discharges from lesions and articles soiled from the discharges.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.113. [Guillain-Barre Syndrome] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required. Those cases occurring with viral infections usually occur after the viral infections have passed.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.113a. [Haemophilus influenza Type b Disease] (Reserved).

- [(a) *Reporting.* Reports shall be made to the local health authority.
- (b) *Isolation.* Respiratory isolation is required until 24 hours of chemotherapy are completed.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine is required.]

§27.114. [Hepatitis A (viral, infectious, acute catarrhal jaundice)] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* Isolation precautions shall be observed in handling blood or blood products and excretions until 1 week after onset of illness. The patient shall be excluded from food and drink preparation, processing and serving for public consumption for a period of 1 week after onset of illness or for as long as indicated by the results of appropriate laboratory examinations.
- (c) *Concurrent disinfection.* Equipment contaminated with blood, serum or other excretions shall be disinfected.
- (d) *Terminal disinfection.* No terminal disinfection is required.

- (e) *Quarantine.* No quarantine of contacts is required.]

§27.115. [Hepatitis B (viral, serum homologous serum jaundice)] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* Isolation precautions shall be observed in handling blood or blood products and excretions until one week after cessation of signs and symptoms of the disease or until 2 weeks after onset of illness, whichever is longer. Blood or blood products containing hepatitis B antigen shall be considered infectious.

(c) *Concurrent disinfection.* Equipment contaminated with blood, serum or other excretions shall be disinfected.

- (d) *Terminal disinfection.* No terminal disinfection is required.

- (e) *Quarantine.* No quarantine of contacts is required.]

§27.115a. [Hepatitis Non-A Non-B] (Reserved).

- [(a) *Reporting.* Reports shall be made to the local health authority.

(b) *Isolation.* Isolation precautions shall be observed in handling blood or blood products and excretions until 1 week after cessation of signs and symptoms of disease.

(c) *Concurrent disinfection.* Equipment contaminated with blood, serum or other excretions shall be disinfected.

- (d) *Terminal disinfection.* No terminal disinfections is required.

- (e) *Quarantine.* No quarantine is required.]

§27.116. [Histoplasmosis] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.

- (b) *Isolation.* No isolation is required.

- (c) *Concurrent disinfection.* No concurrent disinfection is required.

- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.116a. [Kawasaki disease] (Reserved).

- [(a) *Reporting.* Reports shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine is required.]

§27.117. [Lead poisoning or lead toxicity] (Reserved).

[(a) *Reporting.* Report shall be made to the Department in the manner prescribed in §§27.4(b) and 27.22(d)(4) (relating to noncommunicable diseases and conditions; and reporting laboratory results indicative of certain infections or conditions).

- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.117a. [Legionnaires' Disease] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.118. [Leptospirosis (Weil's disease)] (Reserved).

- (a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.118a. [Lyme disease] (Reserved).

- (a) *Reporting.* Reports shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* Carefully examine patients and symptomatic cases and remove and destroy remaining ticks.
- (d) *Terminal disinfection.* No terminal disinfections is required.
- (e) *Quarantine.* No quarantine is required.]

§27.119. [Lymphogranuloma venereum] (Reserved).

- (a) *Reporting.* A physician who treats a patient with a reportable communicable disease which is classed a venereal disease shall report the case in the manner proscribed in 27.21 (relating to physicians who treat patients with reportable diseases including tuberculosis).
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* Care shall be taken in the disposal of discharges from lesions and articles soiled from discharges.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.120. [Malaria] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* No isolation is required; however, patients shall be protected at night by mosquito-proof areas where vector anopheline are present.

(c) *Concurrent disinfection.* No concurrent disinfection is required.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.121. [Measles (rubeola)] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Infected persons shall be restricted to the premises for 4 days after the appearance of the rash.

(c) *Concurrent disinfection.* Articles soiled with the secretions of the nose and throat shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

(e) *Quarantine.* Whenever measles (rubeola) is determined to be present in a school population, the Secretary or his designee may do the following:

(1) Ascertain which pupils are presumed susceptible. A presumed susceptible is a pupil who fits into one of the following categories:

(i) No history of measles vaccination.

(ii) Vaccination with measles vaccine prior to 1969, regardless of age.

(iii) Vaccination with measles vaccine prior to 12 months of age.

(iv) No history of serological evidence of measles immunity. The serological evidence is the presence of antibody to measles determined by the hemagglutination inhibition test or a comparable test.

(2) Order exclusion of the presumed susceptibles from the school until one of the following conditions is met:

- (i) The susceptible pupil is vaccinated with live attenuated measles vaccine.
- (ii) The susceptible pupil presents serological evidence of measles immunity. The serological evidence is the presence of antibody to measles determined by the hemagglutination inhibition test or a comparable test.
- (iii) No cases of measles have occurred for a 14-day period.]

§27.121 a. [Measles immunization requirements for children in childhood group settings] (Reserved).

- [(a) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Caregiver - The organization or individual responsible for the care or education of children at the childhood group setting. The term does not apply to an individual who provides care or education as an employee or otherwise on behalf of an organization or other individual, such as an employee of a day care center.

Child - An individual under 18 years of age.

Childhood group setting - A place where four or more children who are not relatives of a caregiver receive care or education together at one time.

MMR - A vaccine which immunizes against measles, mumps and rubella.

- (b) *Caregiver responsibilities.*

(1) Beginning November 4, 1991, the caregiver at a childhood group setting may not accept or retain a child 15 months of age or older at the setting, for more than 60 days, unless the caregiver has received one of the following:

- (i) Written verification from a physician, the Department or a local health department that the child was vaccinated for measles with MMR vaccine after 12 months of age.
- (ii) Written verification from a physician, the Department or a local health department that the child demonstrates immunity to measles by serological evidence of antibody to measles.

(iii) Written objection to the vaccination on religious grounds from a parent or guardian.

(iv) Written verification from a physician that vaccination with MMR vaccine would be detrimental to the health of the child, with specification as to whether the medical contraindication is temporary or permanent.

(2) If the caregiver receives a written verification under paragraph (1)(iv) excusing timely vaccination due to a temporary medical condition, the caregiver shall exclude the child from the childhood group setting after the expiration of an additional 30 days unless it receives, within that 30-day period, written verification from a physician, the Department or a local health department that the child was vaccinated or that the temporary medical condition still exists. If the caregiver receives a written verification that vaccination has not occurred because the temporary condition persists, the caregiver shall require the presentation of a new verification at 30-day intervals. If a verification is not received as required, the caregiver shall exclude the child from the childhood group setting and not readmit the child until the caregiver receives a verification that meets the requirements of this section.

