Overview of Public Health Law

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130A-17. Right of entry.

(a) The Secretary and a local health director shall have the right of entry upon the premises of any place where entry is necessary to enforce the provisions of this Chapter or the rules adopted by the Commission or a local board of health. If consent for entry is not obtained, an administrative search and inspection warrant shall be obtained pursuant to G.S. 15-27.2. However, if an imminent hazard exists, no warrant is required for entry upon the premises.

(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of Articles 9 and 10 of this Chapter.

130A-18. Injunction.

(a) If a person shall violate any provision of this Chapter, the rules adopted by the Commission or rules adopted by a local board of health, or a condition or term of a permit or order issued under this Chapter, the Secretary or a local health director may institute an action for injunctive relief, irrespective of all other remedies at law, in the superior court of the county where the violation occurred or where a defendant resides.

(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of Articles 9 and 10 of this Chapter.

130A-25. Misdemeanor.

(a) Except as otherwise provided, a person who violates a provision of this Chapter or the rules adopted by the Commission or a local board of health shall be guilty of a misdemeanor.

(b) A person convicted under this section for violation of G.S. 130A-144(f) or G.S. 130A-145 shall not be sentenced under Article 81B of Chapter 15A of the General Statutes but shall instead be sentenced to a term of imprisonment of no more than two years and shall serve any prison sentence in McCain Hospital, Section of Prisons of the Division of Adult Correction, McCain, North Carolina; the North Carolina Correctional Center for Women, Section of Prisons of the Division of Adult Correction, Raleigh, North Carolina; or any other confinement facility designated for this purpose by the Secretary of Public Safety after consultation with the State Health Director. The Secretary of Public Safety shall consult with the State Health Director concerning the medical management of these persons.

(c) Notwithstanding G.S. 148-4.1, G.S. 148-13, or any other contrary provision of law, a person imprisoned for violation of G.S. 130A-144(f) or G.S. 130A-145 shall not be released prior to the completion of the person's term of imprisonment unless and until a determination has been made by the District Court that release of the person would not create a danger to the public health. This determination shall be made only after the medical consultant of the confinement facility and the State Health Director, in consultation with the local health director of the person's county of residence, have made recommendations to the Court.

(d) A violation of Part 7 of Article 9 of this Chapter or G.S. 130A-309.10(m) shall be punishable as a Class 3 misdemeanor.

130A-144. Investigation and control measures.

(a) The local health director shall investigate, as required by the Commission, cases of communicable diseases and communicable conditions reported to the local health director pursuant to this Article.

(b) Physicians, persons in charge of medical facilities or laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition.

(c) A physician or a person in charge of a medical facility or laboratory who permits examination, review or copying of medical records pursuant to subsection (b) shall be immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of complying with a request made pursuant to subsection (b).

(d) The attending physician shall give control measures prescribed by the Commission to a patient with a communicable disease or communicable condition and to patients reasonably suspected of being infected or exposed to such a disease or condition. The physician shall also give control measures to other individuals as required by rules adopted by the Commission.

(e) The local health director shall ensure that control measures prescribed by the Commission have been given to prevent the spread of all reportable communicable diseases or communicable conditions and any other communicable disease or communicable condition that represents a significant threat to the public health. The local health department shall provide, at no cost to the patient, the examination and treatment for tuberculosis disease and infection and for sexually transmitted diseases designated by the Commission.

(f) All persons shall comply with control measures, including submission to examinations and tests, prescribed by the Commission subject to the limitations of G.S. 130A-148.

(g) The Commission shall adopt rules that prescribe control measures for communicable diseases and conditions subject to the limitations of G.S. 130A-148. Temporary rules prescribing control measures for communicable diseases and conditions shall be adopted pursuant to G.S. 150B-13.

(h) Anyone who assists in an inquiry or investigation conducted by the State Health Director for the purpose of evaluating the risk of transmission of HIV or Hepatitis B from an infected health care worker to patients, or who serves on an expert panel established by the State Health Director for that purpose, shall be immune from civil liability that otherwise might be incurred or imposed for any acts or omissions which result from such assistance or service, provided that the person acts in good faith and the acts or omissions do not amount to gross negligence, willful or wanton misconduct, or intentional wrongdoing. This qualified immunity does not apply to acts or omissions which occur with respect to the operation of a motor vehicle. Nothing in this subsection provides immunity from liability for a violation of G.S. 130A-143.

