Kentucky General Assembly
House of Representatives

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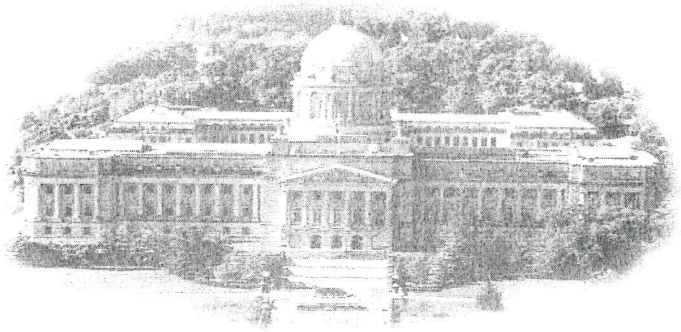

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April 5, 2013

The Honorable Steve Beshear
Governor of Kentucky
700 Capitol Avenue, Suite 100
Frankfort, Kentucky 40601

Dear Governor Beshear:

I am writing in regards to the March 24, 2013, article in the Courier Journal regarding the deadly bacteria carbapenem-resistant enterobacteriaceae (CRE) and to request amending 902 KAR 2:020 (Disease Surveillance) to include CRE, (infection or asymptomatic carrier state), and to require urgent notification under Section 2 of this regulation. CRE represents a large group of gram-negative bacteria, which can spread bacterial resistance between each other.

CRE is a deadly, potentially untreatable, bacterial infection, which can be spread on contact, and when it is in the blood, it has almost a 50 percent fatality rate. Colistin, the only antibiotic that has some activity against CRE, is toxic and causes renal failure in a significant number of patients.

As reported in the Courier Journal article, approximately 20 cases have been treated in the Louisville Hospitals over the past two years. However, the Kentucky Department of Health has received only one report of an outbreak.

Most disturbing is that the 13 cases treated by Norton Healthcare System, appear to be increasing in frequency and came from nursing homes. Dr. Paul Schulz, Norton System Epidemiologist, has described this as a community problem.

It is imperative that CRE does not get into the community and become as prevalent as Methicillin-resistant Staphylococcus aureus (MRSA). Each of the cases treated by Norton Healthcare should have been investigated to determine the source in the Nursing Homes and to make sure the cause of the disease has been eradicated.

As a testament to the threat imposed by CRE, enclosed is a copy of an e-mail message from Dr. Denise M. Cardo, Acting Deputy Director of the Centers for Disease Control and Prevention's Office of Science, Epidemiology and Laboratory Services (OSELS); to Dr. Kevin Kavanagh, stressing her concerns regarding this epidemic and for "healthcare administrators and providers to take immediate steps to ensure that CDC infection prevention measures are aggressively implemented in an effort to protect patients and stop the spread of these organisms."

In addition, Dr. Cardo stated that at least six states have moved forward making CRE a reportable disease with others putting steps in place to enact mandatory reporting. I have enclosed the 2013 Reportable Diseases and Events list of organisms required to be reported by the State of Tennessee; CRE is included in this list. In Kentucky many bacteria, which are more treatable than CRE, are required to be reported (see enclosure: 902 KAR 2:020).

KRS 211.180 requires the Cabinet to implement a statewide program for the detection, prevention, and control of communicable diseases. I would like to request that you implement this authority by making carbapenem-resistant enterobacteriaceae (CRE) disease a mandatory reportable event in the State of Kentucky.

In addition, I request that all carbapenem resistant gram-negative bacteria, including Pseudomonas aeruginosa, and Acinetobacter species also be made mandatory reportable bacteria, requiring priority notification under Section 3 of 902 KAR 2:020.

Since patients are currently being transferred between institutions with CRE, health department engagement is required to fully investigate the source, prevent these potentially deadly bacteria from developing a foothold in Kentucky, placing our population at risk.

It should be obvious to you that I had some technical help drafting this letter, but I feel that the issue is very important to the health and welfare of the Commonwealth. Dr. Kevin Kavanagh provided the technical assistance that I needed to compose this letter.

You consideration of this request is greatly appreciated.

Sincerely,

Tom Burch

Tom Burch
State Representative

TB/KK/gm
Enclosures

Deadly bacteria hitting Louisville hospitals, long-term care facilities

Written by Laura Ungar The Courier-Journal
Mar. 27

courier-journal.com

Caren Chapman, an environmental services associate, cleans an intensive care room at Norton Hospital Brownsboro. A deadly superbug called CRE is on the rise in Kentucky and across the nation. At Norton Healthcare, for example, 13 cases have ever been reported -- three of them this year. March 20, 2013

Purchase Image Zoom

Caren Chapman, an environmental services associate, cleans an intensive care room at Norton Hospital Brownsboro. A deadly superbug called CRE is on the rise in Kentucky and across the nation. At Norton Healthcare, for example, 13 cases have ever been reported -- three of them this year. March 20, 2013 / Angela Shoemaker/Special to The Courier-Journal

By the numbers

- 1 in 2 — Death rate for patients who get bloodstream infections from CRE germs.
- 42 — States reporting a type of CRE infection in medical facilities during the past decade.
- 4 percent — U.S. hospitals with at least one patient with a CRE infection during the first half of 2012.
- 3 — CRE cases at Norton Healthcare this year.
- 2 — CRE cases at Jewish and University hospitals this year, with one at each hospital.
- Less than 6 — CRE cases at Baptist Health Louisville in the past two years.