(3) The caregiver at a childhood group setting shall retain the written verification or objection referenced in paragraphs (1) and (2) for 60 days following the termination of the child's attendance.

(c) *Exemptions.* Caregivers at childhood group settings shall be exempt from the requirements of subsection (b) as follows:

(1) The requirements imposed by subsection (b) do not apply to a kindergarten, elementary school or high school. These caregivers shall comply with the standards in Chapter 23 Subchapter c (relating to immunization).

(2) The requirements imposed by subsection (b) do not apply to a caregiver with regard to children who are known by the caregiver to be 6 years of age or older or to attend a kindergarten, elementary school or higher school.

(3) The requirements imposed by subsection (b) do not apply to the caregiver during a calendar year in which the caregiver does not serve as a caregiver for at least 40 hours during at least 1 month.

(4) The requirements imposed upon a caregiver by subsection (b)(1), to not accept a child at a childhood group setting without receiving a written verification or objection specified in subsection (b)(1), do not apply during a month the caregiver does not serve as a caregiver for at least 40 hours.

(d) *Exclusion when measles is present.* Whenever measles has been identified within a childhood group setting, the Department or a local health department may order, within 14 days after the identification, the exclusion from that childhood group setting or other childhood group setting which is determined to be at high risk of measles transmission, of an individual susceptible to measles in accordance with the public health standards existing at that time.

(e) *Preferred vaccine.* The MMR is the preferred vaccine for immunization against measles, mumps and rubella, individually or in combination.]

§27.122. [Meningitis-all types] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* Appropriate for confirmed or suspected etiologic agent.

(c) *Concurrent disinfection.* Appropriate for confirmed or suspected etiologic agent.

(d) *Terminal disinfection.* Appropriate for confirmed or suspected etiologic agent.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.123. [Meningococcal disease] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* The infected person shall be appropriately isolated until 24 hours after institution of appropriate antimicrobial therapy.

(c) *Concurrent disinfection.* Discharges from the nose and throat and articles soiled from the discharges shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

(e) *Quarantine.* No quarantine is required. Surveillance may be conducted, however, at the discretion of the Department or the local health officer.]

§27.124. [Mumps] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* The infected person shall be appropriately isolated until 9 days after onset or until subsidence of the swelling.

(c) *Concurrent disinfection.* No concurrent disinfection is required.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine is required.]

§27.125. [Neonatal hypothyroidism] (Reserved).

[(a) *Reporting.* Report shall be made to the Department in the manner prescribed in §27.22(d)(3) (relating to reporting laboratory results indicative of certain infections or conditions).

(b) *Isolation.* No isolation is required.

(c) *Concurrent disinfection.* No concurrent disinfection is required.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine is required.]

§27.126. [Pertussis (whooping cough)] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* The patient shall be restricted to his own premises and separated from susceptible children for a period of 4 weeks after onset or 7 days after the institution of appropriate antimicrobial therapy.

(c) *Concurrent disinfection.* Discharges from the nose and throat and articles soiled from the discharges shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.127. [Phenylketonuria] (Reserved).

[(a) *Reporting.* Report shall be made to the Department in the manner prescribed in

§27.22(d)(3) (relating to reporting laboratory results indicative of certain infections or conditions).

- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.128. [Plague] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Patients shall be hospitalized if practical, and reasonable aseptic precautions shall be taken for patients with bubonic plague. Patients with primary pneumonic plague or patients developing plague pneumonia shall be isolated.

(c) *Concurrent disinfection.* Sputum, purulent discharges, urine and feces shall require disinfection.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning. Bodies of persons dying of plague shall be handled with strict aseptic precautions.

(e) *Quarantine.* Quarantine of contacts shall be required as deemed necessary by the local health officer. Contacts of bubonic or pneumonic plague shall be dusted with an appropriate insecticide to which fleas are susceptible.]

§27.129. [Poliomyelitis (paralytic and nonparalytic)] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Isolation shall be for 1 week from the date of onset or, if longer, for the duration of fever.

(c) *Concurrent disinfection.* Throat discharges, feces and articles soiled from the discharges shall require disinfection.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* Quarantine shall be at the discretion of local health officer.]

§27.130. [Psittacosis (Ornithosis)] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Isolation shall be maintained during febrile acute stages.

(c) *Concurrent disinfection.* discharges shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough wet cleaning.

(e) *Quarantine.* No quarantine is required for household contacts. Buildings having housed birds, however, may not be used by human beings until thoroughly cleaned and disinfected. Additional regulations pertaining to psittacosis are found under §§27.181-27.184 (relating to psittacosis).]

§27.131. [Rabies] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Infected persons shall be isolated through the duration of the illness. Immediate attendants shall be warned of the hazard of inoculation through the saliva of the patient.

(c) *Concurrent disinfection.* Saliva and articles soiled from saliva shall be disinfected.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.132. [Reye's Syndrome] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* No isolation is required.

- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.133. [Rickettsial diseases, including Rocky Mountain Spotted Fever] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* Appropriate for confirmed or suspected etiologic agent.
- (c) *Concurrent disinfection.* Appropriate for confirmed or suspected etiologic agent.
- (d) *Terminal disinfection.* Appropriate for confirmed or suspected etiologic agent.
- (e) *Quarantine.* Appropriate for confirmed or suspected etiologic agent.]

§27.134. [Rubella (German measles) and congenital rubella syndrome] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* Infected persons shall be appropriately isolated for 4 days after the appearance of the rash. Strict isolation of infants with congenital rubella syndrome must be effected. The infants may be infectious for up to a year.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.135. [Salmonellosis] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority. Bacterial isolates shall be sent to the Department's Bureau of Laboratories for serotyping.
- (b) *Isolation.* Hospitalized patients shall be isolated according to the recommended standard enteric disease isolation procedures. Infected persons shall be excluded from an occupation that prepares or serves food for public consumption until they have had three negative

successive stool specimens collected at intervals of not less than 24 hours nor earlier than 24 hours after the last dose of any chemotherapeutic drug effective against the etiologic organism.

(c) *Concurrent disinfection.* Feces, urine and articles soiled from them shall be disinfected. In communities with modern and adequate sewage disposal systems, feces and urine may be disposed of directly into the sewer without preliminary disinfection.