130A-145. Quarantine and isolation authority.

(a) The State Health Director and a local health director are empowered to exercise quarantine and isolation authority. Quarantine and isolation authority shall be exercised only when and so long as the public health is endangered, all other reasonable means for correcting the problem have been exhausted, and no less restrictive alternative exists.

(b) No person other than a person authorized by the State Health Director or local health director shall enter quarantine or isolation premises. Nothing in this subsection shall be construed to restrict the access of authorized health care, law enforcement, or emergency medical services personnel to quarantine or isolation premises as necessary in conducting their duties.

(c) Before applying quarantine or isolation authority to livestock or poultry for the purpose of preventing the direct or indirect conveyance of an infectious agent to persons, the State Health Director or a local health director shall consult with the State Veterinarian in the Department of Agriculture and Consumer Services.

(d) When quarantine or isolation limits the freedom of movement of a person or animal or of access to a person or animal whose freedom of movement is limited, the period of limited freedom of movement or access shall not exceed 30 calendar days. Any person substantially affected by that limitation may institute in superior court in Wake County or in the county in which the limitation is imposed an action to review that limitation. The official who exercises the quarantine or isolation authority shall give the persons known by the official to be substantially affected by the limitation reasonable notice under the circumstances of the right to institute an action to review the limitation. If a person or a person's representative requests a hearing, the hearing shall be held within 72 hours of the filing of that request, excluding Saturdays and Sundays. The person

substantially affected by that limitation is entitled to be represented by counsel of the person's own choice or if the person is indigent, the person shall be represented by counsel appointed in accordance with Article 36 of Chapter 7A of the General Statutes and the rules adopted by the Office of Indigent Defense Services. The court shall reduce or terminate the limitation unless it determines, by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others.

If the State Health Director or the local health director determines that a 30-calendar-day limitation on freedom of movement or access is not adequate to protect the public health, the State Health Director or local health director must institute in superior court in the county in which the limitation is imposed an action to obtain an order extending the period of limitation of freedom of movement or access. If the person substantially affected by the limitation has already instituted an action in superior court in Wake County, the State Health Director must institute the action in superior court in Wake County or as a counterclaim in the pending case. Except as provided below for persons with tuberculosis, the court shall continue the limitation for a period not to exceed 30 days if it determines, by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by a preponderance of the evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires and may seek immediate or expedited termination of the order. Before the expiration of an order issued under this section, the State Health Director or local health director may move to continue the order for additional periods not to exceed 30 days each. If the person whose freedom of movement has been limited has tuberculosis, the court shall continue the limitation for a period not to exceed one calendar year if it determines, by a preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of tuberculosis to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by a preponderance of the evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires and may seek immediate or expedited termination of the order. Before the expiration of an order limiting the freedom of movement of a person with tuberculosis, the State Health Director or local health director may move to continue the order for additional periods not to exceed one calendar year each.

130A-148. Laboratory tests for AIDS virus infection.

(a) For the protection of the public health, the Commission shall adopt rules establishing standards for the certification of laboratories to perform tests for Acquired Immune Deficiency Syndrome (AIDS) virus infection. The rules shall address, but not be limited to, proficiency testing, record maintenance, adequate staffing and confirmatory testing. Tests for AIDS virus infection shall be performed only by laboratories certified pursuant to this subsection and only on specimens submitted by a physician licensed to practice medicine. This subsection shall not apply to testing performed solely for research purposes under the approval of an institutional review board.

(b) Prior to obtaining consent for donation of blood, semen, tissue or organs, a facility or institution seeking to obtain blood, tissue, semen or organs for transfusion, implantation, transplantation or administration shall provide the potential donor with information about AIDS virus transmission, and information about who should not donate.

(c) No blood or semen may be transfused or administered when blood from the donor has not been tested or has tested positive for AIDS virus infection by a standard laboratory test.

