



# VIRGINIA EPIDEMIOLOGY BULLETIN

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## Changes to the Regulations for Disease Reporting and Control in Virginia

Periodically, the State Board of Health amends its *Regulations for Disease Reporting and Control*. These amendments are often the result of changes in the *Code of Virginia*, changes in state or national disease control policies, the emergence of new diseases, or changes in what is known about existing diseases. This process ensures that the Commonwealth maintains the ability to respond to diseases that endanger the public health.

A new version of the regulations (available at <http://www.vdh.virginia.gov/epi/regs.asp>) went into effect on **July 28, 2004**. This issue of the *Virginia Epidemiology Bulletin* reviews the importance of disease reporting as a vital component in controlling the spread of disease and highlights the changes that are included in the revised regulations.

### Disease Reporting

Communicable disease reporting in Virginia enables public health surveillance, the ongoing systematic collection, analysis, interpretation, and dissemination of data to prevent and control disease. Some outcomes of disease surveillance include:

- updating healthcare providers on local health issues;
- detecting outbreaks;
- documenting disease transmission;
- estimating trends; and,
- identifying risk factors for disease acquisition and transmission.



Local health departments use disease report data to identify local program priorities and assess the effectiveness of interventions. In addition, when a disease of public health importance is reported to a local health department, community-based disease control activities may be implemented. Depending on the situation, appropriate interventions may include providing prophylaxis and/or testing of contacts, temporarily excluding an individual from a situation with a high risk of transmission (such as a day care, or working in a restaurant), or providing education or counseling about disease transmission and risky behaviors. However, effectively implementing these interventions requires timely notification.

The Virginia Department of Health's (VDH) central office collects the local health department data to carry out statewide surveillance. In fact, one of the results of this activity is the data provided at the back of each issue of the *Virginia Epidemiology Bulletin*. These data also contribute to national weekly surveillance

activities by the Centers for Disease Control and Prevention (CDC).

Therefore, disease surveillance directly impacts the public health at many levels, and as a result the Commonwealth of Virginia has adopted specific rules related to disease reporting.

### Regulations for Disease Reporting and Control

Virginia's *Regulations for Disease Reporting and Control* state the requirements for notifying local health departments of a case or cases of disease, including the conditions that must be reported, who must report them, and how reporting is conducted.

Briefly, all physicians, directors of medical care facilities, and directors of laboratories must report persons **suspected of having, or diagnosed with**, any of the 75 reportable diseases or conditions listed in Table 1. In addition, persons in charge of schools and day care centers are required to report outbreaks of diseases. Reports are submitted to the local health department serving the city or county where the practice, facility, or laboratory is located. Reporting is usually accomplished by completing a Confidential Morbidity Report Form (also known as an Epi-1 form), and mailing it to the health department, although laboratories often use their own form for reporting. However, for diseases where time is critical to interrupting the exposure, rapid reporting (e.g., by telephone) is required (Table 1).

### Confidentiality

The health department protects the confidentiality of the patient information it receives. In addition, anyone reporting information to the health department according to the provisions of the regulations is immune from liability for so reporting.

## What's New in the Regulations

The key revisions to the regulations include:

- Updates to the Reportable Disease list, including the addition of a requirement to report diseases that may be due to a biologic agent used as a weapon;
- Reductions in the time allowed for reporting;
- The addition of information on how laboratories report their inventories of dangerous microbes and pathogens;
- The addition of a requirement for private laboratories to submit designated specimens to the state laboratory for confirmation and further testing;
- The addition and clarification of several definitions used in the regulations;
- The addition of a new section about reporting and control of tuberculosis (TB);
- An update to the list of conditions reportable by laboratories and the tests used to confirm those conditions;
- An update of the immunization schedule; and,
- An update of the reportable cancers.

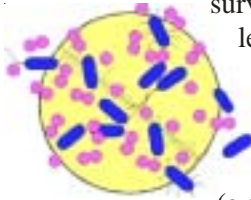
## Major Changes to the Regulations

### Reportable Disease List and Biologic Agents

The diseases and conditions listed as Reportable Diseases (Table 1) are selected carefully. Factors that are considered include:

- The severity of the disease;
- How commonly the disease occurs;
- Whether the health department can intervene to prevent further cases from occurring;
- Whether reporting is necessary in order to identify risk factors for the disease;
- Whether reporting has been effective in identifying the true rate of disease; and,

- Whether the disease is under surveillance at the national level.