Sources: U.S. Centers for Disease Control and Prevention, Norton Healthcare

Superbugs 101

Some of the superbugs creating problems in hospitals and long-term care facilities:

- CRE — Carbapenem-resistant Enterobacteriaceae can cause hard-to-treat and untreatable infections. CRE germs are resistant to all or nearly all antibiotics. They are not common, but they kill half of patients who get bloodstream infections. Almost all infections occur in patients receiving serious medical care. The exact number of infections and deaths from CRE is unknown.
- MRSA — Methicillin-resistant Staphylococcus aureus is a staph infection that doesn't get better with first-line antibiotics. One study showed MRSA infections kill 18,000 Americans a year. A health care provider or visitors may have staph germs on their body that can spread to a patient. Serious staph infections are more common in people with a weakened immune system. MRSA infections can also occur in healthy people who have not recently been in the hospital, but most of these are on the skin.

- C. diff — Clostridium difficile causes diarrhea linked to 14,000 American deaths each year. Those most at risk are people, especially older adults, who take antibiotics and also get medical care. The bacteria are found in the feces, and people can become infected if they touch items contaminated with feces and then touch their mouth or mucous membranes. Health care workers can spread the bacteria to patients or contaminate surfaces through hand contact.

Source: U.S. Centers for Disease Control and Prevention, U.S. National Library of Medicine

They've been called "nightmare bacteria" — deadly superbugs known as CRE that strike hospitalized patients and kill as many as half who get bloodstream infections.

And they're on the rise — in Louisville and across the nation.

The U.S. Centers for Disease Control and Prevention issued a strong warning this month, saying "action is needed now to stop these deadly infections" that have been treated in nearly 200 U.S. hospitals during the first half of 2012.

While neither Kentucky nor the federal government tracks individual cases, local hospitals officials say they've seen a growing number in recent years — and they're enacting measures to combat CRE — short for carbapenem-resistant Enterobacteriaceae, a family of germs that has high resistance to antibiotics.

"If it gets in the community and spreads, we're in trouble," said Dr. Kevin Kavanagh, who leads the Somerset, Ky.-based watchdog group Health Watch USA.

University Hospital officials said they had a case this year in which the patient died, and Norton Healthcare says three of its 13 cases since 2010 have occurred this year, prompting Chief of Microbiology Alan Junkins to say, "I'm kind of worried it's getting worse."

"In my mind, this is one of the most worrisome (group of) germs we as a society have to deal with," said Dr. Paul Schulz, Norton system epidemiologist. "You really get this combination of potentially high virulence and very difficult resistance" to antibiotics.

Experts say the problem is fueled by the overuse of antibiotics and gaps in infection control in hospitals and long-term care facilities — the same problems that give rise to other pernicious, health-care-associated infections such as MRSA and C. difficile (commonly called C. diff).

Officials at Norton and other facilities say they are taking steps to prevent infections — stressing measures such as hand-washing, room-cleaning and using antibiotics more wisely.

The Kentucky Department for Public Health, meanwhile, educates health care providers about preventing superbugs and will soon tap into CDC statistics on health-care-associated infections.

But critics say more needs to be done to ensure CRE doesn't spread — both in hospitals and beyond.

Kavanagh said hospitals must be extra-vigilant about infection control and should be required to report cases to the state. Currently, they must only report "outbreaks" of greater-than-expected numbers of cases, leaving it to hospitals to interpret what that means.

"This is an organism that requires reporting," Kavanagh said. "MRSA looks like a common cold compared to CRE."

"We all own it"

CRE is a family of more than 70 bacteria that are a normal part of people's digestive systems but can cause infections when they get into other areas of the body, such as the bloodstream or bladder.

Over time, they have become resistant to last-resort antibiotics called carbapenems.

"CRE are nightmare bacteria," said CDC Director Dr. Tom Frieden. "Our strongest antibiotics don't work, and patients are left with potentially untreatable infections."

CRE germs can "colonize" in healthy people without making them sick, the CDC says. But almost all CRE infections occur in vulnerable, sick patients undergoing serious medical care, including those with repeated stays in hospitals and long-term care facilities.

CRE-related illnesses vary by where the bacteria infect the body, ranging from gastrointestinal illness to pneumonia to bloodstream infections — which can sometimes be treated with extremely strong antibiotics that often come with serious side effects.

