16-SI-03

Committee: Surveillance

Title: Veterans Health Administration Reporting of Diseases, Conditions, and Outbreaks to Local and State Public Health Authorities

I. Statement of the Problem:

Summary

Health care providers and laboratories, in all states, are mandated to report outbreaks and a defined set of communicable diseases, non-infectious diseases or conditions, designated as 'reportable' by local or state law to public health authorities, for the purpose of disease and condition prevention. This information is used to 1) identify public health problems, initiate investigations, and implement public health interventions, 2) characterize the burden of disease at the population-level, and 3) identify and describe the effectiveness of public health interventions. As federal entities, Veterans Health Administration (VHA) health care facilities and laboratories, are not required to follow state and local reporting laws, which has led to some substantial local and state disease control problems adversely impacting health of veterans that may have been averted if VHAs followed similar reporting rules and regulations as non-VHA providers. While VHAs, as federal entities, do not fall under state law, federal law does not prohibit VHAs from following jurisdictional disease and condition reporting requirements or disclosing identifiable health information, to state and local public health authorities for a purpose authorized by law (excluding 38 U.S.C. § 7332 protected information) (1) see Issue Brief: Disclosure of Identifiable Information by the Veterans Health Administration for Public Health Purposes (2). In recognition and support of disease reporting, the VHA on June 25, 2013, issued a Veterans Health Administrative Directive 2013-008, Infectious Disease Reporting, requiring all VHA health facilities to report diseases designated as reportable to, and in accordance with, the statute, regulations, and policies of the local, district, state, and territorial public health authorities. Despite the VHA directive, a lack of clarity about collaboration, process and reporting to public health remains. As a result, case reports and lab results are frequently delayed, submitted incompletely or never submitted, and state and local public health authorities continue to face challenges when gathering additional information after initial reports are made.

CSTE's Vision

CSTE’s vision is to have VHA facilities cooperate with jurisdictional disease and condition reporting laws in order to support public health disease and condition control and prevention efforts and to enhance the nationally notifiable disease surveillance system (NNDSS).

Breakdowns in VHA Reporting and Lack of Collaboration with State and Local Health Departments (3)

A VHA Office of the Inspector General report regarding an outbreak of Legionnaire's Disease associated with a VHA hospital in Pennsylvania highlighted the importance of a prompt and thorough response to disease control (4). In that instance, improved coordination with state and local public health authorities might have helped prevent infections and deaths associated with the outbreak. However, the Pennsylvania Legionnaire’s case is not an isolated incident. There are other examples of suboptimal coordination of disease reporting and collaboration during investigations with VHA institutions and state and local public health agencies.

Results from a December 2013 CSTE survey of State Epidemiologists to assess national VHA reporting and effectiveness of the VHA directive 2013-008 identified state experiences where VHA reporting either did not occur, was delayed, or problems occurred that limited necessary follow up. Examples gathered during the survey include: (1) Lack of prompt notification of cases of tuberculosis hampered control efforts outside the
institutions in which the person was housed. (2) Lack of information regarding communication with large numbers of persons potentially exposed to infection control lapses within a health care facility made it challenging to respond to public inquiries from many of those persons once they returned to communities. (3) A cluster of illnesses associated with preparation of medications in a health care institution was only reported indirectly by way of an unofficial report through personal acquaintances. (4) Lack of prompt notification of new diagnoses of STDS or HIV/AIDS has hampered control efforts to ensure identification of contacts and assurance the individuals had been referred for additional services, treatment and care. (5) One state reported numerous attempts across multiple years to work with VHA facilities in their state that perform HIV related testing but the laboratory would not commit to reporting and indicated they could not report HIV to public health. The laboratory was provided with state laboratory reporting guidelines and the VHA directive 2013-008 and the laboratory did not respond to follow-up communication. The use of public health surveillance data to help facilitate linkage and retention in HIV medical care is now an essential tool for identifying persons living with diagnosed infection who have fallen out of medical care and are not accessing treatment and other prevention services. As these linkage to care initiatives identify purportedly out of care persons based on reported laboratory data, the lack of comprehensive ongoing reporting to public health of prognostic HIV-related laboratory testing from VHA institutions has resulted in the inefficient use of scarce public health resources in follow up on persons receiving adequate HIV care within the VHA system.