The diseases that are contained in the list of Reportable Diseases may also have the potential to cause outbreaks (e.g., *E. coli* O157:H7 infection, measles), indicate problems in vector control (e.g., arboviral infection), signal that related diseases may be found in patient contacts (e.g., TB infection in young children), help VDH to identify and reduce the risk to contacts (e.g., chlamydial infection, hepatitis A), or alert clinicians about a critical treatment failure (e.g., vancomycin resistant *Staphylococcus aureus*). However, the health department is also interested in learning about ANY outbreaks, even those not on the reportable disease list. Therefore, suspected outbreaks should be reported to the local health department immediately.

In general, a disease is added to the reportable disease list if it is new and more information is needed to define its epidemiology. **Monkeypox, severe acute respiratory syndrome (SARS), and vaccinia** were added to the list of Reportable Diseases as emergency regulations in 2003. The revised regulations finalize the addition of these diseases to the reportable disease list (12 VAC 5-90-80). In addition, a category for “**Disease caused by an agent that may have been used as a weapon**” has been added to the regulations.

No diseases were removed from the list of reportable diseases during this revision of the regulations.

### Reporting Time

Local health departments need to be aware of any changes in the health status of the community they serve as soon as possible so that appropriate interventions can be implemented. The development of new communication technologies has facilitated more rapid notification of local health departments about new or emerging threats. As a result, the new regulations require the reporting of most notifiable conditions **within three days** of suspicion or confirmation (instead of the previous limit of seven days)(Table 1).

However, note that 29 of the reportable diseases/conditions are “**Rapidly Reportable**” (i.e., reportable immediately/within 24 hours by the most rapid means available). Rapid reporting enables the best possible public health response to diseases that are extremely contagious or have the potential for greater harm. Examples of rapidly reportable diseases include: anthrax, botulism, hepatitis A, measles, monkeypox, pertussis, plague, SARS, smallpox, tuberculosis (active), tularemia, viral hemorrhagic fever, any disease caused by an agent that may have been used as a weapon, etc.

### Changes for Laboratories

Laboratories play a critical role in assisting healthcare workers in diagnosing disease. Laboratories also have

an important role in identifying diseases of public health importance and working with the health department to respond to these threats promptly. Therefore, regulations related to laboratories and reportable diseases were updated in the revised regulations to reflect the changes in the technologies used to diagnose diseases.

**Laboratory Reporting.** In the latest revision of the *Regulations for Disease Reporting and Control*, the list of conditions that laboratories must report positive results for has been expanded to include chickenpox, Creutzfeldt-Jakob disease, ehrlichiosis, hepatitis C, psittacosis, Q fever, Rocky Mountain spotted fever, smallpox, *Streptococcus pneumoniae* infection in children <5 years of age, tularemia, typhus, vaccinia, viral hemorrhagic fever, and yellow fever (Table 2). In addition, the regulations have been revised to require the reporting of most notifiable conditions **within three days** of suspicion or confirmation, instead of the previous seven days. However, some conditions continue to be defined as “**Rapidly Reportable**” (i.e., reportable immediately/within 24 hours) due to the need to implement public health actions as soon as possible to control the disease.

In addition, the newly revised regulations update the tests that must be done to confirm the diagnosis of anthrax, arboviral infection, botulism, brucellosis, chancroid, cholera, cryptosporidiosis, diphtheria, *E.*