"The worst thing about CRE is you just can't treat it," said Dr. Forest Arnold, a University of Louisville epidemiologist.

Often, doctors said, it's difficult to determine where a patient picked up the bug, since so many of its victims are in and out of various hospitals and nursing homes.

But Norton's Schulz said no matter where it is found, it's a community problem.

"We all own it," Schulz said. "All the health systems should be working together."

At Norton, Junkins said all of the CRE cases were in people who had previously been hospitalized at long-term care facilities, and all survived.

Other area hospitals have also treated cases.

• Baptist Health Louisville hasn't tracked exact numbers, but Connie Barker, vice president for quality and clinical effectiveness, said it had fewer than six cases in the past two years and no deaths.

• Arnold said University Hospital had no cases between 2010-12, but one this January, and the patient died. "It's just a matter of time before we see more patients," he said.

• Barbara Mackovic, spokeswoman for KentuckyOne Health, said the system's Louisville hospitals also had one case this year, at Jewish Hospital, and that patient survived. She had no statistics from other recent years in KentuckyOne's Louisville hospitals.

• Ruby Jo Cummins Lubarsky, president of the Kentucky Association of Health Care Facilities, said she's not aware of any CRE cases in nursing facilities across the state.

• Kentucky lists just one "outbreak" of CRE in 2012 — in a hospital — but State Epidemiologist Dr. Kraig Humbaugh would not say which hospital or county it was in.

To reduce health care-associated infections, the federal government tries to keep tabs on hospital cleanliness.

Patient survey results collected for the Medicare program's "Hospital Compare" website give the percentages of patients who report that their room and bathroom were "always" clean during their hospital stays. Results for Louisville hospitals listed on the site ranged from 65 percent to 68 percent.

Schulz said such measures are subjective; residue from a cleaner may make a surface look dirty, he said, while a clean-looking room may still harbor bacteria. Nonetheless, he said, it's critical to concentrate on cleanliness.

Fighting back

At Norton, Baptist, KentuckyOne and University, officials said they work to ensure health-care workers, patients and family members wash their hands frequently — one of the best ways to prevent the spread of bacteria.

They said they also work to keep rooms and medical equipment clean, using the proper cleaning agents; stress "contact precautions" such as gowns and gloves; and try to separate infected patients from others.

Officials said they also keep close track of whether patients have had multiple hospitalizations, and ask them whether they have been told they were colonized or infected with CRE.

New infection-control measures are on the horizon.

Junkins said Norton is considering whether to screen high-risk patients for CRE when they come into the hospital. Barker said Baptist is starting to collect CRE statistics more methodically, report them voluntarily to the state and make pharmacists available to review antibiotics prescribed to patients.

And Arnold said University has a new policy of dedicating specific equipment, such as blood-pressure cuffs, to CRE-infected patients, and disposing of that equipment afterward.

Doctors said prescribing antibiotics wisely, both inside and outside the hospital, helps prevent germs from becoming resistant to antibiotics and reduces the emergence of superbugs.

"Today, it's CRE," Barker said. "You really wonder what's around the corner."

Doctors said patients can take steps to protect themselves by telling health care workers about past hospitalizations and any known exposure to CRE, taking antibiotics as prescribed, and insisting people wash their hands before touching them.

"A lot of this is not high-tech stuff," Humbaugh said. "But it's proven to work."

While experts agree on most aspects of infection control, they are divided on whether government should require CRE infections to be reported.

Kavanagh is among the doctors and activists who believe they should be, and said: "I don't think there's a single person in Kentucky who wouldn't want to know whether there has been a case of CRE at their hospital."

Schulz said mandatory reporting might not be a bad thing, because the idea of being watched may spur people to be more vigilant about preventive measures such as washing their hands.

But Ruth Carrico, an infection preventionist and associate professor at the University of Louisville, said there are so many agencies requesting reports on various infections, and so much effort going into reporting them, that it threatens to drain resources from infection prevention and control.

Experts on both sides of the reporting issue said health care workers must stay vigilant, since superbugs threaten us all.

"Any of us can be a patient at any point," Carrico said.

Reporter Laura Ungar can be reached at (502)582-7190 or on Twitter @lauraungarcj.

Gmail by Google

Kevin Kavanagh <kavanagh.ent@gmail.com>

CRE Covered Front Page Louisville Courier Journal - Health Dept Engagement Questioned

Cardo, Denise M. MD (CDC/OID/NCEZID) <dbc0@cdc.gov> Thu, Mar 28, 2013 at 6:46 PM
To: Kevin Kavanagh <kavanagh.ent@gmail.com>

Kevin,

Thank you for bringing this article to our attention.

We agree with your concern about the threat of CRE throughout healthcare facilities. We published the Vital Signs report as a call-to-action for healthcare administrators and providers to take immediate steps to ensure that CDC infection prevention measures are aggressively implemented in an effort to protect patients and stop the spread of these organisms.