In many of these situations, well-meaning VHA staff were equally frustrated with the ambiguity of whether or not they should report to state or local health departments. As such, compliance with state disease reporting laws by VHA staff has been variable, often depending largely on a particular individual’s interpretations of regulations and policies.

Efforts to Improve Disease and Condition Reporting

In an effort to improve disease and condition reporting legislation introduced in 2012 (House [HR 1792] and Senate [S. 875] versions) to mandate VHA reporting. In November 2013 CSTE provided testimony (3) to the Senate Committee on Veterans Affairs in support of the Senate bill which states that VHA facilities should comply with state reporting statutes and rules; both bills stalled. On June 25, 2013 the Veterans Health Administrative Directive 2013-008, Infectious Disease Reporting, requiring all health facilities to report diseases designated as reportable to, and in accordance with, the laws, regulations, and policies of the local, district, state, and territorial public health authorities was issued. This directive is due to expire on June 30, 2018. There are also examples of VHA collaboration with public health authorities for disease reporting, for example electronic laboratory reporting by VHA to New York State and some VHA facilities are also reporting health care associated infection (HAI) data to the National Health Care Network aligning with associated state law.

While some progress has been made, CSTE conducted a survey of State Epidemiologists in December 2013 to evaluate the effectiveness of the directive and found in many situations the directive had limited impact. On April 23, 2014 CSTE sent a letter of survey results to Robert Jesse, MD, PhD, Principal Deputy Under Secretary for Health VHA detailing the “positive but minimal impact” of Directive 2013-008; and on September 15, 2014 CSTE sent a letter Carolyn Clancy, M.D., Deputy Under Secretary for Health, describing the survey findings and requesting a meeting to discuss ways in which CSTE and VHA could work together to achieve the directive’s goals. Identified gaps in Directive 2013-008 including that the directive did not adequately specify the need to follow state and local disease reporting regulations including the time and manner specified in which disease reports should be made; VHA facilities did not have clear designations as to who should make reports to public health or provide needed follow up information to public health once initial reports were made; a general lack of disease reporting ownership by VHA; and no process for mediation or resolution when disease or condition reporting problems arise.

The VHA’s Public Health Surveillance and Research group within the Office of Quality, Safety and Value provides support for disease reporting including the Public Health Reporting Toolkit (published on VHA
intranet). While the toolkit provides some guidance, a lack of clarity still exists. In 2014, an internal VHA survey revealed a number of barriers to effective reporting and collaborations with public health, particularly in the areas of electronic laboratory reporting (ELR) for reportable diseases and healthcare-associated infection (HAI) reporting through the National Health Care Safety Network (NHSN).

II. Statement of the desired action(s) to be taken:

States and territories want all health care providers and laboratories located in their jurisdiction to report outbreaks, and a defined set of communicable diseases, non-infectious diseases and conditions, designated as reportable by local or state statute or regulation, to their public health authorities for additional investigation and public health action as warranted. Consistent with the language in VHA Directive 2013-008, which states that “VHA Handbook 1605.02, Minimum Necessary Standard for Protected Health Information, recognizes the reporting of communicable diseases and other reportable conditions to authorities external to the Department of Veterans Affairs (VA) as one of many routine and recurring disclosures”, states and territories ask that all VHA facilities implement reporting expectations, and collaborate with public health authorities in case investigation and prevention program activities which will improve the health of both the general public and the population of veterans.