**Table 1: Reportable Disease List**

|   |  |
|---|--|
| Acquired immunodeficiency syndrome (AIDS)   | MENINGOCOCCAL INFECTION *  |
| Amebiasis *   | MONKEYPOX *  |
| ANTHRAX *   | Mumps *  |
| Arboviral infection (e.g., EEE, LAC, SLE, WNV) *  | Ophthalmia neonatorum  |
| BOTULISM *  | OUTBREAKS, ALL (including foodborne, nosocomial, occupational, toxic substance-related, waterborne, and other outbreaks) |
| BRUCELLOSIS *   | PERTUSSIS (Whooping cough) *   |
| <i>Campylobacter</i> infection *  | PLAGUE *   |
| Chancroid *   | POLIOMYELITIS *  |
| Chickenpox *  | PSITTACOSIS *  |
| <i>Chlamydia trachomatis</i> infection *  | Q FEVER *  |
| CHOLERA *   | RABIES, HUMAN AND ANIMAL *   |
| Creutzfeldt-Jakob disease if <55 years of age *   | Rabies treatment, postexposure   |
| Cryptosporidiosis *   | Rocky Mountain spotted fever *   |
| Cyclosporiasis *  | RUBELLA (German measles), including congenital rubella syndrome *  |
| DIPHTHERIA *  | Salmonellosis *  |
| DISEASE CAUSED BY AN AGENT THAT MAY HAVE BEEN USED AS A WEAPON                          | SEVERE ACUTE RESPIRATORY SYNDROME (SARS) *   |
| Ehrlichiosis *  | Shigellosis *  |
| <i>Escherichia coli</i> O157:H7 and other enterohemorrhagic <i>E. coli</i> infections * | SMALLPOX (Variola) *   |
| Giardiasis *  | Streptococcal disease, Group A, invasive *   |
| Gonorrhea *   | <i>Streptococcus pneumoniae</i> , invasive if <5 years of age *  |
| Granuloma inguinale   | Syphilis (report PRIMARY and SECONDARY syphilis by rapid means) *  |
| HAEMOPHILUS INFLUENZAE INFECTION, INVASIVE *  | Tetanus  |
| Hantavirus pulmonary syndrome   | Toxic shock syndrome   |
| Hemolytic uremic syndrome (HUS)   | Toxic substance-related illness  |
| HEPATITIS A*  | Trichinosis (Trichinellosis) *   |
| Hepatitis B (acute and chronic) *   | TUBERCULOSIS, ACTIVE DISEASE - (MYCOBACTERIA *-)   |
| Hepatitis C (acute and chronic) *   | Tuberculosis infection in children age <4 years  |
| Hepatitis, other acute viral  | TULAREMIA *  |
| Human immunodeficiency virus (HIV) infection *  | Typhoid fever  |
| Influenza *¶  | Typhus *   |
| Kawasaki syndrome   | UNUSUAL OCCURRENCE OF DISEASE OF PUBLIC HEALTH CONCERN   |
| Lead elevated blood levels *  | VACCINIA, DISEASE OR ADVERSE EVENT *   |
| Legionellosis *   | Vancomycin-resistant <i>Staphylococcus aureus</i> *  |
| Leprosy (Hansen's disease)  | VIBRIO INFECTION *   |
| Listeriosis *   | VIRAL HEMORRHAGIC FEVER *  |
| Lyme disease  | YELLOW FEVER *   |
| Lymphogranuloma venereum  |  |
| Malaria *   |  |
| MEASLES (Rubeola)   |  |

UPPER CASE indicates conditions that must be reported rapidly to the local health director via telecommunication. Report all other diseases within three days of suspected or confirmed diagnosis.

\* These conditions are reportable by directors of laboratories. These and all other conditions are reportable by physicians and directors of medical care facilities as well.

¶ Physicians and directors of medical care facilities should report influenza by number of cases only (report total number per week and by type of influenza, if known).

- AFB on smear, speciation, and drug susceptibility.

*coli*, gonococcal infection, *H. influenzae*, hepatitis B, influenza, blood lead levels, malaria, measles, meningococcal infection, mycobacterial diseases, and syphilis.

The revised regulations also require that all laboratories (including private laboratories) submit isolates for 14 different organisms (as well as any Shiga

toxin positive stool specimens) to the state laboratory for confirmation of the agent and other studies (Table 3). Previously this regulation had applied only to laboratories operating within a medical care facility.

**Inventories.** In the revised regulations (12 VAC 5-90-280 through 12 VAC 5-90-360) new procedures and requirements

have been added for the reporting of dangerous microbes and pathogens by laboratories. These regulations list the specific agents, the timing of reports, those required to report, exemptions from reporting, and release of reported information. This section was added in response to a mandate in the *Code of Virginia* and applies to laboratories maintaining an inventory of organisms on the Centers for Disease Control and Prevention's Select Agents list (i.e., not clinical specimens that are destroyed within two weeks of confirmation).