We appreciate and agree with your feedback regarding the need to define what constitutes an outbreak of CRE. We are currently working with the Council of State and Territorial Epidemiologists to standardize approaches for tracking and reporting CRE. This will help to inform the work that all states are doing to monitor CRE infections. At this time, at least six states have moved forward with making CRE a reportable condition (CO, ND, OR, TN, WA, WI) and others are putting steps in place to make this possible. Additionally, we are working with the HAI coordinators in each state to better address HAI prevention efforts, including CRE prevention.

We appreciate your continued collaboration in HAI prevention, particularly your work to raise awareness about these issues.

Denise.

From: Kevin Kavanagh [mailto:kavanagh.ent@gmail.com]
Sent: Monday, March 25, 2013 10:47 AM
To: Cardo, Denise M. MD (CDC/OID/NCEZID)
Cc: Thomas R. Frieden (CDC)
Subject: CRE Covered Front Page Louisville Courier Journal - Health Dept Engagement Questioned

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Office of Surveillance, Epidemiology, and Laboratory Services

Leadership

Office of the Director

Denise Cardo, MD
Acting Director

Dr. Denise Cardo is the Acting Director of the Centers for Disease Control and Prevention's Office of Science, Epidemiology and Laboratory Services (OSELS). In this role, Dr. Cardo provides critical leadership in the application of information, computer science, and technology to improve public health practice, research, and learning.

Previously, Dr. Cardo served as the director of the Division of Healthcare Quality Promotion at the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID). She joined CDC in 1993 as a medical epidemiologist in the HIV Infections Branch, Hospital Infections Program, National Center for Infectious Diseases, and in 1998 she became chief of this branch. In 2000, she became the chief of the Prevention and Evaluation Branch in the same division.

Prior to joining CDC, Dr. Cardo had a distinguished career in the division of infectious diseases at one of Brazil's prestigious medical institutions, Escola Paulista de Medicina, Sao Paulo, Brazil, where she received her medical degree in 1980, completed her residency and fellowship, and joined the faculty as an associate professor of infectious diseases. In addition, she was a co-founder and president of Sao Paulo Association of Infection Control and a consultant to the Brazilian Ministry of Health. During 1990-1991, she did a sabbatical at the Hospital Epidemiology Program, University of Tennessee, Memphis, under the supervision of Dr. Glen Mayhall.

Dr. Cardo's interests include patient safety, prevention of healthcare-associated infections, and antimicrobial resistance. She is the author of numerous research and peer-reviewed papers and book chapters.

Page last reviewed: February 27, 2013
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Content source: Centers for Disease Control and Prevention

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - Contact CDC–INFO

Tennessee Department of Health
Reportable Diseases and Events

The diseases and events listed below are declared to be communicable and/or dangerous to the public and are to be reported to the local health department by all hospitals, physicians, laboratories, and other persons knowing of or suspecting a case in accordance with the provision of the statutes and regulations governing the control of communicable diseases in Tennessee (T.C.A. §68 Rule 1200-14-01-.02). See matrix for additional details.

Category 1A: Requires immediate telephonic notification (24 hours a day, 7 days a week), followed by a written report using the PH-1600 within 1 week.

[002] Anthrax (*Bacillus anthracis*)[B]
[005] Botulism-Foodborne (*Clostridium botulinum*)[B]
[004] Botulism-Wound (*Clostridium botulinum*)
[505] Disease Outbreaks (e.g., foodborne, waterborne, healthcare, etc.)
[023] Hantavirus Disease
[096] Measles-Imported
[026] Measles-Indigenous
[095] Meningococcal Disease (*Neisseria meningitidis*)
[516] Novel Influenza A
[032] Pertussis (Whooping Cough)
[037] Rabies: Human
[112] Ricin Poisoning[B]
[132] Severe Acute Respiratory Syndrome (SARS)
[107] Smallpox[B]
[110] Staphylococcal Enterotoxin B (SEB) Pulmonary Poisoning[B]
[111] Viral Hemorrhagic Fever[B]

Category 1B: Requires immediate telephonic notification (next business day), followed by a written report using the PH-1600 within 1 week.

[006] Brucellosis (*Brucella* species)[B]
[502] *Burkholderia mallei* infection[B]
[010] Congenital Rubella Syndrome
[011] Diphtheria (*Corynebacterium diphtheriae*)
[123] Eastern Equine Encephalitis Virus Infection
[507] *Francisella* species infection (other than *F. tularensis*)[B]
[053] Group A Streptococcal Invasive Disease (*Streptococcus pyogenes*)
[047] Group B Streptococcal Invasive Disease (*Streptococcus agalactiae*)
[054] *Haemophilus influenzae* Invasive Disease
[016] Hepatitis, Viral-Type A acute
[513] Influenza-associated deaths, age <18 years
[520] Influenza-associated deaths, pregnancy-associated
[515] Melioidosis (*Burkholderia pseudomallei*)
[102] Meningitis-Other Bacterial
[031] Mumps
[033] Plague (*Yersinia pestis*)[B]
[035] Poliomyelitis-Nonparalytic
[034] Poliomyelitis-Paralytic
[119] Prion disease-variant Creutzfeldt Jakob Disease
[109] Q Fever (*Coxiella burnetii*)[B]
[040] Rubella
[041] Salmonellosis: Typhoid Fever (*Salmonella* Typhi)
[131] *Staphylococcus aureus*: Vancomycin non-sensitive – all forms
[075] Syphilis (*Treponema pallidum*): Congenital
[519] Tuberculosis, confirmed and suspect cases of active disease (*Mycobacterium tuberculosis* complex)
[113] Tularemia (*Francisella tularensis*)[B]
[108] Venezuelan Equine Encephalitis Virus Infection[B]