(d) No tissue or organs may be transplanted or implanted when blood from the donor has not been tested or has tested positive for AIDS virus infection by a standard laboratory test unless consent is obtained from the recipient, or from the recipient's guardian or a responsible adult relative of the recipient if the recipient is not competent to give such consent.

(e) Any facility or institution that obtains or tranfuses, implants, transplants, or administers blood, tissue, semen, or organs shall be immune from civil or criminal liability that otherwise might be incurred or imposed for transmission of AIDS virus infection if the provisions specified in subsections (b), (c), and (d) of this section have been complied with.

(f) Specimens may be tested for AIDS virus infection for research or epidemiologic purposes without consent of the person from whom the specimen is obtained if all personal identifying information is removed from the specimen prior to testing.

(g) Persons tested for AIDS virus infection shall be notified of test results and counseled appropriately. This subsection shall not apply to tests performed by or for entities governed by Article 39 of Chapter 58 of the General Statutes, the Insurance Information and Privacy Protection Act, provided that said entities comply with the notice requirements thereof.

(h) The Commission may authorize or require laboratory tests for AIDS virus infection when necessary to protect the public health.

A test for AIDS virus infection may also be performed upon any person solely by order of a physician licensed to practice medicine in North Carolina who is rendering medical services to that person when, in the reasonable medical judgment of the physician, the test is necessary for the appropriate treatment of the person; however, the person shall be informed that a test for AIDS virus infection is to be conducted, and shall be given clear opportunity to refuse to submit to the test prior to it being conducted, and

further if informed consent is not obtained, the test may not be performed. A physician may order a test for AIDS virus infection without the informed consent of the person tested if the person is incapable of providing or incompetent to provide such consent, others authorized to give consent for the person are not available, and testing is necessary for appropriate diagnosis or care of the person.

An unemancipated minor may be tested for AIDS virus infection without the consent of the parent or legal guardian of the minor when the parent or guardian has refused to consent to such testing and there is reasonable suspicion that the minor has AIDS virus or HIV infection or that the child has been sexually abused.

(i) Except as provided in this section, no test for AIDS virus infection shall be required, performed or used to determine suitability for continued employment, housing or public services, or for the use of places of public accommodation as defined in G.S. 168A-3(8), or public transportation.

Further it shall be unlawful to discriminate against any person having AIDS virus or HIV infection on account of that infection in determining suitability for continued employment, housing, or public services, or for the use of places of public accommodation, as defined in G.S. 168A-3(8), or public transportation.

Any person aggrieved by an act or discriminatory practice prohibited by this subsection relating to housing shall be entitled to institute a civil action pursuant to G.S. 41A-7 of the State Fair Housing Act. Any person aggrieved by an act or discriminatory practice prohibited by this subsection other than one relating to housing may bring a civil action to enforce rights granted or protected by this subsection.

The action shall be commenced in superior court in the county where the alleged discriminatory practice or prohibited conduct occurred or where the plaintiff or defendant resides. Such action shall be tried to the court without a jury. Any relief granted by the court shall be limited to declaratory and injunctive relief, including orders to hire or reinstate an aggrieved person or admit such person to a labor organization.

In a civil action brought to enforce provisions of this subsection relating to employment, the court may award back pay. Any such back pay liability shall not accrue from a date more than two years prior to the filing of an action under this subsection. Interim earnings or amounts earnable with reasonable diligence by the aggrieved person shall operate to reduce the back pay otherwise allowable. In any civil action brought under this subsection, the court, in its discretion, may award reasonable attorney's fees to the substantially prevailing party as a part of costs.

A civil action brought pursuant to this subsection shall be commenced within 180 days after the date on which the aggrieved person became aware or, with reasonable diligence, should have become aware of the alleged discriminatory practice or prohibited conduct.

Nothing in this section shall be construed so as to prohibit an employer from:

(1) Requiring a test for AIDS virus infection for job applicants in preemployment medical examinations required by the employer;

(2) Denying employment to a job applicant based solely on a confirmed positive test for AIDS virus infection;

(3) Including a test for AIDS virus infection performed in the course of an annual medical examination routinely required of all employees by the employer; or

(4) Taking the appropriate employment action, including reassignment or termination of employment, if the continuation by the employee who has AIDS virus or HIV infection of his work tasks would pose a significant risk to the health of the employee, coworkers, or the public, or if the employee is unable to perform the normally assigned duties of the job.