### ***Other Changes to the Regulations***

Additional notable changes to the regulations include:

#### **Definitions**

Some definitions have been updated in the regulations to bring them into agreement with current public health practices. These include:

- Updating acute and chronic hepatitis C infection;
- Adding a definition to clarify the use of the term "invasive" on the reportable disease list;
- Removing the requirement that the blood test for lead levels in children 15 years of age and younger must be performed on venous blood; and,
- Changing the definitions for tuberculosis (including defining active disease, tubercle bacilli, tuberculosis, tuberculin skin test and an update of the definition of tuberculosis infection in children age <4 years).

#### **Tuberculosis**

Regulation 12 VAC 5-90-225 specifies additional data to be reported on persons with active tuberculosis disease by physicians, directors of medical care facilities, directors of correctional facilities, and laboratories in initial, secondary, and subsequent reports. In addition, these regulations require that healthcare providers have documented treatment plans for patients with tuberculosis, and that for some patient populations these plans must be coordinated with or reported to the local health department.

**Table 2. List of Conditions Reportable by Laboratory Directors\***

Any person who is in charge of a laboratory conducting business in the Commonwealth shall report any laboratory examination of any specimen derived from the human body, whether performed in-house or referred to an out-of-state laboratory, which yields evidence, by the laboratory method(s) indicated or any other confirmatory test, of a disease listed below. Conditions listed in capital and bold letters require rapid communication (immediately/within 24 hours) - all others require notification within three days.

| <b>Condition</b>                             | <b>Method</b>   |
|--|---|
| Amebiasis                                    | microscopic examination, antigen detection or serology  |
| <b>ANTHRAX</b>                               | culture or PCR/NAA  |
| Arboviral infection                          | viral isolation, serology or PCR/NAA  |
| <b>BOTULISM</b>                              | culture or identification of toxin in stool, serum or gastric aspirate  |
| <b>BRUCELLOSIS</b>                           | culture, serology or PCR/NAA  |
| <i>Campylobacter</i> infection               | culture   |
| Chancroid                                    | culture, immunofluorescent antibody or PCR/NAA  |
| Chickenpox                                   | culture or serology   |
| <i>Chlamydia trachomatis</i> infection       | culture, antigen detection or NAA   |
| <b>CHOLERA</b>                               | culture or serology   |
| Creutzfeldt-Jakob disease                    | histopathology (patients 55 years of age and under)   |
| Cryptosporidiosis                            | microscopic examination of stool or biopsy specimens, antigen detection, immunofluorescent antibody or PCR/NAA  |
| Cyclosporiasis                               | microscopic examination of stool  |
| <b>DIPHTHERIA</b>                            | culture   |
| Ehrlichiosis                                 | culture, serology or PCR/NAA  |
| <i>Escherichia coli</i> O157:H7              | isolation of <i>E. coli</i> O157:H7, <i>E. coli</i> O157, or other Shiga toxin-producing enterohemorrhagic <i>E. coli</i> from a clinical specimen  |
| Giardiasis                                   | microscopic examination or antigen detection  |
| Gonococcal infection                         | culture, microscopic examination of a urethral smear specimen (males only) or NAA   |
| <b>HAEMOPHILUS INFLUENZAE INFECTION</b>      | culture, immunofluorescent antibody, EIA or PCR/NAA of a normally sterile site  |
| <b>HEPATITIS A</b>                           | serology specific for IgM antibodies  |
| Hepatitis B                                  | serology specific for IgM antibodies or HBsAg positive results  |
| Hepatitis C                                  | laboratory results that demonstrate: (i) serum aminotransferase levels greater than seven times the upper limit of normal; (ii) IgM anti-HAV negative; (iii) IgM anti-HBc negative (if done) or HBsAg negative; and (iv) antibody to hepatitis C virus (anti-HCV) positive verified by a repeat anti-HCV positive test by EIA and confirmed by a more specific assay or positive by RIBA, nucleic acid test, or anti-HCV by EIA with a signal-to-cutoff ratio of 3.8 or greater |
| Human immunodeficiency virus (HIV) infection | laboratory results which indicate the presence of HIV antigen, nucleic acid, or antibodies such as EIA positive confirmed with a supplemental test such as the western blot or by rapid tests with confirmation   |
| Influenza                                    | culture, serology or antigen detection (report total number per week and by type, if available)   |
| Lead-elevated blood levels                   | blood lead level greater than or equal to 10µg/dL in children ages 0-15 years or greater than or equal to 25 µg/dL in persons older than 15 years of age  |
| Legionellosis                                | culture, direct fluorescent antibody test, serology, urine antigen detection or PCR/NAA   |