Category 2: Requires written report using form PH-1600 within 1 week.

[528] *Acinetobacter* species, Carbapenem-resistant (Davidson County)
[501] Babesiosis
[003] Botulism-Infant (*Clostridium botulinum*)
[121] California/LaCrosse Serogroup Virus Infection
[007] Campylobacteriosis (including EIA or PCR positive stools)
[526] Carbon Monoxide Poisoning
[503] Chagas Disease
[069] Chancroid
[055] *Chlamydia trachomatis*-Genital
[057] *Chlamydia trachomatis*-Other
[009] Cholera (*Vibrio cholerae*)
[001] Cryptosporidiosis (*Cryptosporidium* species)
[106] Cyclosporiasis (*Cyclospora* species)
[504] Dengue Fever
[522] Ehrlichiosis/Anaplasmosis – Any
[506] Enterobacteriaceae, Carbapenem-resistant
[060] Gonorrhea-Genital (*Neisseria gonorrhoeae*)
[064] Gonorrhea-Ophthalmic (*Neisseria gonorrhoeae*)
[061] Gonorrhea-Oral (*Neisseria gonorrhoeae*)
[062] Gonorrhea-Rectal (*Neisseria gonorrhoeae*)
[133] Guillain-Barré syndrome

[B]Possible Bioterrorism Indicators

Effective 01/01/2013

Category 2: Requires written report using form PH-1600 within 1 week. (continued)

[022] Hansen's Disease [Leprosy] (*Mycobacterium leprae*)
[058] Hemolytic Uremic Syndrome (HUS)
[480] Hepatitis, Viral-HbsAg positive infant
[048] Hepatitis, Viral-HbsAg positive pregnant female
[017] Hepatitis, Viral-Type B acute
[018] Hepatitis, Viral-Type C acute
[021] Legionellosis (*Legionella* species)
[094] Listeriosis (*Listeria* species)
[024] Lyme Disease (*Borrelia burgdorferi*)
[025] Malaria (*Plasmodium* species)
[521] Powassan virus infection
[118] Prion disease-Creutzfeldt Jakob Disease
[036] Psittacosis (*Chlamydia psittaci*)
[105] Rabies: Animal
[122] St. Louis Encephalitis Virus Infection
[042] Salmonellosis: Other than *S. Typhi* (*Salmonella* species)
[517] Shiga-toxin producing *Escherichia coli* (including Shiga-like toxin positive stools, *E. coli* O157 and *E. coli* non-O157)
[043] Shigellosis (*Shigella* species)
[039] Spotted Fever Rickettsiosis (*Rickettsia* species including Rocky Mountain Spotted Fever)
[130] *Staphylococcus aureus*: Methicillin resistant Invasive Disease
[518] *Streptococcus pneumoniae* Invasive Disease (IPD)
[074] Syphilis (*Treponema pallidum*): Cardiovascular
[072] Syphilis (*Treponema pallidum*): Early Latent
[073] Syphilis (*Treponema pallidum*): Late Latent
[077] Syphilis (*Treponema pallidum*): Late Other
[076] Syphilis (*Treponema pallidum*): Neurological
[070] Syphilis (*Treponema pallidum*): Primary
[071] Syphilis (*Treponema pallidum*): Secondary
[078] Syphilis (*Treponema pallidum*): Unknown Latent
[044] Tetanus (*Clostridium tetani*)
[045] Toxic Shock Syndrome: Staphylococcal
[097] Toxic Shock Syndrome: Streptococcal
[046] Trichinosis
[101] Vancomycin resistant enterococci (VRE) Invasive Disease
[114] *Varicella* deaths
[104] Vibriosis (*Vibrio* species)
[125] West Nile virus Infections-Encephalitis
[126] West Nile virus Infections-Fever
[124] Western Equine Encephalitis Virus Infection
[098] Yellow Fever
[103] Yersiniosis (*Yersinia* species)

Category 3: Requires special confidential reporting to designated health department personnel within 1 week.