(j) It shall not be unlawful for a licensed health care provider or facility to:

(1) Treat a person who has AIDS virus or HIV infection differently from persons who do not have that infection when such treatment is appropriate to protect the health care provider or employees of the provider or employees of the facility while providing appropriate care for the person who has the AIDS virus or HIV infection; or

(2) Refer a person who has AIDS virus or HIV infection to another licensed health care provider or facility when such referral is for the purpose of providing more appropriate treatment for the person with AIDS virus or HIV infection.

130A-134. Reportable diseases and conditions.

The Commission shall establish by rule a list of communicable diseases and communicable conditions to be reported.

130A-141.1. Temporary order to report.

(a) The State Health Director may issue a temporary order requiring health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information when necessary to conduct a public health investigation or surveillance of an illness, condition, or symptoms that may indicate the existence of a communicable disease or condition that presents a danger to the public health. The order shall specify which health care providers must report, what information is to be reported, and the period of time for which reporting is required. The period of time for which reporting is required pursuant to a temporary order shall not exceed 90 days. The Commission may adopt rules to continue the reporting requirement when necessary to protect the public health.

(b) For the purposes of this section, the term "health care provider" has the same meaning as that term is defined in G.S. 130A-476(g).

130A-142. Immunity of persons who report.

A person who makes a report pursuant to the provisions of this Article shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of making that report.

CHAPTER 41 – HEALTH: EPIDEMIOLOGY

SUBCHAPTER 41A – COMMUNICABLE DISEASE CONTROL

SECTION .0100 – REPORTING OF COMMUNICABLE DISEASES

10A NCAC 41A .0101 REPORTABLE DISEASES AND CONDITIONS

(a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist:

(1) acquired immune deficiency syndrome (AIDS) - 24 hours;
(2) anthrax - immediately;
(3) botulism - immediately;
(4) brucellosis - 7 days;
(5) campylobacter infection - 24 hours;
(6) chancroid - 24 hours;
(7) chlamydial infection (laboratory confirmed) - 7 days;
(8) cholera - 24 hours;
(9) Creutzfeldt-Jakob disease – 7 days;
(10) cryptosporidiosis - 24 hours;
(11) cyclosporiasis - 24 hours;
(12) dengue - 7 days;
(13) diphtheria - 24 hours;
(14) Escherichia coli, shiga toxin-producing - 24 hours;
(15) ehrlichiosis - 7 days;
(16) encephalitis, arboviral - 7 days;
(17) foodborne disease, including Clostridium perfringens, staphylococcal, Bacillus cereus, and other and unknown causes - 24 hours;
(18) gonorrhea - 24 hours;
(19) granuloma inguinale - 24 hours;
(20) Haemophilus influenzae, invasive disease - 24 hours;
(21) Hantavirus infection – 7 days;
(22) Hemolytic-uremic syndrome – 24 hours;
(23) Hemorrhagic fever virus infection – immediately;
(24) hepatitis A - 24 hours;
(25) hepatitis B - 24 hours;
(26) hepatitis B carriage - 7 days;
(27) hepatitis C, acute - 7 days;
(28) human immunodeficiency virus (HIV) infection confirmed - 24 hours;
(29) influenza virus infection causing death - 24 hours;
(30) legionellosis - 7 days;
(31) leprosy – 7 days;
(32) leptospirosis - 7 days;
(33) listeriosis – 24 hours;
(34) Lyme disease - 7 days;
(35) lymphogranuloma venereum - 7 days;
(36) malaria - 7 days;
(37) measles (rubeola) - 24 hours;
(38) meningitis, pneumococcal - 7 days;

