

## NOTICE OF PROPOSED RULEMAKING: NEW DEFINITIONS AND DISEASE REPORTING REQUIREMENTS

"It is the beginning of wisdom when you recognize that the best you can do is choose which rules you want to live by, and it's persistent and aggravated imbecility to pretend you can live without any."

Wallace Stegner, *All the Little Live Things*

In response to statutory changes, bacterial nomenclatures, and advancements in testing relevant to public health reporting, the Oregon Health Authority (OHA) Public Health Division proposes to amend its administrative rules. This *CD Summary* serves as official notice of the proposed changes and summarizes them (*infra*). Read the [full text of the proposed changes](#).

### HEALTH CARE-ACQUIRED INFECTIONS

In addition to removing the sunset clause in the legislation that established reporting of health care-acquired infections (HAIs) in Oregon, [House Bill 2301](#) eliminated the requirement for OHA to produce an annual report of these infections. The latter change was made to avoid mere duplication of reporting concurrently required by federal regulatory agencies, especially the Centers for Medicare & Medicaid Services (CMS), which already report facility-specific data from Oregon and across the United States. Accordingly, we propose removal from Oregon Administrative Rule (OAR) 333-018-0130 language specifying the timing and nature of public disclosure of HAI data for the State of Oregon. Language conferring the ability to publicly disclose state- and facility-level HAI data in the form of a report or other methods of data visualization will be retained. A data review period for facilities prior to public release of data will also remain in place. Reporting of HAI data from healthcare facilities will still be required,

### RULEMAKING COMMENTS

You may comment in person on the proposed changes at a public hearing to be held at 1:30 P.M. on Friday, December 1, 2017, in room 1C of the Portland State Office Building, 800 NE Oregon Street, Portland, Oregon, 97232. Alternatively, you may send written comments before 5:00 P.M. on December 8, 2017, to the Public Health Division Rules Coordinator:

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and OHA's HAI Program will use the data to inform public health action to prevent these infections and to respond to emerging trends. This change does not preclude the communication of findings, but aims to improve efficiency with less duplication of federal reporting and more infection prevention.

### WHAT NOT TO REPORT

Though peste des petits ruminants virus is a select agent of bioterrorism, it has not been known to infect *humans*; so we propose to purge it from the list of diseases reportable by physicians. We have communicated with our Department of Agriculture regarding the reportability of Ruminants virus on their list instead of ours.

### WHAT STILL TO REPORT

The erstwhile species *Chlamydomphila* has been re-merged with *Chlamydia*. Yes, psittacosis is still reportable, as is *Chlamydia trachomatis* infection, for that matter; but expunge the genus *Chlamydomphila* from the taxonomy, that its name be remembered no more.\*

Speaking of what is still reportable: we discovered to our chagrin that *Yersinia pestis* (yes, plague) had been inadvertently removed from the official list of reportable diseases, probably when

we were addressing other *Yersinia* species; we propose to restore it to its rightful place in the pantheon of particularly nasty infections meriting immediate public health attention.†

Lastly, we've removed "acute and chronic" as qualifiers for hepatitis B, as all hepatitis B is reportable.

### NOT JUST ISOLATES; SPECIMENS WANTED

Because whole-genome sequencing will continue to displace culturing in clinical laboratories, we have changed the submission requirement to include specimens from which the sequences were identified. Please send CSF (or other specimen from a normally sterile body site) from which the laboratory has identified sequence indicating *Neisseria meningitidis* or *Haemophilus influenzae*.

### WHAT NEW TO REPORT

Enterotoxigenic *Escherichia coli* (ETEC) has long been recognized as a major cause of "travelers' diarrhea," and we know that it can also be acquired in the United States.<sup>1</sup> Moreover, we know that it can cause outbreaks: a waterborne outbreak involving more than 2,000 visitors to Crater Lake National Park during 1975 was shown to

†After all, the current epidemic of plague in Madagascar is only a plane flight away.

\* as Jeremiah might have said.

be due to ETEC serogroup O6.<sup>2</sup> The reason that ETEC has not hitherto been reportable is that it has been impossible for a clinical laboratory to identify it on an agar plate. But with the rise of newer molecular testing platforms<sup>‡</sup>, some laboratories can test for it and detect it. We propose to make ETEC reportable with an eye to detecting outbreaks — hopefully before they afflict 2,000 people.

**Figure 1. *Escherichia coli*.**



Colorized scanning electron microscopic (SEM) image revealing some of the morphologic details displayed by a single Gram-negative, rod-shaped, *Escherichia coli* bacterium. This bacterium was a member of the strain, O:169 H41 ETEC (Enterotoxigenic *E. coli*). Source: CDC

How many cases are we likely to see? Our colleagues at Minnesota Department of Health, who always seem to be miles ahead of other state health departments, did a study with two clinical laboratories that had been recruited to send fecal specimens to the Minnesota State Public Health Lab for pathogen testing, including ETEC. From Laboratory A, a University Laboratory, ETEC was detected more commonly than *Salmonella*: 1.9% versus 1.2%; ETEC was second only to *Campylobacter*. In specimens from Laboratory B, ETEC was less common: it was found in 0.8% of isolates, compared to 1.0% in which *Salmonella* was identified.<sup>1</sup> Oregon has averaged 433 cases of salmonellosis reported annually during 2012–2016. If every stool that is tested for *Salmonella* were also tested for ETEC, and applying the above-mentioned ratios seen in Minnesota, we guesstimate that Oregon might see between 346 and 686 ETEC cases per year. While making ETEC reportable, we are not proposing that ETEC-positive specimens or isolates be routinely submitted to the Oregon State Public Health Laboratory. Oregon local public health department officials will investigate unusual clusters of ETEC cases.