[500] Acquired Immunodeficiency Syndrome (AIDS)
[512] Human Immunodeficiency Virus (HIV)
[525] All CD4+ T-cell and HIV-1 Viral Load testing results from those laboratories performing these tests

Category 4: Laboratories and physicians are required to report all blood lead tests. Levels ≥ 5µg/dl should be reported within 1 week. Levels < 5µg/dl should be reported within 1 month.

[514] Lead Levels (blood)

Category 5: Events will be reported monthly (no later than 30 days following the end of the month) using the the designated reporting mechanism. For Healthcare Associated Infections, events should by reported via the National Healthcare Safety Network (NHSN - see http://health.state.tn.us/ceds/hai/index.htm for more details); *Clostridium difficile* infections (Davidson County residents only) will also be reported monthly to the Emerging Infections Program (EIP). For Neonatal Abstinence Syndrome (NAS), a diagnosis should be reported using the NAS reporting portal (http://health.tn.gov/MCH/NAS/index.shtml).

[523] Healthcare Associated Infections, Catheter Associated Urinary Tract Infections
[508] Healthcare Associated Infections, Central Line Associated Bloodstream Infections
[509] Healthcare Associated Infections, *Clostridium difficile*
[524] Healthcare Associated Infections, Dialysis Events
[529] Healthcare Associated Infections, Healthcare Personnel Influenza Vaccination
[510] Healthcare Associated Infections, Methicillin resistant *Staphylococcus aureus* positive blood cultures
[511] Healthcare Associated Infections, Surgical Site Infections
[527] Neonatal Abstinence Syndrome

[B]Possible Bioterrorism Indicators

Effective 01/01/2013

902 KAR 2:020. Disease surveillance.

RELATES TO: KRS 211.180(1), 214.010, 214.645, 333.130

STATUTORY AUTHORITY: KRS 194A.050, 211.090(3), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health and Family Services and placed the Department for Public Health under the Cabinet for Health and Family Services. KRS 211.180 requires the cabinet to implement a statewide program for the detection, prevention, and control of communicable diseases, chronic and degenerative diseases, dental diseases and abnormalities, occupational diseases and health hazards peculiar to industry, home accidents and health hazards, animal diseases which are transmissible to man, and other diseases and health hazards that may be controlled. KRS 214.010 requires every physician and every head of family to notify the local health department of the existence of diseases and conditions of public health importance, known to him or her. This administrative regulation establishes notification standards and specifies the diseases requiring urgent, priority, or routine notification, in order to facilitate rapid public health action to control diseases, and to permit an accurate assessment of the health status of the Commonwealth.

Section 1. Notification Standards. (1) A health professional licensed under KRS Chapters 311 through 314, and a health facility licensed under KRS Chapter 216B, shall give notification pursuant to subsection (3) of this section, if:

(a) The health professional makes a probable diagnosis of a disease specified in Section 2, 3, or 4 of this administrative regulation; and

(b) The diagnosis is supported by:

1. "Case Definitions for Infectious Conditions under Public Health Surveillance"; or

2. A reasonable belief that the disease is present.

(2)(a) A single report by a hospital of a condition diagnosed by a test result from the hospital laboratory shall constitute notification on behalf of the hospital and its laboratory.

(b) A hospital may designate an individual to report on behalf of the hospital's laboratory and the hospital's clinical facilities.

(3) The notification shall be given to the:

(a) Local health department serving the jurisdiction in which the patient resides; or

(b) Department for Public Health.

(4) The reporting professional shall furnish the:

(a) Name, birthdate, address, county of residence, and telephone number of the patient; and

(b) Clinical, epidemiologic, and laboratory information pertinent to the disease.

(5) Upon the confirmation of a laboratory test result which indicates infection with an agent associated with one (1) or more of the diseases or conditions specified in Section 2, 3, or 4 of this administrative regulation, the director of a clinical laboratory licensed under KRS Chapter 333 shall:

(a) Report the result to the:

1. Local health department serving the jurisdiction in which the patient resides; or

2. Department for Public Health; and

(b) Report the patient's name, birthdate, address, and county of residence; and

Section 2. Diseases Requiring Urgent Notification. (1) Notification pursuant to Section 1(3) of this administrative regulation of the following diseases shall be made within twenty-four (24) hours:

(a) Anthrax;

(b) Botulism;

(c) Brucellosis;

(d) Campylobacteriosis;

(e) Cryptosporidiosis;

(f) Cholera;

(g) Diphtheria;

(h) Escherichia coli O157:H7;

(i) Escherichia coli, shiga toxin positive;

(j) Encephalitis, California group;

(k) Encephalitis, Eastern equine;
(l) Encephalitis, St. Louis;
(m) Encephalitis, Venezuelan equine;
(n) Encephalitis, Western;
(o) Encephalitis, West Nile Virus;
(p) Hansen's Disease;
(q) Hantavirus infection;
(r) Hemophilus influenzae invasive disease;
(s) Hepatitis A;
(t) Listeriosis;
(u) Measles;
(v) Meningococcal infections;
(w) Pertussis;
(x) Plague;
(y) Poliomyelitis;
(z) Psittacosis;
(aa) Q fever;
(bb) Rabies, animal;
(cc) Rabies, human;
(dd) Rubella;
(ee) Rubella syndrome, congenital;
(ff) Salmonellosis;
(gg) Shigellosis;
(hh) Syphilis, primary, secondary, early latent or congenital;
(ii) Tetanus;
(jj) Tularemia;
(kk) Typhoid fever;
(ll) Vibrio parahaemolyticus;
(mm) Vibrio vulnificus;
(nn) Yellow fever.