1. A response to the CSTE Executive Board in regard to this position statement should be provided by September 1, 2016.

2. Establishment of an intergovernmental (see Appendix B) working group on disease/condition/outbreak reporting from VHA to states. Workgroup deliberations should not interfere with ongoing progress in improved reporting.
   - Membership should be explicitly joint: the federal agency (VHA), CDC, and the organization representing states and territories (CSTE).
   - The work group charge will be:
     A. Review policies and procedures for public health reporting including but not limited to:
        - Review existing VHA policies (such as Handbook 1605.1 “Privacy and Release of Information” and Handbook 1080.01 “Data Use Agreements”) and directives (such as Directive 2013-008 “Infectious Disease Reporting” and Directive 2014-1072 “Release of VHA Data to State Cancer Registries”) for clarity and completeness, including the issue of explicit inclusion of non-infectious/non-communicable conditions (e.g. health care associate infections) and outbreak reporting where appropriate, as well as disease reporting to state and local registries.
        - Review existing procedures for participation in case reporting in states and territories.
        - Review existing procedures for not only what, but how reports should be submitted to public health; support for ongoing and comprehensive electronic laboratory reporting (ELR) from VHA facilities to public health authorities in accordance with state laws and using existing standards.
        - Review the language in existing contracts between VHA and external laboratories to identify barriers to reporting of laboratory results to public health authorities.
        - Review existing procedures and emerging methods for electronic case reporting.
        - Review existing procedures for participation in public health registries where reporting to public health agencies is authorized or mandated by statute or rule, such as birth defects, cancer, immunization, and trauma registries; prescription monitoring (controlled substances); antimicrobial resistance; and others as appropriate.
        - In collaboration with staff from CDC Division of Healthcare Quality Promotion, review existing procedures for participation in the National Healthcare Safety Network (NHSN), to report health care associated infections.
        - Review the role of the facility-level Standing Letter Request and consider the
III. Public Health Impact:
Clear guidance and defined expectations for disease/condition/outbreak reporting to public health can improve the quality and consistency of data received. Data submission can improve the completeness and accuracy of surveillance, morbidity, and mortality information available. Consistent, accurate, and comprehensive disease reporting to state and local public health agencies will:

- Result in more complete case ascertainment, reporting, and contact tracing in states further identifying routes of disease transmission.
- Limit further spread of disease.
- Improve the understanding of morbidity of chronic conditions and associated risk factors.
- Allow for improved delivery and provision of partner services for STI’s, HIV, and other diseases and conditions where applicable.
- Allow for analysis and sharing of information that is actionable.
• Result in appropriate response to outbreaks, public health emergencies and other threats posing a potential risk to our communities.
• Place VHA health care facilities on a level playing field with other reporting health care facilities by requiring compliance with jurisdictional, i.e., state and local reporting laws, and procedures. Referring federal requirements to these laws, and procedures will ensure VHA facilities remain on equal footing with private health care facilities as these rules evolve over time. Similarly, requiring that the VHA adhere to existing standards will enhance, rather than reinvent, the already effective NNDSS; requiring the VHA to diverge from existing standards could place an unnecessary administrative burden on the system.

If VHA facilities comply with jurisdictional reporting laws, many facility-based outbreaks will be detected, investigated, and stopped earlier than they may be otherwise. In addition, no patient of any health care institution is a resident of an encapsulated universe. Patients, staff, and families are active members of the communities surrounding those facilities, and their inevitable interactions have important public health implications both inside and outside those buildings. It is impossible to separate a health care facility from its community, and vice versa. Public health law must acknowledge this, and facilitate VHA health care facilities to follow the same laws that govern all other institutions in our states, which protect the health of us all.

IV. Revision History

V. References

(1) Federal law addresses partner notification by allowing the individual's physician or professional counselor to notify, without the individual's consent, the individual's spouse or other sexual contacts, that the individual is infected with the HIV virus. The physician or professional counselor can only do this if he or she has first made reasonable efforts to counsel and encourage the individual to provide the information to the spouse or sexual partner and reasonably believes that the individual will not provide the information to the spouse or sexual partner and that the disclosure is necessary to protect the health of the spouse or sexual partner. See 38 U.S.C.§ 7332(f). The VHA HIV Prevention Handbook recognizes "[i]t is the professional and ethical responsibility of VHA providers to make use of available partner notification services by contacting the state and local health department" when permitted under 38 U.S.C. § 7332(f). See VHA HIV Prevention Handbook: A Guide for Clinicians, 2nd Edition. United States Department of Veterans Affairs. Veterans Health Administration, Office of Public Health. May 2013. Available at http://www.hiv.va.gov/pdf/manual-HIV-prevention2013.pdf.