| <b>Table 2. List of Conditions Reportable by Laboratory Directors* [continued]</b>  |   |
|---|---|
| <b>Condition</b>  | <b>Method</b>   |
| Malaria   | microscopic examination, PCR/NAA or antigen detection   |
| <b>MEASLES</b>  | serology specific for IgM antibodies, paired sera results indicating a significant rise in antibody level, culture or PCR/NAA   |
| <b>MENINGOCOCCAL INFECTION</b>  | culture or antigen detection of a normally sterile site   |
| <b>MONKEYPOX</b>  | culture or NAA  |
| Mumps   | serology specific for IgM antibodies or paired sera results indicating a significant rise in antibody level or culture  |
| <b>MYCOBACTERIAL DISEASES</b>   | Report any of the following: 1. Acid fast bacilli - on smear, 2. Mycobacterial identification - preliminary identification by rapid methodologies and/or by culture or PCR, or 3. Drug susceptibility test results for <i>M. tuberculosis</i> |
| <b>PERTUSSIS</b>  | confirmed by culture or PCR/NAA or suspected by direct fluorescent antibody test  |
| <b>PLAGUE</b>   | culture or direct fluorescent antibody test   |
| <b>POLIOMYELITIS</b>  | culture or serology   |
| <b>PSITTACOSIS</b>  | culture, antigen detection or PCR/NAA   |
| <b>Q FEVER</b>  | serology, immunofluorescent antibody, EIA or PCR/NAA  |
| <b>RABIES, HUMAN AND ANIMAL</b>   | direct fluorescent antibody test  |
| Rocky Mountain spotted fever  | serology, indirect immunofluorescent antibody, enzyme immunoassay, PCR/NAA or immunohistochemical staining  |
| <b>RUBELLA</b>  | serology specific for IgM antibodies or paired sera results indicating a significant rise in antibody level or by culture   |
| <i>Salmonella</i> infection   | culture   |
| <b>SEVERE ACUTE RESPIRATORY SYNDROME</b>  | culture, serology or NAA  |
| <i>Shigella</i> infection   | culture   |
| <b>SMALLPOX (VARIOLA)</b>   | culture or PCR/NAA  |
| Streptococcal disease, Group A  | culture from a normally sterile site  |
| <i>Streptococcus pneumoniae</i> , invasive  | culture from a normally sterile site in a child under the age of five years   |
| <b>SYPHILIS</b>   | serology, dark field examination, direct fluorescent antibody or equivalent   |
| Trichinosis   | serology or microscopic examination of a muscle biopsy  |
| <b>TULAREMIA</b>  | culture, paired serology, PCR/NAA or direct immunofluorescent assay   |
| Typhus  | immunofluorescent assay, enzyme immunoassay, complement fixation or immunohistochemical staining  |
| <b>VACCINIA</b>   | culture or NAA  |
| Vancomycin-resistant <i>Staphylococcus aureus</i>   | antimicrobial susceptibility testing conducted on culture   |
| <b>VIBRIO INFECTION</b>   | culture   |
| <b>VIRAL HEMORRHAGIC FEVER</b>  | immunofluorescent assay, complement fixation, virus isolation, EIA or PCR/NAA   |
| <b>YELLOW FEVER</b>   | immunofluorescent assay, virus isolation, EIA or PCR/NAA  |
| *Independent pathology laboratories must also report cancer. For more information, call the Virginia Cancer Registry at (804) 864-7866.         |   |
| PCR = Polymerase Chain Reaction, NAA = Nucleic Acid Amplification, EIA = Enzyme-linked Immunosorbent Assay, RIBA = Recombinant Immunoblot Assay |   |