(d) *Terminal disinfection.* Terminal disinfection shall consist of thorough cleaning.

(e) *Quarantine.* Quarantine shall conform with the following:

(1) Asymptomatic household contacts who prepare or serve food for public consumption are not permitted to continue working until they have submitted a stool specimen to an appropriate laboratory for bacteriologic examination. Symptomatic household contacts who prepare or serve food for public consumption are not permitted to continue working until bacteriologic examination of their stool specimen is reported as negative.

(2) Pregnant woman in the household should submit a stool specimen to determine if they are infected. If the stool specimen is positive, this information shall be furnished to the appropriate physician in charge of her case.

(f) *Restrictions on infected persons.* If a case or household contact is not a food handler or pregnant, no follow-up stool cultures are required. A case investigation form shall be completed only on those cases that appear to be epidemiologically related.

(g) *Outbreaks of salmonellosis.* Investigations of outbreaks of salmonellosis shall conform with the following:

(1) *Food borne.* Suspected food borne outbreaks of salmonellosis shall be investigated. The Department has the authority to require stool cultures on individuals involved in the outbreak. Suspect food handlers may be excluded from work until the result of their stool cultures are negative.

(2) *Institutional outbreaks.* The Department has the authority to conduct an epidemiologic investigation, to require stool specimens on patients and employees, and to exclude from work an individual who is a threat to the health of others in that institution.]

§27.136. [Shigellosis (bacillary dysentery)] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority. Bacterial isolates shall be sent to the Department's Bureau of Laboratories for serotyping.

(b) *Isolation.* Hospitalized patients shall be isolated according to the recommended standard enteric disease isolation procedures. Infected persons shall be excluded from an occupation that prepares or serves food for public consumption until they have had three negative successive stool specimens collected at intervals of not less than 24 hours nor earlier than 24 hours after the last dose of a chemotherapeutic drug effective against the etiologic organism.

(c) *Concurrent disinfection.* Feces and articles soiled by feces shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of cleaning.

(e) *Quarantine.* Quarantine shall conform with the following:

(1) Asymptomatic household contacts who prepare or serve food for public consumption may not be permitted to continue working until they have submitted a stool specimen to an appropriate laboratory for bacteriologic examination. Symptomatic household contacts who prepare or serve food for public consumption shall not be permitted to continue working until bacteriologic examination of their stool specimen is reported as negative.

(2) Pregnant women in the household shall submit a stool specimen to determine if they are infected. If the stool specimen is positive, this information shall be furnished to the appropriate physician in charge of her case.

(f) *Restrictions on infected persons.* If a case or household contact is not a food handler or pregnant, no follow-up stool cultures are required. A case investigation form shall be completed only on those cases that appear to be epidemiologically related.

(g) *Outbreaks of shigellosis.* Investigations of outbreaks of shigellosis shall conform with the following:

(1) *Food borne.* Suspected food borne outbreaks of shigellosis shall be investigated. The Department has the authority to require stool cultures on individuals involved in the outbreak. Suspect food handlers may be excluded from work until the results of their stool culture are negative.

(2) *Institutional outbreaks.* The Department has the authority to conduct an epidemiologic investigation, to require stool specimens on patients and employees, and to exclude from work an individual who is a threat to the health of others in that institution.]

§27.137. [Smallpox] (Reserved).

(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Infected persons shall be isolated in an appropriate isolation facility until complete cicatrization of all lesions *per* the Center for Disease Control handbook "Comprehensive Action in a Smallpox Emergency."

(c) *Concurrent disinfection.* Articles associated with the patient shall be sterilized by high pressure steam or by boiling or other appropriate means *per* the Center for Disease Control handbook "Comprehensive Action in a Smallpox Emergency."

(d) *Terminal disinfection.* Terminal disinfection shall consist of a thorough cleaning of sickroom and furniture and sterilization of mattress, pillow and bedding *per* the Center for Disease Control handbook "Comprehensive Action in a Smallpox Emergency."

(e) *Quarantine.* Persons living or working on the same premises as the person who develops smallpox or who otherwise have intensive exposure shall be considered contacts and promptly vaccinated or revaccinated or quarantined for 16 days from the last exposure. If the contacts are considered immune by reason of prior attack or successful revaccination within the previous 3 years, they shall be kept under surveillance until the height of the reaction of the recent vaccination has passed. If the contact is not considered immune, he may be kept under surveillance until 16 days have passed since last contact. A rise of temperature during surveillance shall necessitate prompt isolation until smallpox is excluded *per* the Center for Disease Control handbook "Comprehensive Action in a Smallpox Emergency."]

§27.138. [Syphilis] (Reserved).

(a) *Reporting.* A physician who treats a patient with a reportable communicable disease which is classed as a venereal disease shall report the case in the manner prescribed in 27.21 (relating to physicians who treat patients with reportable diseases including tuberculosis).

(b) *Isolation.* No isolation is required.

(c) *Concurrent disinfection.* In adequately treated cases, no concurrent disinfection may be required. Care shall be taken in the disposal of discharges from open lesions and articles soiled from the discharges.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine of contacts is required.

(f) *Premarital examination.* A premarital examination for syphilis shall be required as prescribed by §§27.89-27.93 (relating to premarital examination for syphilis; appeal from a denial of statement of the physician; form for statement of physician; misrepresentation of facts

and release of information; and waiver of syphilis examination).

(g) *Prenatal examination.* A prenatal examination for syphilis is required as prescribed by §27.94 (relating to prenatal examination for syphilis).]

§27.139. [Tetanus] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.139a. [Toxic Shock Syndrome] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.140. [Toxoplasmosis] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.141. [Trichinosis] (Reserved).

- [(a) *Reporting.* Report shall be made to the local health authority.
- (b) *Isolation.* No isolation is required.
- (c) *Concurrent disinfection.* No concurrent disinfection is required.
- (d) *Terminal disinfection.* No terminal disinfection is required.
- (e) *Quarantine.* No quarantine of contacts is required.]

§27.142. [Tuberculosis] (Reserved).

(a) *Reporting.* A private physician who treats a patient for tuberculosis or an authorized person of a hospital, State or county institution, nursing or convalescent home, or tuberculosis clinic which treats a patient for tuberculosis within this Commonwealth shall promptly report the case in the manner prescribed in §§27.21 and 27.22(d)(2) (relating to physicians who treat patients with reportable diseases including tuberculosis; and reporting laboratory results indicative of certain infections or conditions).