(2) Issue Brief: Disclosure of Identifiable Information by the Veterans Health Administration for Public Health Purposes, Revised June 7, 2016 https://www.networkforphl.org/resources_collection/2016/06/07/351/issue_brief_disclosure_of_identifiable_information_by_the_veterans_health_administration_for_public_health_purposes

(3) Nov. 2013, Tim Jones testifies at Senate Committee on Veterans Affairs, much of the language here has been adapted from this testimony.


(5) Under 38 U.S.C. § 7332, information pertaining to VHA facilities' treatment of drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia is afforded special protection. HIV is the only of these conditions which may be disclosed to state and local public health authorities, and re-disclosure of such information is prohibited. See 38 U.S.C. § 7332(b)(2)(C) and 38 C.F.R. § 1.486 for heightened requirements associated with disclosure of HIV related data. The statute and regulations further specify the limited circumstances in which a patient’s infection with HIV may be disclosed by a physician or professional counselor to the infected individual's spouse or known sexual partner(s). The law also permits certain information concerning the prescription of controlled substances to be disclosed to State controlled substance monitoring programs to prevent misuse and diversion of prescription drugs. See 38 U.S.C. § 7332(b)(2)(G); 38 C.F.R. §§1.483, 1.515.)
VI. Coordination

Agencies for Response:

(1) U.S. Department of Veterans Affairs
    Robert A. McDonald, MBA
    Secretary of Veterans Affairs
    810 Vermont Avenue NW Washington, D.C. 20420
    Robert.a.mcdonald@va.gov

(2) Veterans Health Administration
    David J. Shulkin, MD
    Under Secretary for Health
    810 Vermont Avenue NW
    Washington, D.C. 20420
    David.shulkin@va.gov

(3) Veterans Health Administration
    Richard A. Stone, MD
    Principal Deputy Under Secretary for Health
    810 Vermont Avenue NW
    Washington, D.C. 20420
    Richard.stone2@va.gov

(4) Veterans Health Administration
    Jennifer Lee, MD
    Deputy Under Secretary for Health for Policy and Services
    810 Vermont Avenue NW
    Washington, D.C. 20420
    Jennifer.s.lee@va.gov

(5) Veterans Health Administration
    Carolyn M. Clancy, MD
    Deputy Under Secretary for Health for Organizational Excellence
    810 Vermont Avenue NW
    Washington, D.C. 20420

(6) Centers for Disease Control and Prevention
    Thomas R Frieden, MD, MPH
    Director
    1600 Clifton Rd NE, MS G-14
    Atlanta, GA 30333
    404-639-7000
    Txf2@cdc.gov
Agencies for Information:

(1) Centers for Disease Control and Prevention
Office of Public Health Scientific Services
Chesley Richards, MD, MPH, FACP
Director
1600 Clifton Rd NE, MS G-14
Atlanta, GA 30333
404-498-6001
Cir6@cdc.gov

(2) Centers for Disease Control and Prevention
Center for Surveillance, Epidemiology, and Laboratory Services
Michael F. Iademarco, MD, MPH
Director
Captain, USPHS
1600 Clifton Rd NE, MS G-14
Atlanta, GA 30333
404-498-6010
miademarco@cdc.gov

(3) Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)
Beth Bell, MD, MPH
Director
1600 Clifton Rd NE, MS G-14
Atlanta, GA 30333
404-498-6001
Bzb8@cdc.gov

(4) Centers for Medicare and Medicaid Services
Andrew Slavitt, MBA
Acting Administrator
7500 Security Boulevard
Baltimore, MD 21244
202-690-6726
Andy.slavitt@cms.hhs.gov

(5) Association of State and Territorial Health Officials
Sharon Moffatt, RN, BSN
Interim Executive Director
2231 Crystal Drive Suite 450
Arlington, VA 22202
smoffatt@asto.org

(6) National Association of County and City Health Officials
LaMar Hasbrouck, MD, MPH
Executive Director
1100 17th Street NW, Seventh Floor
Washington DC 20036
202-783-1583
Ihasbrouck@naccho.org
(7) Office of the National Coordinator for Health Information Technology
Karen B. DeSalvo, MD, MPH, MSc
Acting Assistant Secretary for Health
National Coordinator for Health Information Technology
200 Independence Avenue SW, Suite 729-D
Washington, DC 20201
Karen.desalvo@hhs.gov