**Table 3: Initial cultures indicating the presence of these organisms/diseases must be forwarded by ALL laboratories to the state laboratory when a report is made to the health department:**

- Bacillus anthracis* (Anthrax)
- Vibrio cholerae* (Cholera)
- Corynebacterium diphtheriae* (Diphtheria)
- Escherichia coli* O157:H7
- Hemophilus influenzae* infection, invasive
- Listeria monocytogenes* (Listeriosis)
- Neisseria meningitidis* (Meningococcal) infection
- Mycobacterium tuberculosis* (TB)\*
- Bordetella pertussis* (Pertussis)
- Yersinia pestis* (Plague)
- Poliomyelitis
- Salmonella* infection
- Shigella* infection
- Streptococcal infection, Group A, invasive

\*For TB, forwarding isolates may not be required, but is strongly encouraged.

**Immunization Schedule**

The revised regulations update the childhood immunization schedule so that it reflects current recommendations. The schedule in the regulations addresses:

- Diphtheria, Tetanus, and Pertussis (Whooping cough) Vaccine
- Poliomyelitis Vaccine
- Measles (Rubeola) Vaccine
- Rubella (German measles) Vaccine
- Mumps Vaccine
- *Haemophilus influenzae* type b (Hib) Vaccine
- Hepatitis B Vaccine
- Varicella (Chickenpox) Vaccine

**Reportable Cancers**

In the revised regulations, 12 VAC 5-90-160 has updated the definition of reportable cancers to include central nervous system tumors and to exclude the reporting of carcinoma *in situ* of the cervix.

**How to Report**

Although electronic reporting of cancer is preferred, a standardized form known as the Virginia Cancer Registry Reporting Form is available from the Virginia Cancer Registry. For all other reportable diseases and conditions use the Confidential Morbidity Report (Epi-1) Form

(available from your local health department). An Epi-1 form, or a computer generated printout containing the data requested on the Epi-1 form, or a CDC surveillance form that provides the same information, should be completed for each case of the disease (exception: influenza should be reported by the number of cases, and type if available).

Disease reports must include as much of the following as is known:

- Case's name, address, age, date of birth, sex, and race;
- Disease or condition that has been diagnosed or is suspected;
- Date of disease onset;

- Attending physician's name, address and phone number
- Name and phone number of person making the report;
- Hospital admission information (if applicable);
- Pertinent laboratory results and specimen information; and,
- Other information that might be of public health importance (e.g., social security number, pregnancy status of females who test positive for HBsAg [if available], dates of diagnosis and death [if applicable], risk factors, signs/symptoms, treatment, etc.).

Note that additional elements are required when reporting individuals

with confirmed or suspected active tuberculosis disease.

Reports can be submitted through the mail or by FAX. Local health departments should also be notified immediately/within 24 hours by telephone or pager of any rapidly reportable conditions, followed by submission of the Epi-1 form by mail or by FAX. Note that the patient's consent is NOT needed to report confirmed or suspected cases of reportable diseases or conditions, or to supply additional information requested by public health officials.

**Penalties**

Some physicians are not aware of the need to notify their local health department of cases of reportable diseases. However, timely and accurate reporting is a professional responsibility, and laboratory reporting of a particular disease does not relieve the physician of this responsibility.

Failure to report can result in increased disease in the community, increased costs for diagnosis and treatment, and for the patient additional time lost from work or school or prolonged hospitalization. In general, most conditions that need to be reported are rare, and it is expected that the value of reporting is greater than the

**HIPAA and Public Health Reporting**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides protection for the privacy of certain individually identifiable health data, referred to as protected health information (PHI). However, the Privacy Rule recognizes 1) the legitimate need for public health authorities and others responsible for ensuring the public's health and safety to have access to PHI to conduct their missions; and 2) the importance of public health reporting by covered entities to identify threats to the public and individuals.

Therefore, the Privacy Rule **specifically allows providing PHI to public health authorities** who are permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to public health surveillance, investigation, and intervention without requiring individual authorization.<sup>1</sup>

But remember: you must be able to provide an individual (upon their request) with an accounting of disclosures of their PHI, including disclosures to public health authorities.