(b) *Isolation.* A person having tuberculosis or suspected tuberculosis in its communicable stage shall be isolated in the following manner:

(1) Isolation for tuberculosis shall be established at the usual residence of the patient suffering from tuberculosis whenever facilities for adequate isolation of the infectious patient are available in the home and where the patient will accept such isolation. Isolation of the patients treated at home shall consist of instruction in the need to cover the mouth and nose when coughing and careful handling and disposal of sputum. Since control of infection is best achieved by prompt specific drug therapy which reduces infectiousness and results in sputum conversion, the results of sputum examination shall be used to determine how long the patient needs to remain at home.

(2) If isolation for tuberculosis cannot be accomplished or maintained at the usual residence of the patient and whenever, in the opinion of the Department or of the local health authorities, such a person is a menace to others by reason of his habits or his neglect of treatment or of the measures designed to protect others from infection, the isolation shall be enforced by removing the patient to an institution in this Commonwealth determined by the Department to be suitable for the care and treatment of the cases. Isolation of the patients treated in hospitals shall consist of an appropriate form of respiratory isolation. Removal from isolation while in hospitals shall depend on the institution of treatment and results

of subsequent sputum examinations.

(3) The act provides for the isolation of persons infected with tuberculosis in the communicable stage, and the Department designates as an institution suitable for isolation, safekeeping and treatment of persons refusing to submit to treatment for tuberculosis: those general hospitals in this Commonwealth found by the Secretary to possess the requisite staff and facilities for the proper isolation, safekeeping and treatment of the persons.

(c) *Concurrent disinfection.* Sputum and articles soiled with sputum, including handkerchiefs and napkins shall be properly disposed of. Disinfection of air by ventilation with or without ultraviolet light shall be used. Ordinary hygienic precautions suffice when the patient is on specific therapy.

(d) *Terminal disinfection.* Normal hospital procedures shall be followed.

(e) *Quarantine or commitment.* Quarantine or commitment may be established of this chapter, relating to venereal disease, tuberculosis and other communicable diseases. Contacts themselves may not be considered as public health problems unless proven by examination to be infectious cases of tuberculosis. Household contacts and other intimate contacts shall be required to have a tuberculin test or chest X-ray, or both. if lesions suspicious of tuberculosis are found on X-ray of contacts, laboratory studies shall be conducted as are necessary to determine whether or not the patients represent public health problems.]

§27.143. [Tularemia] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority.

(b) *Isolation.* Gloves shall be worn when handling lesions, discharges or dressings.

(c) *Concurrent disinfection.* Discharges from ulcer, lymph nodes and conjunctival sac shall be disinfected.

(d) *Terminal disinfection.* Terminal disinfection shall consist of cleaning.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.144. [Typhoid and paratyphoid] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* Hospitalized patients shall be isolated according to the recommended standard enteric disease isolation procedures: Infected persons shall be excluded from an occupation that prepares or serves food for public consumption until they have had three negative successive stool specimens collected at intervals of not less than 24 hours nor earlier than 7 days after the last dose of a chemotherapeutic drug effective against the etiologic organism.

(c) *Concurrent disinfection.* Feces, urine and articles soiled from them shall require disinfection. In communities with modern and adequate sewage disposal systems, feces and urine may be disposed of directly into the sewer without preliminary disinfection.

(d) *Terminal disinfection.* Terminal disinfection shall consist of cleaning.

(e) *Quarantine.* Household contacts shall be cultured to identify chronic carriers. Household contacts and cases may not be employed in an occupation that prepares or serves food for public consumption until they have had three negative successive stool specimens collected at intervals of not less than 24 hours nor earlier than 7 days after the last dose of a chemotherapeutic drug effective against the typhoid bacillus. If a pregnant woman in the household has typhoid bacilli in her stool, this information shall be furnished to the appropriate physician in charge of her case.

(f) *Restriction on infected persons.* Convalescents from typhoid shall have their stools examined bacteriologically once a month to determine if they are chronic carriers of the organism. If the stools are negative for 3 consecutive months, they are not considered as carriers and may be discharged from further investigation. Individuals who excrete the typhoid bacillus in their stools for greater than 1 year are considered as chronic carriers of the typhoid bacillus. These individuals are not allowed to work in an occupation that prepares or serves food for public consumption and they may not change their address without notifying the Department.

(g) *Cure or release from chronic carrier state.* The local health authority shall maintain a line listing of chronic carriers of the typhoid bacillus. The line listing shall include the name, age, sex, address, telephone number and occupation of carriers. An individual may be removed from the carrier list if he satisfies the requirements as determined by the Secretary or his official designee.

(h) *Outbreaks of typhoid.* Investigations of outbreaks of typhoid shall conform with the following:

(1) *Food borne.* Suspected food borne outbreaks of typhoid shall be investigated. The Department has the authority to require stool specimens on all individuals involved in the outbreak. Suspect food handlers may be excluded from work until the results of their stool culture are negative.

(2) *Institutional outbreaks.* The Department has the authority to conduct an epidemiologic investigation, to require stool specimens on patients and

employees, and to exclude from work an individual who is a threat to the health of others in that institution.]

§27.145. (Reserved).

§27.146. [Yellow fever] (Reserved).

[(a) *Reporting.* Report shall be made to the local health authority by telephone or other equally prompt means.

(b) *Isolation.* No isolation is required; however, the patient shall be protected from mosquitoes for the first 3 days in a mosquito-proof room.

(c) *Concurrent disinfection.* No concurrent disinfection shall be required; however, the home of the patient and houses in its vicinity shall be sprayed promptly with an insecticide having residual action.

(d) *Terminal disinfection.* No terminal disinfection is required.

(e) *Quarantine.* No quarantine of contacts is required.]

§27.151. Restrictions on the donation of blood, blood products, tissue, sperm and ova.

(a) A person known to be, OR SUSPECTED OF BEING, infected with the causative agent of a reportable disease shall not be allowed to donate blood, blood products, tissue, sperm or ova for use in other human beings.

(1) In addition, no person or entity shall accept any of these materials FROM A PERSON KNOWN TO BE, OR SUSPECTED OF BEING, INFECTED WITH THE CAUSATIVE AGENT OF A REPORTABLE DISEASE for donation without obtaining laboratory evidence showing the absence of hepatitis B, hepatitis C, HIV or other diseases and infections, which the Department may specify by placing a notice in the *Pennsylvania Bulletin*.