(8) International Society for Disease Surveillance
Laura C. Streichert, PhD, MPH
Executive Director
26 Lincoln St., Suite #3
Brighton, MA 02135
617-779-7351
lstreichert@syndromic.org

(9) Association of Public Health Laboratories
Scott J. Becker, MS
Executive Director
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
240-485-2745
Scott.becker@aphl.org

(10) National Academy for State Health Policy
Trish Riley, MS
Executive Director
1233 20th St., NW, Suite 303
Washington DC, 20036
202-903-0101
triley@nashp.org

(11) Joint Public Health Informatics Taskforce
Charlie Ishikawa, MSPH
Executive Secretary, JPHIT Secretariat
617-955-0990
cishikawa@jphit.org

(12) American Medical Informatics Association
Douglas B. Fridsma, MD, PhD, FACP, FACMI
President and Chief Executive Officer
4720 Montgomery Lane, Suite 500
Bethesda, MD 20814
301-657-1291
fridsma@amia.org

(13) The Network for Public Health Law
Donna Levin, JD
Network National Director
875 Summit Avenue
St. Paul, MN 55105
651-695-7749
(14) National Association for Public Health Statistics and Information Systems
Patricia W. Potrzebowski, PhD
Executive Director
962 Wayne Avenue, Suite 701
Silver Spring, MD 20910
301-563-6001
ppotrzebowski@naphsis.org

(15) North American Association of Central Cancer Registries
Betsy Kohler, MPH, CTR
Executive Director
2050 W. Iles, Suite A
Springfield, IL 62704
217-698-0800 ext. 2
bkohler@naaccr.org

(16) American Immunization Registry Association
Rebecca Coyle, MS
Executive Director
1155 F Street NW, Suite 1050
Washington, DC 20004
202-552-0208
coyler@immregistries.org

(17) Centers for Disease Control and Prevention
Division of Healthcare Quality Promotion
Denise Cardo, MD
Division Director
1600 Clifton Rd NE, MS G-14
Atlanta, GA 30333
404-639-4023
Dbc0@cdc.gov
VI. Submitting Author:

(1) □ Active Member □ Associate Member
    Janet J. Hamilton, MPH
    Surveillance and Surveillance Systems Section Manager
    Florida Department of Health
    Bureau of Epidemiology
    Bald Cypress Way, Bin A-12
    Tallahassee, FL, 32399
    Janet.Hamilton@flhealth.gov

Co-Author:

(1) □ Active Member □ Associate Member
    Mary G. McIntyre, M.D., M.P.H.,
    SSBB State Epidemiologist
    Assistant State Health Officer for Disease Control and Prevention
    Alabama Department of Health
    201 Monroe Street, Ste. 1418
    RSA Tower, P.O. Box 202017
    Montgomery, AL 36130
    Mary.mcintyre@adph.state.al.us

(2) □ Active Member □ Associate Member
    Bridget J. Anderson, PhD
    Director, Bureau of HIV/AIDS Epidemiology
    AIDS Institute
    New York State Department of Health
    Albany NY 12237
    Bridget.Anderson@health.ny.gov

(3) □ Active Member □ Associate Member
    Steven Macdonald, PhD, MPH
    William Farr Applied Epidemiology
    PO Box 2749
    Vashon Island, WA 98070
    Steven.p.macdonald@comcast.net

(4) □ Active Member □ Associate Member
    Tim Jones, MD
    State Epidemiologist
    Tennessee Department of Health
    710 James Robertson Parkway; 4th floor Andrew Johnson Tower
    Nashville, TN 37243
    Tim.F.Jones@tn.gov
(5)  □ Active Member  □ Associate Member
Denise Chrysler, J.D., Director
Mid-States Regional Center
The Network for Public Health Law
dchrysler@networkforphl.org
denichry@umich.edu