(2) Weekend or evening urgent notification.

(a) If health department personnel cannot be contacted directly, notification shall be made by electronic submission or by telephone to an emergency number provided by the local health department or the Department for Public Health.

(b) For the protection of patient confidentiality, this notification shall include:

1. The name of the condition being reported; and
2. A telephone number that can be used by the department to contact the reporting professional.

(3) Upon receipt of a report for a disease specified in subsection (1) of this section, the local health department shall:

(a) Immediately notify the Department for Public Health; and
(b) Assist the department in carrying out a public health response as instructed.

Section 3. Diseases Requiring Priority Notification. (1) Notification pursuant to Section 1(3) of this administrative regulation of the following diseases shall be made within one (1) business day:

(a) Group A streptococcal infection, invasive;
(b) Hepatitis B, acute;
(c) Hepatitis B infection in a pregnant woman or a child born in or after 1992;
(d) Mumps;
(e) Toxic shock syndrome;
(f) Tuberculosis.

(2) Upon receipt of a report for a disease or condition specified in subsection (1) of this section, a local health department:

(a) Shall investigate the report and carry out public health measures appropriate to the disease or condition;

(b) Shall notify the Department for Public Health of the case, in writing, within five (5) business days; and

(c) May seek assistance from the Department for Public Health.

Section 4. Diseases Requiring Routine Notification. (1) Notification pursuant to Section 1(3) of this administrative regulation of the following diseases shall be made within five (5) business days:

(a) Chancroid;

(b) Chlamydia trachomatis infection;

(c) Ehrlichiosis;

(d) Gonorrhea;

(e) Granuloma inguinale;

(f) Hepatitis C, acute;

(g) Histoplasmosis;

(h) Lead poisoning;

(i) Legionellosis;

(j) Lyme Disease;

(k) Lymphogranuloma venereum;

(l) Malaria;

(m) Rabies postexposure prophylaxis;

(n) Rocky Mountain Spotted Fever;

(o) Streptococcus pneumoniae, drug-resistant invasive disease;

(p) Syphilis, other than primary, secondary, early latent or congenital; and

(q) Toxoplasmosis.

(2) Upon receipt of a report for a disease or condition specified in subsection (1) of this section, a local health department shall:

(a) Make a record of the report;

(b) Answer inquiries or render assistance regarding the report if requested by the reporting entity; and

(c) Forward the report to the Department for Public Health within three (3) business days.

Section 5. Outbreaks or Unusual Public Health Occurrences. (1) If, in the judgment of a health professional licensed under KRS Chapters 311 through 314, or a health facility licensed under KRS Chapter 216B, an unexpected pattern of cases, suspected cases, or deaths which may indicate a newly-recognized infectious agent, an outbreak, epidemic, related public health hazard or an act of bioterrorism, such as smallpox, appears, a report shall be made immediately by telephone to the:

(a) Local health department where the professional is practicing or where the facility is located; or

(b) Department for Public Health.

(2) An instance of suspected staphylococcal or other foodborne intoxication or an instance of salmonellosis or other foodborne or waterborne infection shall be reported within one (1) business day, and shall include all known information about the persons affected.

(3) The local health department:

(a) Shall investigate the outbreak or occurrence;

(b) Shall carry out public health measures appropriate to the disease or condition involved;

(c) Shall make medical and environmental recommendations appropriate to prevent future similar outbreaks or occurrences; and

(d) May seek assistance from the Department for Public Health.

Section 6. Laboratory Surveillance. (1)(a) In addition to the reports required by Sections 1 through 4 of this administrative regulation, laboratory results shall be reported weekly for influenza virus isolates.

(b) The report shall include the:

1. Name, birthdate, address, and county of residence of the person with the disease; and

2. Specific laboratory information pertinent to the result.

(c) The format of the report shall be an alphabetical listing of each person for whom a report is submitted.