## How To Think Public Health<sup>2</sup>

The effectiveness of the disease control regulations lies in their application by healthcare providers. Therefore, some ways to make these regulations work for the public health include:

- Know what is reportable...and report it. The chart of Reportable Diseases in this issue lists the diseases reportable to local health departments—contact information for your local health department can be found at <http://www.vdh.virginia.gov/LHD/LocalHealthDistricts.asp>
- Know your patient—where appropriate, expand your interviewing techniques to include questions of public health importance. Think of the patient in the context of family and community, including school/daycare, occupation, living environment, friends and contacts.
- Know when to call—health department staff have a wide variety of skills and knowledge, and are available for consultation and intervention. Call anytime you:
  - ◇ Think your patient may have exposed others—the health department can determine the public health risk and take measures to limit additional illness.
  - ◇ Need advice on a disease of public health concern.
  - ◇ See something unusual. Outbreaks are made up of individual cases. By notifying your local health department of unusual cases or small clusters, outbreaks can be detected earlier. If you notice something out of the ordinary, don't wait to respond routinely—call right away.

burden on healthcare providers. Disease reporting is considered important enough that the *Code of Virginia* specifies penalties for not complying with Board of Health regulations.

Specifically, failure to comply with a health regulation is considered a Class 1 misdemeanor and may result in significant fines and even incarceration. Each day of violation is considered a separate offense. Therefore, developing ways to improve disease reporting in your practice or facility should be considered.

## The Future

As this issue goes to press, the Office of Epidemiology is already working on updating the regulations to address the legislation passed in 2004 related to changes in the Commonwealth's laws for quarantine and/or isolation of individuals exposed or infected with a communicable disease of public health threat. Emergency regulations to deal with the amendments to the *Code of Virginia* will be in place by January 2005.

**For More Information** on disease reporting and control, please contact your local health department or the Virginia Department of Health's Office of Epidemiology.

### References:

1. MMWR. HIPAA Privacy Rule and Public Health. April 11, 2003. 52:1-12.
2. Adapted from the "Maine Epi-Gram, November 1995."

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## Common Myths about Disease Surveillance

**Myth #1. I don't need to report because someone else will do it.**

While multiple health care professionals are responsible for reporting the same information, the health department does not receive very many duplicate reports. Sometimes information is needed from more than one source, such as when clinical information is needed from physicians to supplement the laboratory results received. Computer systems are in place to weed out duplicate reports. Therefore, even if all who are required to report complied with the regulations, overinflation of morbidity statistics would not occur.

**Myth #2. The health department does not need to know the name of a person with disease.**

For many diseases, the health department needs to contact the patient, their family, or other close contacts to provide health education or institute disease control measures in order to interrupt the disease transmission cycle. Names are also useful for identifying duplicate reports received on the same individual. However, the identities of patients and physicians are kept strictly confidential by the health department, as required by law.

**Myth #3. The health department does not do anything with the information it receives.**

Every case is assessed to determine what disease control measures can be put in place to stop disease transmission. Compiling statistics from case reports received is another use for the information—this helps to determine patterns of disease in a community so that disease control activities can be planned and evaluated.

**Myth #4. I should not report until the diagnosis is confirmed.**

Both Virginia law and the Regulations require physicians to report "any person who is suffering from or who is suspected of having a reportable disease..." Some diseases, for example tuberculosis, should be reported based on a presumptive diagnosis. This gives the health department an opportunity to assess the need for control measures to minimize the risk to the public.

**Myth #5. Only conditions listed on the reportable disease list should be reported to the health department.**

Any circumstance in which an individual or group experiences an illness that may be of public health importance should be reported to the health department.

**Myth #6. Diseases which occur in military personnel or their dependents should not be reported.**

All cases of reportable diseases diagnosed in Virginia must be reported. Notifying the health department of a reportable disease, whether the person is in the military or civilian population, is vital to our disease control efforts.