(2) The list of additional diseases and conditions will not remain in effect for more than 90 days after publication unless the Board acts to affirm it within that 90-day period.

(b) The only exception to a person or entity accepting donations without obtaining laboratory evidence showing the absence of diseases and infections designated by the Department is when the delay that would be necessary to properly test the blood of the donor would threaten the recipient's survival.

§27.152. Investigation of cases and outbreaks.

(a) The Department or a local health authority may investigate any case or outbreak of disease judged by the Department or local health authority to be a potential threat to the public health.

(b) A person may not interfere with or obstruct a representative of the Department or a local health authority who seeks to enter a house, health care facility, building or other premises to carry out an investigation of a case or outbreak, if the representative presents documentation to establish that he is an authorized representative of the Department or the local health authority.

(c) In the course of conducting an investigation of a case or outbreak, the authorized representative of the Department or local health authority may conduct a confidential review of medical records. A person may not interfere with or obstruct this review.

§27.153. Restrictions on food handlers.

A person with the following diseases or conditions is MAY not ~~permitted to~~ work as a food handler, See SEE, also, 3 Pa. C.S. Chapter 65 (relating to the Food Employee Certification Act) and 7 Pa. Code §§78.41-78.43 (relating to health and disease control of employees)), except as follows:

(1) *Amebiasis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antiparasitic treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.156 (relating to the special requirements for amebiasis).

(2) *Enterohemorrhagic E. coli.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.157 (relating to the special requirements for enterohemorrhagic E. coli).

(3) *Shigellosis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.158 (relating to the special requirements for shigellosis).

(4) *Typhoid fever or paratyphoid fever.* Until the etiologic organism has been eradicated as proven by three negative successive stool specimens collected at intervals of no less than 24 hours nor earlier than 48 hours after receiving the last dose of a chemotherapeutic drug effective against Salmonella typhi OR PARATYPHI, and no earlier than 1 month after onset. See §27.159 (relating to the special requirements for typhoid and paratyphoid fever).

(5) *Hepatitis A, viral hepatitis, or jaundice of unspecified etiology.* Until 1 week following the onset of jaundice, or 2 weeks following symptom onset or IgM antibody positivity if jaundice is not present, as verified by a physician.

(6) *Diarrhea-PERSISTENT DIARRHEA.* Until resolved or judged to be noninfective by a physician.

§27.154. Restrictions on caregivers in a child care group setting.

A person with the following diseases or conditions is MAY not permitted to work as a care giver in a child care group setting if the caregiver attends or works in a capacity which requires direct contact with children except as follows:

(1) *Amebiasis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.156 (relating to the special requirements for amebiasis).

(2) *Enterohemorrhagic E. coli.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.157 (relating to the special requirements for enterohemorrhagic E. coli).

(3) *Shigellosis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given the specimens may not be collected sooner than 48 hours after treatment was completed. See ~~§27.161~~ §27.158 (relating to the special requirements for shigellosis).

(4) *Typhoid fever or paratyphoid fever.* Until the etiologic organism is eradicated as proven by three negative successive stool specimens collected at intervals of no less than 24 hours nor earlier than 48 hours after receiving the last dose of a chemotherapeutic drug effective against Salmonella typhi OR PARATYPHI, and no earlier than 1 month after onset. See §27.159 (relating to the special requirements for typhoid and paratyphoid

fever).

(5) *Hepatitis A, viral hepatitis, or jaundice of unspecified etiology.* Until 1 week following the onset of jaundice, or 2 weeks following symptom onset or IgM antibody positivity if jaundice is not present, as verified by a physician.

(6) *Diarrhea PERSISTENT DIARRHEA.* Until resolved or judged to be noninfective by a physician.

§27.155. Restrictions on health care practitioners.

Persons with the following diseases or conditions are MAY not permitted to work as health care practitioners who provide direct patient care:

(1) *Amebiasis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antiparasitic treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.156 (relating to the special requirements for amebiasis).

(2) *Enterohemorrhagic E. coli.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given, the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.157 (relating to the special requirements for enterohemorrhagic E. coli).

(3) *Shigellosis.* Until the etiologic organism is eradicated as proven by two consecutive negative stool specimens, obtained at least 24 hours apart, as verified by a physician. If antibacterial treatment has been given the specimens may not be collected sooner than 48 hours after treatment was completed. See §27.158 (relating to the special requirements for shigellosis).

(4) *Typhoid fever or paratyphoid fever.* Until the etiologic organism is eradicated as proven by three negative successive stool specimens collected at intervals of no less than 24 hours nor earlier than 48 hours after receiving the last dose of a chemotherapeutic drug effective against *Salmonella typhi* OR PARATYPHI, and no earlier than 1 month after onset. See §27.159 (relating to the special requirements for typhoid or paratyphoid fever).

(5) *Hepatitis A, viral hepatitis, or jaundice of unspecified etiology.* Until 1 week following the onset of jaundice, or 2 weeks following symptom onset or IgM antibody positivity if jaundice is not present, as verified by a physician.

(6) *Diarrhea PERSISTENT DIARRHEA.* Until resolved or judged to be noninfective

by a physician.

§27.156. Special requirements for amebiasis.

A household contact of a case of amebiasis who prepares or serves food for public consumption, who attends or works in a child care group setting in a capacity which requires contact with children, or who provides direct patient care shall be required to cease work until the contact has submitted two consecutive stool specimens, taken at least 24 hours apart and at least 48 hours after the last dose of any antiparasitic therapy, to an appropriate clinical laboratory for bacteriologic examination and those specimens are determined by the laboratory to be negative for Entamoeba histolytica.

§27.157. Special requirements for enterohemorrhagic E. coli.

A household contact of a case of enterohemorrhagic E. coli, who prepares or serves food for public consumption, who attends or works in a child care group setting in a capacity which requires contact with children, or who provides direct patient care shall be required to cease work until the contact has submitted two consecutive stool specimens, taken at least 24 hours apart and at least 48 hours after the last dose of any antimicrobial therapy, to an appropriate clinical laboratory for bacteriologic examination and those specimens are determined by the laboratory to be negative for enterohemorrhagic E. coli.

§27.158. Special requirements for shigellosis.

A household contact of a case of shigellosis, who prepares or serves food for public consumption, who attends or works in a child care group setting in a capacity which requires contact with children, or who provides direct patient care shall be required to cease work until the contact has submitted two consecutive stool specimens, taken at least 24 hours apart and at least 48 hours after the last dose of any antimicrobial therapy, to an appropriate clinical laboratory for bacteriologic examination and the specimens are determined by the laboratory to be negative for shigella.