(39) meningococcal disease - 24 hours;
(40) monkeypox – 24 hours;
(41) mumps - 7 days;
(42) nongonococcal urethritis - 7 days;
(43) novel influenza virus infection – immediately;
(44) plague - immediately;
(45) paralytic poliomyelitis - 24 hours;
(46) pelvic inflammatory disease – 7 days;
(47) psittacosis - 7 days;
(48) Q fever - 7 days;
(49) rabies, human - 24 hours;
(50) Rocky Mountain spotted fever - 7 days;
(51) rubella - 24 hours;
(52) rubella congenital syndrome - 7 days;
(53) salmonellosis - 24 hours;
(54) severe acute respiratory syndrome (SARS) – 24 hours;
(55) shigellosis - 24 hours;
(56) smallpox –immediately;
(57) Staphylococcus aureus with reduced susceptibility to vancomycin – 24 hours;
(58) streptococcal infection, Group A, invasive disease - 7 days;
(59) syphilis - 24 hours;
(60) tetanus - 7 days;
(61) toxic shock syndrome - 7 days;
(62) trichinosis - 7 days;
(63) tuberculosis - 24 hours;
(64) tularemia - immediately;
(65) typhoid - 24 hours;
(66) typhoid carriage (Salmonella typhi) - 7 days;
(67) typhus, epidemic (louse-borne) - 7 days;
(68) vaccinia – 24 hours;
(69) vibrio infection (other than cholera) - 24 hours;
(70) whooping cough - 24 hours;
(71) yellow fever - 7 days.

(b) For purposes of reporting, confirmed human immunodeficiency virus (HIV) infection is defined as a positive virus culture, repeatedly reactive EIA antibody test confirmed by western blot or indirect immunofluorescent antibody test, positive nucleic acid detection (NAT) test, or other confirmed testing method approved by the Director of the State Public Health Laboratory conducted on or after February 1, 1990. In selecting additional tests for approval, the Director of the State Public Health Laboratory shall consider whether such tests have been approved by the federal Food and Drug Administration, recommended by the federal Centers for Disease Control and Prevention, and endorsed by the Association of Public Health Laboratories.

(c) In addition to the laboratory reports for Mycobacterium tuberculosis, Neisseria gonorrhoeae, and syphilis specified in G.S. 130A-139, laboratories shall report:

(1) Isolation or other specific identification of the following organisms or their products from human clinical specimens:
  (A) Any hantavirus or hemorrhagic fever virus.
  (B) Arthropod-borne virus (any type).
  (C) Bacillus anthracis, the cause of anthrax.
  (D) Bordetella pertussis, the cause of whooping cough (pertussis).
  (E) Borrelia burgdorferi, the cause of Lyme disease (confirmed tests).
  (F) Brucella spp., the causes of brucellosis.
  (G) Campylobacter spp., the causes of campylobacteriosis.
  (H) Chlamydia trachomatis, the cause of genital chlamydial infection, conjunctivitis (adult and newborn) and pneumonia of newborns.
  (I) Clostridium botulinum, a cause of botulism.
  (J) Clostridium tetani, the cause of tetanus.

(K) Corynebacterium diphtheriae, the cause of diphtheria.
(L) Coxiella burnetii, the cause of Q fever.
(M) Cryptosporidium parvum, the cause of human cryptosporidiosis.
(N) Cyclospora cayetanesis, the cause of cyclosporiasis.
(O) Ehrlichia spp., the causes of ehrlichiosis.
(P) Shiga toxin-producing Escherichia coli, a cause of hemorrhagic colitis, hemolytic uremic syndrome, and thrombotic thrombocytopenic purpura.
(Q) Francisella tularensis, the cause of tularemia.
(R) Hepatitis B virus or any component thereof, such as hepatitis B surface antigen.
(S) Human Immunodeficiency Virus, the cause of AIDS.
(T) Legionella spp., the causes of legionellosis.
(U) Leptospira spp., the causes of leptospirosis.
(V) Listeria monocytogenes, the cause of listeriosis.
(W) Monkeypox.
(X) Mycobacterium leprae, the cause of leprosy.
(Y) Plasmodium falciparum, P. malariae, P. ovale, and P. vivax, the causes of malaria in humans.
(Z) Poliovirus (any), the cause of poliomyelitis.
(AA) Rabies virus.
(BB) Rickettsia rickettsii, the cause of Rocky Mountain spotted fever.
(CC) Rubella virus.
(DD) Salmonella spp., the causes of salmonellosis.
(EE) Shigella spp., the causes of shigellosis.
(FF) Smallpox virus, the cause of smallpox.
(GG) Staphylococcus aureus with reduced susceptibility to vanomycin.
(HH) Trichinella spiralis, the cause of trichinosis.
(II) Vaccinia virus.
(JJ) Vibrio spp., the causes of cholera and other vibrioses.
(KK) Yellow fever virus.
(LL) Yersinia pestis, the cause of plague.