**Cases of Selected Notifiable Diseases Reported in Virginia\***

| Disease                      | Total Cases Reported, June 2004 |         |    |    |     |     | Total Cases Reported Statewide, January - June |           |          |
|------------------------------|---------------------------------|---------|----|----|-----|-----|--|-----------|----------|
|                              | State                           | Regions |    |    |     |     | This Year                                      | Last Year | 5 Yr Avg |
|                              |                                 | NW      | N  | SW | C   | E   |  |           |          |
| AIDS                         | 75                              | 1       | 35 | 10 | 6   | 23  | 362  | 435       | 418      |
| Campylobacteriosis           | 55                              | 11      | 8  | 11 | 7   | 18  | 239  | 292       | 242      |
| <i>E. coli</i> O157:H7       | 6                               | 1       | 2  | 2  | 1   | 0   | 7  | 17        | 20       |
| Giardiasis                   | 29                              | 6       | 3  | 5  | 7   | 8   | 173  | 153       | 152      |
| Gonorrhea                    | 663                             | 68      | 41 | 85 | 165 | 304 | 4,259  | 4,329     | 4,738    |
| Hepatitis, viral             |                                 |         |    |    |     |     |  |           |          |
| A, acute                     | 9                               | 1       | 2  | 3  | 0   | 3   | 48   | 43        | 60       |
| B, acute                     | 20                              | 6       | 1  | 5  | 2   | 6   | 102  | 74        | 76       |
| C, acute                     | 1                               | 0       | 0  | 0  | 0   | 1   | 11   | 2         | 3        |
| HIV Infection                | 80                              | 5       | 27 | 9  | 18  | 21  | 431  | 381       | 406      |
| Lead in Children†            | 63                              | 13      | 6  | 17 | 15  | 12  | 309  | 326       | 255      |
| Legionellosis                | 1                               | 0       | 0  | 0  | 0   | 1   | 9  | 9         | 9        |
| Lyme Disease                 | 12                              | 3       | 0  | 0  | 0   | 9   | 24   | 21        | 30       |
| Measles                      | 0                               | 0       | 0  | 0  | 0   | 0   | 0  | 0         | <1       |
| Meningococcal Infection      | 1                               | 0       | 0  | 1  | 0   | 0   | 9  | 17        | 25       |
| Mumps                        | 0                               | 0       | 0  | 0  | 0   | 0   | 1  | 1         | 4        |
| Pertussis                    | 14                              | 10      | 1  | 2  | 1   | 0   | 71   | 58        | 38       |
| Rabies in Animals            | 33                              | 5       | 8  | 8  | 3   | 9   | 220  | 285       | 270      |
| Rocky Mountain Spotted Fever | 1                               | 0       | 0  | 1  | 0   | 0   | 2  | 3         | 3        |
| Rubella                      | 0                               | 0       | 0  | 0  | 0   | 0   | 0  | 0         | 0        |
| Salmonellosis                | 70                              | 11      | 11 | 17 | 10  | 21  | 325  | 357       | 410      |
| Shigellosis                  | 14                              | 0       | 5  | 0  | 8   | 1   | 50   | 190       | 186      |
| Syphilis, Early§             | 35                              | 1       | 17 | 0  | 3   | 14  | 104  | 84        | 132      |
| Tuberculosis                 | 13                              | 2       | 0  | 2  | 3   | 6   | 93   | 112       | 124      |

*Localities Reporting Animal Rabies This Month:* Accomack 2 raccoons; Albemarle 1 raccoon; Alexandria 1 raccoon; Bland 1 cow; Botetourt 1 fox, 1 skunk; Culpeper 1 fox; Cumberland 1 fox; Essex 1 raccoon; Fairfax 1 bat, 1 raccoon, 1 skunk; Fauquier 1 raccoon; Hanover 1 raccoon; Loudoun 1 cat; Lunenburg 1 skunk; Northampton 3 raccoons; Northumberland 1 fox; Pittsylvania 2 raccoons; Prince William 1 fox, 2 raccoons; Rockingham 1 cat; Tazewell 2 raccoons; Virginia Beach 1 raccoon; Warren 1 skunk; Westmoreland 1 raccoon; Wythe 1 cat.

*Toxic Substance-related Illnesses:* Adult Lead Exposure 5; Asbestosis 1; Mercury Exposure 3; Mesothelioma 1; Methemoglobinemia 1; Pneumoconiosis 6.

\*Data for 2004 are provisional. †Elevated blood lead levels  $\geq 10\mu\text{g/dL}$ . §Includes primary, secondary, and early latent.

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