§27.159. Special requirements for typhoid and paratyphoid fever.

(a) An asymptomatic household contact of a case of typhoid fever or paratyphoid fever who prepares or serves food for public consumption, who attends or works in a child care group setting in a capacity which requires contact with children, or who provides direct patient care shall be required to cease work until the contact has submitted two stool specimens, taken at least 24 hours apart, to an appropriate clinical laboratory for bacteriologic examination and those specimens are determined by the laboratory to be negative for Salmonella typhi or Salmonella

paratyphi.

(b) A symptomatic household contact of a case of typhoid or paratyphoid fever who prepares or serves food for public consumption, who attends or works in a child care group setting in a capacity which involves contact with children, or who provides direct patient care shall be required to cease work until bacteriologic examination of three consecutive stool specimens, taken at least 24 hours apart and no sooner than 48 hours after any microbial therapy, and no earlier than 1 month after onset, are reported as negative.

(c) A chronic carrier of typhoid or paratyphoid fever shall be excluded from preparing or serving food for public consumption, attending or working in a child care group setting in a capacity which involves contact with children, and providing direct patient care, until three consecutive negative fecal cultures are obtained from specimens taken at least 1 month apart and at least 48 hours after antibiotic therapy has stopped.

§27.160. Special requirements for measles.

(a) Isolation - An infected person shall be restricted to the premises for 4 days after the appearance of the rash.

(b) Quarantine - Whenever measles is determined to be present in a school or child care group setting population, the Department or a local health department may do the following:

(1) Ascertain which children and staff persons are presumed susceptibles. A presumed susceptible is a person who fits into all of the following categories:

(i) Presents no history of two doses of measles vaccination, separated by at least 1 month, while 12 months of age or older.

(ii) Does not demonstrate serological evidence of measles immunity. The serological evidence is the presence of antibody to measles determined by the hemagglutination inhibition test or a comparable test.

(iii) Was born after December 31, 1956.

(2) Order exclusion from the school or child care group setting of presumed susceptible children and staff persons who do not present evidence of having received measles vaccination within 30 days prior to the outbreak. Exclusion shall continue until the excluded persons prove they do not meet the exclusion criteria specified in subsection (b)(1), they receive a measles vaccination, or no case of measles has occurred for a 14-day period.

§27.161. Special requirements for tuberculosis.

(a) Isolation. A person suspected of having tuberculosis in its communicable stage shall be isolated in the following manner:

(1) Isolation for tuberculosis shall be established at the usual residence of the person suffering from tuberculosis whenever facilities for adequate isolation of the infectious person are available at the residence, if the person will accept such isolation. Isolation of a person treated at a residence shall include instruction in the need to cover the mouth and nose when coughing and sneezing, and careful handling and disposal of sputum.

(2) If isolation for tuberculosis cannot be accomplished or maintained at the usual residence of the person and whenever, in the opinion of the Department or local health authority, the person is a health threat to others, by reason of the person's habits, neglect of treatment, or noncompliance with the measures designed to protect others from infection, the isolation shall be enforced by following the procedures in §27.87 (relating to refusal to submit to treatment for communicable disease DISEASES).

(i) Isolation of a person treated in an appropriate institution shall be in accordance with *CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities* and any updates thereto as approved by the Board.

(ii) The Department shall publish notice in the *Pennsylvania Bulletin* of updates of this publication within 30 days after Board approval is obtained.

(b) Handling of contacts. A human household contact or other close human contact shall be required to have a Mantoux tuberculin test or chest X-ray, or both. A close human contact means a person who spends a substantial amount of time with a person who has infectious tuberculosis. If the person refuses, enforcement shall be accomplished as designated in §§27.82 and 27.83 (relating to request to submit to examination; and court ordered examinations). If evidence of tuberculosis in contacts is found on chest X-rays or by symptoms, laboratory studies shall be conducted to determine if the contacts represent a public health threat.

§27.162. Special requirements for animal bites.

Except as may be otherwise required by the Dog Law (3 P.S. §§459-101 - 459-1205) and regulations promulgated by the Department of Agriculture thereunder, quarantine of a biting animal shall conform to the following:

(1) When an animal bites or otherwise potentially exposes a human to rabies, the Department or local health authority shall, after the case of an animal bite is reported, determine whether the animal shall be immediately destroyed and its head submitted to one of the State or county diagnostic laboratories for a rabies examination or whether some other action shall be pursued.

(2) Notwithstanding paragraph (1), when a healthy dog or cat bites or otherwise potentially exposes a human to rabies, the dog or cat shall be quarantined in a place and manner approved by the Department or the local health officer for 10 days after the date of the bite, unless the Department or local health officer directs otherwise.

(3) If a quarantine is imposed, the Department or the local health officer may order the owner or custodian of a biting animal to have the animal examined for symptoms of rabies during the quarantine period by a veterinarian licensed by the State Board of Veterinary Medicine. The cost of the examinations and other associated costs shall be borne by the owner or custodian of the biting animal.

§27.163. Special requirements for psittacosis.

A quarantine is not required for household contacts of a bird that is a carrier of psittacosis. However, parts of any buildings that housed birds infected with psittacosis may not be used by human beings until thoroughly cleaned and disinfected.

§27.164. Special requirements for close contacts of cases of plague, pharyngitis or pneumonia.

A close contact of any person or animal that is diagnosed as having plague (*Yersinia pestis*) pharyngitis, or pneumonia shall be provided chemoprophylaxis and placed under surveillance for 7 days.

Subchapter F. MISCELLANEOUS PROVISIONS

PSITTACOSIS

Sec

27.181. Records of the sale, purchase or exchange of psittacine birds.

27.182. Procurement of birds where psittacosis exists.

27.183. Occurrence of psittacosis.

27.184. [Violation of regulations] (Reserved).

**IMPORTATION OF [LIVE WILD RABBITS, HARES OR RODENTS,
AND IMPORTATION AND SALE OF LIVE TURTLES] ANIMALS
AND ANIMAL PRODUCTS**

27.191. Importation of [live wild rabbits, hares or rodents] animals and animal products during a public health emergency.