(2) Upon request by the Department for Public Health, a clinical laboratory within a hospital licensed under KRS Chapter 216B, or a

laboratory licensed under KRS Chapter 333, shall report:

(a) The numbers of isolates and information regarding the antimicrobial resistance patterns of the isolates;

(b) At intervals agreed upon between the laboratory and the department, not less frequently than three (3) months, for the following:

1. Staphylococcus aureus;

2. Enterococcus species; or

3. Other organism specified in a request that includes a justification of the public health importance of the organism.

Section 7. Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance. (1) Physicians and Medical Laboratories shall report:

(a)1. A positive test result for HIV infection including a result from:

a. Elisa;

b. Western Blot;

c. PCR;

d. HIV antigen; or

e. HIV culture;

2. CD4+ assay including absolute CD4+ cell counts and CD4+%;

3. HIV detectable Viral Load Assay; and

4. A positive serologic test result for HIV infection; or

(b) A diagnosis of AIDS that meets the definition of AIDS established within the Centers for Disease Control and Prevention (CDC) guidelines and reported in the:

1. "Adult HIV/AIDS Confidential Case Report Form," or

2. "Pediatric HIV/AIDS Confidential Case Report Form."

(2) An HIV infection or AIDS diagnosis shall be reported within five (5) business days and, if possible, on the "Adult HIV/AIDS Confidential Case Report form" or the "Pediatric HIV/AIDS Confidential Case Report form."

(a) A report for a resident of Jefferson, Henry, Oldham, Bullitt, Shelby, Spencer, and Trimble Counties shall be submitted to the HIV/AIDS Surveillance Program of the Louisville-Metro Health Department.

(b) A report for a resident of the remaining Kentucky counties shall be submitted to the HIV/AIDS Surveillance Program of the Kentucky Department for Public Health, or as directed by the HIV/AIDS project coordinator.

(3) A report for a person with HIV infection without a diagnosis of AIDS shall include the following information:

(a) The patient's full name;

(b) Date of birth, using the format MMDDYY;

(c) Gender;

(d) Race;

(e) Risk factor, as identified by CDC;

(f) County of residence;

(g) Name of facility submitting report;

(h) Date and type of HIV test performed;

(i) Results of CD4+ cell counts and CD4+%;

(j) Results of viral load testing;

(k) PCR, HIV culture, HIV antigen, if performed;

(l) Results of TB testing, if available; and

(m) HIV status of the person's partner, spouse or children.

(4) Reports of AIDS cases shall include the information in subsections (1) through (3) of this section; and

(a) The patient's complete address;

(b) Opportunistic infections diagnosed; and

(c) Date of onset of illness.

(5) (a) Reports of AIDS shall be made whether or not the patient has been previously reported as having HIV infection.

(b) If the patient has not been previously reported as having HIV infection, the AIDS report shall also serve as the report of HIV infection.

Section 8. Reporting of Communicable Diseases in Animals. (1) Upon arriving at a probable diagnosis in an animal of a condition known to be communicable to humans, a veterinarian licensed under the provisions of KRS Chapter 321 shall report the occurrence within one (1) business day to:

(a) The local health department in which the animal is located; or

(b) If the local health department cannot be reached, the Department for Public Health.

(2) Upon the confirmation of a laboratory test result which indicates infection of an animal with an agent associated with a condition known to be communicable to humans, the director of a clinical laboratory licensed under KRS Chapter 333 shall, within one (1) business day, report the result to the:

(a) Local health department serving the jurisdiction in which the animal is located; or

(b) Department for Public Health.

(3) The local health department:

(a) Shall investigate the report and carry out public measures for the control of communicable diseases appropriate to the condition;

(b) Shall notify the Department for Public Health of the occurrence, in writing, within five (5) business days; and

(c) May seek assistance from the Department for Public Health.

Section 9. Asbestosis, Coal Worker's Pneumoconiosis, and Silicosis. (1) A reporting provider shall submit the following information relating to a person diagnosed with asbestosis, coal worker's pneumoconiosis, or silicosis:

(a) Name;

(b) Address;

(c) Birthdate; and

(d) County of residence.

(2) A reporting provider shall submit the required information to the department within three (3) months following the diagnosis.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Case Definitions for Infectious Conditions under Public Health Surveillance, MMWR, May 2, 1997, Volume 46, Number RR-10", published by the Epidemiology Program Office, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services, Atlanta, Georgia;

(b) "Adult HIV/AIDS Confidential Case Report (CDC 50.42A, Revised January, 2003)"; and

(c) "Pediatric HIV/AIDS Confidential Case Report form (CDC 50.42B, Revised January, 2003)"; and

(d) "Control of Communicable Diseases Manual 17th Edition, An Official Report of the American Public Health Association, American Public Health Association, Washington, D.C., 2000".

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Public Health, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (CDS-2; 1 Ky.R. 187; eff. 12-11-74; Am. 2 Ky.R. 464; eff. 4-14-76; 11 Ky.R. 1518; 1786; eff. 6-4-85; 16 Ky.R. 663; 1185; eff. 11-29-89; 21 Ky.R. 128; eff. 8-17-94; 23 Ky.R. 3119; 3597; 4131; eff. 6-16-97; 27 Ky.R. 1099; 1489; eff. 12-21-2000; 29 Ky.R. 812; 1273; eff. 10-16-02; 31 Ky.R. 873; eff. 1-4-05.)