(6)  □ Active Member  □ Associate Member
Sita Smith
Health Information Coordinator
Office of Integrated Surveillance and Informatics Services
Bureau of Infectious Disease Prevention, Response and Services
Massachusetts Department of Public Health
305 South Street, Jamaica Plain, MA 02130
Sita.c.smith@state.ma.us

(7)  □ Active Member  □ Associate Member
Nancy L. Barrett, MS, MPH
Informatics Lead, Infectious Disease Section
Connecticut Department of Public Health
410 Capitol Avenue, MS #11EPI, Hartford, CT 06134
nancy.l.barrett@ct.gov

(8)  □ Active Member  □ Associate Member
Kathryn Turner, PhD MPH
Deputy State Epidemiologist
Chief, Bureau of Communicable Disease Prevention
Idaho Division of Public Health
Email: turnerk@dhw.idaho.gov
Appendix A

History of Disease Reporting:

The long-standing history of disease reporting in the United States serves as an example of effective federalism that has been refined over 135 years. Beginning in 1878, Congress authorized the U.S. Marine Hospital Service (forerunner of the Public Health Service or PHS) to collect reports from U.S. consuls overseas about local occurrences of diseases such as cholera, smallpox, plague, and yellow fever. This information was used to institute quarantine measures to prevent introducing or spreading these diseases in the United States. In 1879, Congress funded the collection and publishing of reports of these notifiable diseases and in 1893 expanded the authority for weekly reporting and publishing of these cases to include data from states and municipal authorities.

To improve the uniformity of the data, Congress in 1902 directed the Surgeon General to provide specific forms to be used for collecting and compiling these data and for publishing reports at the national level. In 1903, the PHS convened the first annual conference of state and territorial health officers to begin implementation of the congressional act, thus marking the dawn of national surveillance for communicable diseases of public health importance.

In 1950, a new federal agency, then named the Centers for Disease Control (now the Centers for Disease Control and Prevention or CDC), recognized the importance of state input in reporting communicable diseases, and asked the Association of State and Territorial Health Officials (ASTHO) to convene state epidemiologists and charge them with the responsibility of deciding which diseases should be reported nationally. A conference of state and territorial epidemiologists generated a fully documented list of nationally notifiable diseases.

Today, these data are the foundation of the National Notifiable Diseases Surveillance System (NNDSS), a multifaceted public health disease surveillance system that gives public health officials powerful capabilities to monitor the occurrence and spread of diseases. Fifty-seven jurisdictions contribute to the NNDSS: the 50 states, New York City, the District of Columbia, and 5 territories including Guam, Commonwealth of Northern Mariana Islands, American Samoa, U.S. Virgin Islands and Puerto Rico.

Disease Reporting Governed by State and Local Laws

Effective public health disease/condition/outbreak surveillance and control is a primary responsibility of state and local health departments. Mandatory disease/condition reporting of individual patients and public health access to corresponding health records with personal identifying information is governed by state and local statutes and regulations, which vary by jurisdiction. Many jurisdictions also collect public health information, such as cancer diagnoses and immunizations, through state registries; depending on the jurisdiction, reporting to registries may be required or simply authorized by law. Additionally, in some instances, state and local laws require or authorize additional reporting or identification of persons, for example: reporting of sexual, needle-sharing or social contacts of persons with sexually transmitted infections (STIs); reporting of vaccinations given to children to state-based immunization registries; or pathology reports of cancer to state-based cancer registries. These data provide the direction and scope of many state and local health department activities, from detecting individual cases and controlling outbreaks to implementing prevention and intervention activities for infectious, non-infectious and chronic diseases and conditions, as well as the provision of services for STI contacts or vaccines for children. Because of the Health Information Portability and Accountability Act (HIPAA) exemptions for public health reporting [See 42 U.S.C. § 1320d-7(b); 45 C.F.R. § 164.512(b)], health department staff are able to identify persons affected by the diseases of concern to investigate and institute control measures to prevent further spread of disease. State health departments support national public health surveillance by voluntarily sharing their notifiable disease reports with CDC using de-identified data.