(2) Isolation or other specific identification of the following organisms from normally sterile human body sites:
(A) Group A Streptococcus pyogenes (group A streptococci).
(B) Haemophilus influenzae, serotype b.
(C) Neisseria meningitidis, the cause of meningococcal disease.

(3) Positive serologic test results, as specified, for the following infections:
(A) Fourfold or greater changes or equivalent changes in serum antibody titers to:
(i) Any arthropod-borne viruses associated with meningitis or encephalitis in a human.
(ii) Any hantavirus or hemorrhagic fever virus.
(iii) Chlamydia psittaci, the cause of psittacosis.
(iv) Coxiella burnetii, the cause of Q fever.
(v) Dengue virus.
(vi) Ehrlichia spp., the causes of ehrlichiosis.
(vii) Measles (rubeola) virus.
(viii) Mumps virus.
(ix) Rickettsia rickettsii, the cause of Rocky Mountain spotted fever.
(x) Rubella virus.
(xi) Yellow fever virus.
(B) The presence of IgM serum antibodies to:
(i) Chlamydia psittaci
(ii) Hepatitis A virus.
(iii) Hepatitis B virus core antigen.
(iv) Rubella virus.
(v) Rubeola (measles) virus.
(vi) Yellow fever virus.

(4) Laboratory results from tests to determine the absolute and relative counts for the T-helper (CD4) subset of lymphocytes that have a level below that specified by the Centers for Disease Control and Prevention as the criteria used to define an AIDS diagnosis.

History Note: *Authority G.S. 130A-134; 130A-135; 130A-139; 130A-141;*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
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Temporary Amendment Eff. November 1, 2003; May 16, 2003;
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Temporary Amendment Eff. January 1, 2010;
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10A NCAC 41A .0102 METHOD OF REPORTING

(a) When a report of a disease or condition is required to be made pursuant to G.S. 130A-135 through 139 and 10A NCAC 41A .0101, with the exception of laboratories, which shall proceed as in Subparagraph (d), the report shall be made to the local health director as follows:

(1) For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone, and the report required by Subparagraph (2) of this Paragraph shall be made within seven days.

(2) In addition to the requirements of Subparagraph (1) of this Paragraph, the report shall be made on the communicable disease report card or in an electronic format provided by the Division of Public Health and shall include the name and address of the patient, the name and address of the parent or guardian if the patient is a minor, and epidemiologic information.

(3) In addition to the requirements of Subparagraphs (1) and (2) of this Paragraph, forms or electronic formats provided by the Division of Public Health for collection of information necessary for disease control and documentation of clinical and epidemiologic information about the cases shall be completed and submitted for the following reportable diseases and conditions identified in 10A NCAC 41A .0101(a):

(A) acquired immune deficiency syndrome (AIDS);
(B) brucellosis;
(C) cholera;
(D) cryptosporidiosis;
(E) cyclosporiasis;
(F) E. coli 0157:H7 infection;
(G) ehrlichiosis;
(H) Haemophilus influenzae, invasive disease;
(I) Hemolytic-uremic syndrome/thrombotic thrombocytopenic purpura;
(J) hepatitis A;
(K) hepatitis B;
(L) hepatitis B carriage;
(M) hepatitis C;
(N) human immunodeficiency virus (HIV) confirmed;
(O) legionellosis;
(P) leptospirosis;
(Q) Lyme disease;
(R) malaria;

(S) measles (rubeola);
(T) meningitis, pneumococcal;
(U) meningococcal disease;
(V) mumps;
(W) paralytic poliomyelitis;
(X) psittacosis;
(Y) Rocky Mountain spotted fever;
(Z) rubella;
(AA) rubella congenital syndrome;
(BB) tetanus;
(CC) toxic shock syndrome;
(DD) trichinosis;
(EE) tuberculosis;
(FF) tularemia;
(GG) typhoid;
(HH) typhoid carriage (Salmonella typhi);
(II) vibrio infection (other than cholera); and
(JJ) whooping cough.