‡ e.g., the BioFire FilmArray®

## HEPATITIS E NOW "RESTRICTABLE"

"Restrictable" diseases are those that require exclusion of persons in settings that pose a high risk for transmission, specifically food-handling, health care, and child care settings. This list includes the usual suspects of diphtheria, shigellosis, hepatitis A, and tuberculosis, for example. Like the hepatitis A virus, the hepatitis E virus (HEV)<sup>§</sup> is a small, non-enveloped RNA virus transmitted by the fecal-oral route. Although all viral hepatitis has long been reportable (remember "non-A, non-B"?), until recently, clinical labs weren't able to test for hepatitis E. However, with the advent of specific serologic tests, cases are being detected. Hepatitis E was made explicitly reportable in Oregon in 2011, and since then, 9 IgM-confirmed cases and another 5 "presumptive" cases have been reported; of the 13 cases investigated, 6 had had no known foreign travel. Although HEV is found in a variety of animals, including domestic and wild pigs, cattle, sheep, deer, elk, rats and rabbits, humans are the reservoir of concern. With its potential for human-to-human spread via the fecal-oral route, we believe that restrictions akin to those for hepatitis A are warranted for the duration of the communicable period (14 days after onset of jaundice).

## INFECTIOUS TUBERCULOSIS DISEASE

We propose that "tuberculosis disease" be changed to "infectious tuberculosis." The term "tuberculosis disease" was intended to distinguish between latent TB (positive skin test only) and (infectious) cavitary TB. This distinction is insufficient, however, because one can have tuberculosis disease (e.g., meningeal, pleural, peritoneal) without being infectious. We hope that this language represents more accurately who can actually spread the disease and should therefore be restricted.

## INFECTION CONTROL IN HEALTH CARE SETTINGS

As advised by Rules Advisory Committee members, we are proposing to repeal [OAR 333-022-0400 through 333-022-0460](#) and replace it with [OAR 333-019-0061](#). The rules that we are repealing called for the OHA Public Health Division to interview health care providers who test positive for *Shunimarginatively* classified as a member of the *hepeviridae* family

HIV or hepatitis B antigens (HBsAg and HBeAg) indicating infectiousness; and to convene an expert panel to make recommendations regarding potential restriction of the provider's scope of practice. This rule was crafted in the context of the HIV epidemic and to our knowledge has been implemented just once in over two decades. We believe that oversight of clinical practice is more readily handled by the hospitals that grant privileges and by licensing boards. We are replacing it with language in a new rule, viz, [OAR 333-019-0061](#), admonishing health care professionals to observe standard precautions as described in CDC's [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#) (2007).

## ACKNOWLEDGMENTS

Thank you for reading this necessary *CD Summary*, which serves as official notification of our proposed rule changes.

Special thanks to this year's Rules Advisory Committee members:

Claudia Atherton (Legacy Health Services), Jackson Baures and Cindy Morgan (Conference of Local Health Officials, Communicable Disease Subcommittee), Trevor Beltz and Danielle Sobel (Oregon Medical Association), Julie Koch (Salem Health), Shannon O'Fallon (Oregon Department of Justice).

HAI Rules Advisory Committee: Kelli Coelho (RiverBend Ambulatory Surgery Center), Jordan Ferris (Oregon Nurses Association), Jon Furuno (Oregon State University/OHSU); April Gillette (Blue Mountain Hospital District), Judy Guzman-Cottrill (OHSU), Tiah Kershaw (Providence Health Plan), Kate Medred (Oregon Patient Safety Commission), Rebecca Pawlak (Oregon Association of Hospital & Health Systems), Rachel Plotinsky (Providence St. Vincent Medical Center), Laurie Polneau (Vibra Specialty Hospital Portland), Pat Preston (Center for Geriatric Infection Control), (Oregon Patient Safety Commission/OHA), Dee Dee Vallier (Consumer Advocate).

## FOR MORE INFORMATION

Visit our [proposed rule page](#).

## REFERENCES

1. Medus C, Besser JM, Juni BA, et al. Long-term sentinel surveillance for enterotoxigenic *Escherichia coli* and non-O157 Shiga toxin-producing *E. coli* in Minnesota. *Open Forum Infect Dis* 2016. doi 10.1093/ofid/ofw003
2. Epidemic diarrhea at Crater Lake from enterotoxigenic *Escherichia coli*: a large waterborne outbreak. Rosenberg ML, Koplan JP, Wachsmuth IK, et al. *Ann Intern Med* 1977; 86:714–8.



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