Health Care Providers Are Critical Partners in Surveillance

16-SI-03
State and local public health departments are reliant on their partners in the health care community—those who interact directly with patients—to obtain case reports on infectious, non-infectious and chronic diseases and conditions. While public health reporting laws and rules differ by locale, they are similar in that these health care providers—including physicians, laboratories, and other providers of care—are legally required to report to their jurisdiction’s public health authorities when they reasonably suspect a patient of having a disease or condition of concern. Health care facilities, including acute care hospitals, long-term care facilities, and outpatient facilities, also fall under mandated reporting requirements. In practice, physicians often assume that the acute care hospital infection prevention staff will initiate a report to the public health agency on a patient for whom the physician is caring. Notably, for health care facility reporting mandates, a specific individual responsible for reporting is not named in the law or rule, but rather it is expected that the facility shall report or designate a reporter on behalf of the facility. Other individuals or entities may also be mandated to report events of potential public health concern. For example, in many places school principals or restaurant owners must report when outbreaks occur that may be associated with their establishments (such as influenza-like illness, or gastrointestinal illness clusters). For certain diseases or conditions, facilities and providers are required to immediately report by phone on immediate suspicion of such occurrences.

Failure of an individual or entity to report is frequently a crime and potentially punishable as a misdemeanor offense with imprisonment, de-licensing, or fines. In practice, however, criminal penalties are exceedingly rarely used; compliance is encouraged by continuing education and public health relationships with health care providers. While VHAS serve as important health care providers in our communities, they are often unable to report, confused about how to report, or unable to implement an operational reporting structure and thus provide their patients the same opportunities for disease control and prevention as is available to non-VHA care seeking individuals.

Public Health Agencies Collect, Investigate Disease and Condition Reports

The public health agency to which disease reports are sent depends on the jurisdiction, but is generally the state or local health department in the jurisdiction where the patient sought care or the disease is diagnosed. In most instances, medical providers and health care facilities report directly to the local or county health department where they are located, or in the absence of local health departments, directly to the state health agency. Because there is variability in state and local reporting requirements, which are complicated by patient travel, movement, and care seeking, especially in areas where the health care continuum crosses jurisdictional boundaries, all states have mechanisms to share reports with other jurisdictions as appropriate, depending on where a disease was contracted or treated, where a patient resides, and where and how measures to investigate and control them must be implemented.

Generally, state and local health departments are responsible for investigating these disease and condition reports, and responding appropriately. Depending on the situation, such responsibilities may involve compiling of data for routine reporting, or investigating outbreaks or emergent events which require an immediate and vigorous response to protect the public’s health. Rapid access to information is critical to accurately and promptly investigating such reports. Additionally, once reported, assigning residence (by state, county, etc.), de-duplicating reports, and other reconciliations are responsibilities of the public health agency.

Consistent and Complete Disease and Condition Reporting Necessary to Protect Public Health

State and local laws and rules require reporting of a list of diseases and conditions designated as reportable in their jurisdiction. When making these determinations jurisdictions utilize the list of identified nationally notifiable diseases and conditions determined by CSTE and other recommendations by CSTE and CDC. Jurisdictions can and do make changes to the list of nationally notifiable diseases and conditions to fit local or regional needs, such as the addition of "Valley Fever," which is caused by a fungus (Coccidioidomycosis) that is historically endemic only to the Southwest region of the United States.
The goal of public health reporting and the collection of other data of public health importance, such as vaccinations, is to detect, investigate and prevent diseases and conditions that pose a potential threat to others in the local, state, regional, national or even international communities. Many examples of this are well-known. A report of a case of tuberculosis leads to provision of treatment for the patient to render them no longer infectious, identification and notification of close contacts for evaluation and treatment, and occasionally quarantine or other public health measures as necessary to prevent additional spread of disease. Persons with sexually transmitted diseases are promptly treated, and their close contacts are identified and treated to prevent further spread. Persons who have had close contact with a patient with meningococcal meningitis are traced and urgently treated to prevent them from contracting disease. Clusters of illness associated with restaurants are investigated immediately in order to ensure that conditions at the implicated establishment are corrected immediately or it is closed until that is accomplished. Foodborne disease outbreaks often lead to traceback of foods, with recalls of many thousands of pounds of product, preventing potential illness over very large areas of distribution (http://www.foodpoisonjournal.com/foodborne-illness-outbreaks/cdc-and-fda-call-chipotle-e-coli-o26-outbreaks-over-but/#.VvJWCY3rt9A), (http://www.cdc.gov/salmonella/bredeney-09-12/index.html) and (http://www.fda.gov/Safety/Recalls/ucm490751.htm). For example, the nationwide outbreak of fungal meningitis (http://www.cdc.gov/hai/outbreaks/meningitis.html), in which identification and recall of a contaminated pharmaceutical product prevented potentially hundreds of additional deaths. Clusters of illness associated with vaccine preventable diseases such as the measles outbreak in California result in hundreds of persons contacted and provided further prophylactic treatment in order to prevent further illness and death from occurring (http://www.cdc.gov/MMWR/preview/mmwrhtml/mm6406a5.htm). In these instances immunization registries play a substantial role in prioritizing high priority contacts to ensure those most vulnerable are identified and rapidly followed up.