27.192. Importation and sale of live turtles.

DISPOSITION OF EFFECTS AND REMAINS OF INFECTED PERSONS

27.201. Disposition of articles exposed to contamination.

27.202. Lease of premises occupied by a person with a communicable disease.

27.203. Preparation for burial or transportation of deceased human bodies.

27.204. Funeral services.

27.205. [Private transportation of human bodies] (Reserved).

§27.181. Records of the sale, purchase or exchange of psittacine birds.

[Dealers] A dealer who [purchase, sell, exchange or give] purchases, sells, exchanges or gives away a bird of the psittacine family shall keep a record for a period of 2 years of each transaction. This record shall include the number of birds purchased, sold, exchanged or given away, the date of the transaction, and the name and address of the person from whom purchased, to whom sold or given away, or with whom exchanged. Records shall be available for official inspection.

§27.183. Occurrence of psittacosis.

(a) The occurrence of a case of psittacosis in the human or avian family shall be cause for the [health authorities of competent jurisdiction] LMRO to make an epidemiologic investigation to determine the source of infection.

(b) Psittacine birds or other birds found on the same premises with a case of human or avian psittacosis shall be quarantined and treated, or destroyed, as prescribed by the [health authorities] Department or local health authority. Aviaries, pet shops or other sources from

which the birds were procured shall be quarantined until [it can be determined that psittacosis does not exist] the quarantine is terminated by the Department or local health authority. If quarantine is not maintained, the [health authorities] Department or local health authority may seize and destroy the [bird or] birds for which quarantine was ordered. [Bodies] The Department or local health authority shall destroy the bodies of the birds [so destroyed shall be disposed of] in a manner which will preclude, insofar as possible, the dissemination of the suspected infecting organism.

(C) A BIRD WITH PSITTACOSIS THAT HAS BEEN PLACED UNDER QUARANTINE MAY NOT BE SOLD OR REMOVED FROM ISOLATION UNTIL IT HAS BEEN TREATED FOR AT LEAST 7 DAYS. AFTER 7 DAYS, THE BIRD MAY BE SOLD, BUT THE SELLER SHALL MAKE THE BUYER AWARE IN WRITING OF THE SIGNIFICANCE OF PSITTACOSIS AND THE SIGNS AND SYMPTOMS FOR WHICH TO LOOK. THE SIGNED RECEIPT SHALL INCLUDE A COPY OF ANY DOCUMENTS PROVIDED TO THE NEW OWNER, AND SHALL BE MAINTAINED AT THE PLACE OF SALE FOR 6 MONTHS AFTER THE SALE OF THE QUARANTINED BIRD. THE DURATION OF ADDITIONAL TREATMENT NECESSARY SHALL BE ESTABLISHED AT THE TIME OF SALE AND THE SELLER SHALL INFORM THE NEW OWNER OF THE DURATION OF THE ADDITIONAL TREATMENT. THE SELLER SHALL SUPPLY THE NEW OWNER WITH A SUPPLY OF MEDICATED FEED SUFFICIENT FOR THE DURATION OF THE TREATMENT.

§27.184. [Violation of regulations] (Reserved).

[The act provides that inspection and prosecution for violation of §§27.181-27.183 (relating to psittacosis) may be made or brought by an agent of the health authorities or agent of an agency authorized by the Department to investigate and prosecute the violations. The investigation or prosecution shall be under the act.]

**IMPORTATION OF [LIVE WILD RABBITS, HARES OR RODENTS,
AND IMPORTATION AND SALE OF LIVE TURTLES] ANIMALS AND
ANIMAL PRODUCTS**

§27.191. Importation of [live wild rabbits, hares or rodents] animals and animal products during a public health emergency.

In the event of a public health emergency, the [Secretary] Department may direct the following procedures for the importation of [wild rabbits, hares or rodents] animals or animal products:

- (1) *Permit required.* [No person, organization or corporation may bring, cause to] The Department may designate a specific type of animal or animal product which may not be brought or [transport a live wild rabbit, hare or rodent] transported into this Commonwealth unless [the] that animal or animal product is accompanied by a permit

issued by the Department or other agency authorized by the Department to issue permits.

(2) *Issuance of permits.* A permit will be issued upon request if the source of the animal or animal product is [submitted] established to the satisfaction of the Department or its agent and that source is known to be free of infection.

(3) *Destruction of animals and animal products.* If the animal or animal product is not accompanied by a permit or if the source [of the animal] is not the same as that set forth in the permit, the animal or animal product shall be immediately seized and destroyed and the means of conveyance disinfected at the expense of the owner.

[(4) *Violations.* The act provides that prosecutions may be initiated by the Department, by a local board or department of health or by a person having knowledge of a violation the act or this chapter.]

§27.192. Importation and sale of live turtles.

[No] A live [turtles] turtle may not be sold or distributed or offered for sale or distribution within this Commonwealth [on or after July 1, 1972,] except [where] when the seller or distributor of the turtles shall warrant to the satisfaction of the Department that the shipment of turtles is free from salmonella [and Arizona] contamination. The Department [in its discretion,] may waive the requirements of this section for live turtles sold or distributed within this Commonwealth for the purposes of research, other zoological purposes or for food.

**DISPOSITION OF EFFECTS AND REMAINS OF
INFECTED PERSONS**

§27.201. Disposition of articles exposed to contamination.

[No] A person may not give, lend, sell, transmit or expose, without previous cleaning and a certificate from the [health authorities] Department or local health authority attesting to the cleaning of bedding, clothing, rags or other articles which have been exposed to contamination from bubonic plague, {smallpox (variola, varioloid)} or anthrax, except [where] when the transmission of the articles is made with proper precaution and with the permission of the [health authorities] Department or local health authority for the purpose of having them cleaned.

§27.202. Lease of premises occupied by a person with a communicable disease.

[No] A person may not rent a room, house or part of a house in which there has been a person suffering from a communicable disease to another person without having the room, house or part of a house and articles therein{, previously} cleaned [to the satisfaction of the health authorities]

TO THE SATISFACTION OF THE DEPARTMENT OR LOCAL HEALTH AUTHORITY prior to occupancy. The keeping of a hotel, boarding house or an apartment house shall be deemed as renting part of a house to a person who shall be admitted as a guest into the hotel, boarding house or apartment house.

§27.203. Preparation for burial or transportation of deceased human bodies.