Communicable disease report cards, surveillance forms, and electronic formats are available from the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915, and from local health departments.

(b) Notwithstanding the time frames established in 10A NCAC 41A .0101, a restaurant or other food or drink establishment shall report all outbreaks or suspected outbreaks of foodborne illness in its customers or employees and all suspected cases of foodborne disease or foodborne condition in food-handlers at the establishment by telephone to the local health department within 24 hours in accordance with Subparagraph (a)(1) of this Rule. However, the establishment is not required to submit a report card or surveillance form pursuant to Subparagraph (a)(2) of this Rule.

(c) For the purposes of reporting by restaurants and other food or drink establishments pursuant to G.S.130A-138, the following diseases and conditions listed in 10A NCAC 41A .0101(a) shall be reported:

(1) anthrax;
(2) botulism;
(3) brucellosis;
(4) campylobacter infection;
(5) cholera;
(6) cryptosporidiosis;
(7) cyclosporiasis;
(8) E. coli 0157:H7 infection;
(9) hepatitis A;
(10) salmonellosis;
(11) shigellosis;
(12) streptococcal infection, Group A, invasive disease;
(13) trichinosis;
(14) tularemia;
(15) typhoid;
(16) typhoid carriage (Salmonella typhi); and
(17) vibrio infection (other than cholera).

(d) Laboratories required to report test results pursuant to G.S. 130A-139 and 10A NCAC 41A .0101(c) shall report as follows:

(1) The results of the specified tests for syphilis, chlamydia and gonorrhea shall be reported to the local health department by the first and fifteenth of each month. Reports of the results of the specified tests for gonorrhea, chlamydia and syphilis shall include the specimen collection date, the patient's age, race, and sex, and the submitting physician's name, address, and telephone numbers.
(2) Positive darkfield examinations for syphilis, all reactive prenatal and delivery STS titers, all reactive STS titers on infants less than one year old and STS titers of 1:8 and above shall be reported within 24 hours by telephone to the HIV/STD Prevention and Care

Branch at (919) 733-7301, or the HIV/STD Prevention and Care Branch Regional Office where the laboratory is located.

(3) With the exception of positive laboratory tests for human immunodeficiency virus, positive laboratory tests as defined in G.S. 130A-139(1) and 10A NCAC 41A .0101(c) shall be reported to the Division of Public Health electronically, by mail, by secure telefax or by telephone within the time periods specified for each reportable disease or condition in 10A NCAC 41A .0101(a). Confirmed positive laboratory tests for human immunodeficiency virus as defined in 10A NCAC 41A .0101(b) and for CD4 results defined in 10A NCAC 41A .0101(c)(4) shall be reported to the HIV/STD Prevention and Care Branch within 24 hours of obtaining reportable test results. Reports shall include as much of the following information as the laboratory possesses:
   (A) the specific name of the test performed;
   (B) the source of the specimen;
   (C) the collection date(s);
   (D) the patient's name, age, race, sex, address, and county; and
   (E) the submitting physician's name, address, and telephone number.

History Note: *Authority G.S. 130A-134; 130A-135; 130A-138; 130A-139; 130A-141;*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. October 1, 1994; February 3, 1992; December 1, 1991; May 1, 1991;
Temporary Amendment Eff. December 16, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Temporary Amendment Expired June 16, 1995;
Amended Eff. December 1, 2007; November 1, 2007; August 1, 2005, April 1, 2003; August 1, 1998.