It is not at all uncommon for public health agencies to receive several reports of illness from various sources, which to an individual clinician or institution may appear isolated or sporadic, but which in aggregate signify an important cluster or outbreak. This is an example of the critical importance of all health care providers and facilities consistently and promptly reporting diseases to their local authorities.

While many cases of reportable diseases are “sporadic,” or unrelated to others and require limited additional follow-up, some extent of public health investigation is necessary to ensure that they are not a sign of a potentially more widespread situation requiring interventions to mitigate additional spread. It is not uncommon for public health investigations to identify causes of disease involving such things as widely disseminated food products, contaminated medications, malfunctioning equipment, unsafe food-handling or manufacturing processes, intentionally perpetrated acts, or unsafe environmental conditions to which the public may be exposed (sometimes including health care facilities). All these condition items can impact persons living in our communities including those seeking care at VHAs. In the large majority of cases, persons or establishments potentially involved in an outbreak are extremely cooperative with public health authorities in working toward identifying and eliminating the sources of health threats. Rarely, however, concerns such as legal culpability, economic sequelae, or adverse publicity can hinder investigations and response. Uniform adherence to legal reporting requirements is essential to ensure that there are no such barriers to protecting the public's health and safety.

Public health authorities work closely with private and institutional health care providers in this capacity. Confidentiality is rigorously protected by public health laws at all times (1). Authorities make every effort not to interfere with personal physician-patient relationships and individual treatment decisions, but rather work to provide additional services and resources beyond those which a physician or institution that would not otherwise have available or performed. This can include performing investigations in the broader community, coordinating with other public health and regulatory agencies, identifying contacts and providing prophylactic treatment to ensure exposed individuals do not become ill, providing of services otherwise inaccessible to high-risk populations, ensuring public information management, and occasionally using of public health legal authorities to overcome barriers to appropriate disease control.

Appendix B

Rationale for “intergovernmental working group”

The 1972 Federal Advisory Committee Act (FACA), Public Law 92-463, requires committees that provide advice to federal agencies to follow a complex set of rules on open meetings, chartering, public involvement and reporting, with oversight from the General Services Administration (GSA) (http://www.gsa.gov/portal/content/100916). FACA defines advisory committee as "any committee, board, commission, council, conference, panel, task force, or other similar group" that dispenses "advice or recommendations". Section 204(b) of Public Law 104-4, the "Unfunded Mandates Reform Act of 1995", provides an exemption from FACA for intergovernmental consultations involving intergovernmental responsibilities or administration, as explained in Memorandum M-95-20 issued by the Office of Management & Budget (OMB): under PL 104-4, section 204(b) provides an exemption from FACA "for the exchange of official views regarding the implementation of public laws requiring shared intergovernmental responsibilities or administration." The OMB memo specifies that "This exemption applies to meetings between Federal officials and employees and State, local, or tribal governments, acting through their elected officers, officials, employees, and Washington representatives, at which 'views, information, or advice' are exchanged concerning the implementation of intergovernmental responsibilities or administration, including those that arise explicitly or implicitly under statute, regulation, or Executive order." (http://www.gsa.gov/portal/content/1010)