{In the preparation for burial of a body of a person who had died of amebiasis, anthrax, cholera, diphtheria, plague, poliomyelitis, scarlet fever, shigellosis, smallpox, typhoid fever, paratyphoid fever, salmonellosis or other known or suspected communicable diseases, it shall be the duty of the undertaker or person acting as such to disinfect thoroughly by arterial and cavity injection with approved disinfectant fluid and to wash the surface of the body with an efficient germicidal solution and to effectually plug the body orifices.}

~~When handling deceased human bodies, appropriate precautions shall be taken to prevent the spread of communicable diseases.~~

§27.204. Funeral services.

Services held in connection with the funeral of a person who has died with a disease for which isolation or quarantine is required, [or from measles or whooping cough, may be public but] shall be private when so ordered by the [health authorities of the jurisdiction] Department or local health authority having jurisdiction in the area in which the services shall be held. When the local health authority is not an LMRO, the local health authority shall consult with and receive the approval of the Department prior to making the order. The attendance at private funerals shall include only the immediate relatives of the deceased and the necessary number of pallbearers.

§27.205. [Private transportation of human bodies] (Reserved).

[The body of a person who has died of amebiasis, anthrax, cholera, diphtheria, plague, shigellosis, smallpox, hemolytic streptococcal sore throat, typhoid fever, paratyphoid fever or other salmonella infections may be transported by private conveyance if the body is placed in a leak-proof container or is embalmed and the surface of the body washed with an efficient germicidal solution and the body orifices effectually plugged.]

PART IV. HEALTH FACILITIES
SUBPART C. LONG-TERM CARE FACILITIES
CHAPTER 211. PROGRAM STANDARDS FOR LONG-TERM CARE NURSING
FACILITIES

§211.1 Reportable diseases.

(a) When a resident develops a reportable disease, the administrator shall report the information to the appropriate health agencies and appropriate Division of Nursing Care Facilities field office. Reportable diseases, INFECTIONS AND conditions are[:

- AIDS (Acquired Immune Deficiency Syndrome)
- Amebiasis
- Animal Bites
- Anthrax
- Botulism
- Brucellosis
- Campylobacteriosis
- Cancer
- Chlamydia Trachomatis Infections
- Cholera
- Diphtheria
- Encephalitis
- Food poisoning
- Giardiasis
- Gonococcal infections
- Guillain-Barre syndrome
- Haemophilus influenzae type b disease
- Hepatitis, Viral, including Type A and Type B
- Hepatitis, non-A and non-B
- Histoplasmosis
- Kawasaki disease
- Legionnaires' disease
- Leptospirosis
- Lyme Disease
- Lymphogranuloma venereum
- Malaria
- Measles
- Meningitis--all types
- Meningococcal Disease
- Mumps
- Pertussis (whooping cough)

Plague
Poliomyelitis
Psittacosis (ornithosis)
Rabies
Reye's syndrome
Rickettsial diseases including Rocky Mountain Spotted Fever
Rubella (German Measles) and congenital rubella syndrome
Salmonellosis
Shigellosis
Syphilis--all stages
Tetanus
Toxic Shock Syndrome
Toxoplasmosis
Trichinosis
Tuberculosis--all forms
Tularemia
Typhoid

Yellow Fever] LISTED IN §27.21A (RELATING TO REPORTING OF CASES BY HEALTH CARE PRACTITIONERS AND HEALTH CARE FACILITIES).

(b) Cases of scabies and lice shall be reported to the appropriate Division of Nursing Care Facilities field office.

(c) Significant nosocomial outbreaks, as determined by the facility's medical director, Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin-Resistant Staphylococcus Aureus (VRSA), Vancomycin-Resistant Enterocci (VRE) and Vancomycin-Resistant Staphylococcus Epidermidis (VRSE) shall be reported to the appropriate Division of Nursing Care Facilities field office.

NAMES AND ADDRESSES OF COMMENTATORS REQUESTING COPIES OF
FINAL FORM REGULATION

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Commonwealth of Pennsylvania



DEPARTMENT OF HEALTH

HARRISBURG

ROBERT S. ZIMMERMAN, JR., MPH
SECRETARY OF HEALTH

November 26, 2001

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, 333 Market Street
Harrisburg, Pennsylvania 17101

Re: Department of Health Final Regulation No. 10-156
Communicable and Noncommunicable Diseases

Dear Mr. Nyce:

Enclosed is a copy of final-form regulations for review by the Commission pursuant to the Regulatory Review Act (Act) (71 P.S. §§745.1-745.15). Section 5.1(a) of the Act provides that, upon completion of the agency's review of comments following proposed rulemaking, the agency is to submit to the Commission and the Standing Committees, a copy of the agency's response to the comments received, the names and addresses of commentators who have requested additional information relating to the final-form regulations, and the text of the final-form regulations which the agency intends to adopt.

A list of the names and addresses of the commentators who requested a copy of the final-form regulations is enclosed. Their comments, which discussed a number of provisions contained in the proposed regulations, were forwarded to the Commission upon receipt by the Department.

Section 5.1(e) of the Act provides that within 10 days following the expiration of the Standing Committee review period, or at its next regularly scheduled meeting, the Commission shall approve or disapprove the final-form regulations.


Robert E. Nyce

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November 26, 2001

The Department will provide the Commission with any assistance it requires to facilitate a thorough review of the regulations. If you have any questions, please contact Deborah Griffiths, Director, Office of Legislative Affairs.

Sincerely,

A handwritten signature in cursive script that reads "Robert S. Zimmerman, Jr." The signature is written in black ink and is positioned above the printed name.

Robert S. Zimmerman, Jr.
Secretary of Health

Enclosures

**TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE
REGULATORY REVIEW ACT**

I.D. NUMBER: 10-156

SUBJECT: Communicable and Noncommunicable Diseases; Program Standards for Long-Term Care Nursing Facilities

AGENCY: Department of Health

TYPE OF REGULATION

- Proposed Regulation
- X Final Regulation
- Final Regulation with Notice of Proposed Rulemaking Omitted
- 120-day Emergency Certification of the Attorney General
- 120-day Emergency Certification of the Governor
- Delivery of Tolled Regulation
 - a. With Revisions
 - b. Without Revisions

RECEIVED
 DEPARTMENT OF HEALTH
 11/14/01

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
11/20/01	<u>Lila Burris</u>	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
11/20/01	<u>Karen Shaffer</u>	
11/20/01	<u>Bruce Kreiser</u>	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
11/26	<u>L. Calin</u>	
11/26/01	<u>Pera Eckert</u>	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL
		LEGISLATIVE REFERENCE BUREAU

November 14, 2001