10A NCAC 41A .0103 DUTIES OF LOCAL HEALTH DIRECTOR: REPORT COMMUNICABLE DISEASES

(a) Upon receipt of a report of a communicable disease or condition pursuant to 10A NCAC 41A .0101, the local health director shall:

(1) immediately investigate the circumstances surrounding the occurrence of the disease or condition to determine the authenticity of the report and the identity of all persons for whom control measures are required. This investigation shall include the collection and submission for laboratory examination of specimens necessary to assist in the diagnosis and indicate the duration of control measures;

(2) determine what control measures have been given and ensure that proper control measures as provided in 10A NCAC 41A .0201 have been given and are being complied with;

(3) forward the report as follows:
   (A) The local health director shall forward all authenticated reports made pursuant to G.S. 130A-135 to 137 of syphilis, chancroid, granuloma inguinale, and lymphogranuloma venereum within seven days to the regional office of the Division of Public Health. In addition, the local health director shall telephone reports of all cases of primary, secondary, and early latent (under one year's duration) syphilis to the regional office of the HIV/STD Prevention and Care Branch within 24 hours of diagnosis at the health department or report by a physician.
   (B) The local health director shall telephone all laboratory reports of reactive syphilis serologies to the regional office of the Division of Public Health within 24 hours of receipt if the person tested is pregnant. This shall also be done for all other persons tested unless the dilution is less than 1:8 and the person is known to be over 25 years of age or has been previously treated. In addition, the written reports shall be sent to the regional office of the Division of Public Health within seven days.

(C) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person residing in that jurisdiction shall forward the authenticated report to the Division of Public Health within seven days.

(D) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resides in another jurisdiction in North Carolina shall forward the report to the local health director of that jurisdiction within 24 hours. A duplicate report card marked "copy" shall be forwarded to the Division of Epidemiology within seven days.

(E) A local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resided outside of North Carolina at the time of onset of the illness shall forward the report to the Division of Public Health within 24 hours.

(b) If an outbreak exists, the local health director shall submit to the Division of Public Health within 30 days a written report of the investigation, its findings, and the actions taken to control the outbreak and prevent a recurrence.

(c) Whenever an outbreak of a disease or condition occurs which is not required to be reported by 10A NCAC 41A .0101 but which represents a significant threat to the public health, the local health director shall give appropriate control measures consistent with 10A NCAC 41A .0200, and inform the Division of Public Health of the circumstances of the outbreak within seven days.

History Note: *Authority G.S. 130A-141; 130A-144;*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. April 1, 2003; December 1, 1991; September 1, 1990.

10A NCAC 41A .0104 RELEASE OF COMMUNICABLE DISEASE RECORDS: RESEARCH PURPOSES

(a) A person may request, for bona fide research purposes, the release of records which pertain to a communicable disease or communicable condition and which identify individuals. The request shall be in writing and shall contain the following information:

(1) Name of organization requesting the data;
(2) Names of principal investigators;
(3) Name of project;
(4) Purpose of project;
(5) Description of the proposed use of the data, including protocols for contacting patients, relatives, and service providers;
(6) Descriptions of measures to protect the security of the data;
(7) An assurance that the data will not be used for purposes other than those described in the protocol;
(8) An assurance that the data will be properly disposed of upon completion of the project; and
(9) An assurance that the results of the project will be provided to the custodian of the records.

(b) The request for release of the records shall be granted or denied in writing based upon the following considerations:

(1) Whether the objectives of the project require patient identifying information;
(2) Whether the objective of the project can be reached with the use of the data;
(3) Whether the project has a reasonable chance of answering a legitimate research question;
(4) Whether the project might jeopardize the ability of the Epidemiology Division to obtain reports and information regarding communicable diseases and communicable conditions;
(5) Whether the patient's right to privacy would be adequately protected.

History Note: *Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;*
Authority G.S. 130A-143(9);
Eff. March 1, 1988;
Amended Eff. September 1, 1991.

10A NCAC 41A .0105 HOSPITAL EMERGENCY DEPARTMENT DATA REPORTING

Hospitals, as defined in G.S. 130A-480(d), shall submit electronically to the Division of Public Health the following electronically available emergency department data elements for all emergency department visits:

(1) Patient record number or other unique identification number;
(2) Patient date of birth and age;
(3) Patient's sex;
(4) City of residence;
(5) County of residence;
(6) Five digit ZIP code;
(7) Alpha numeric patient control number assigned by the hospital for each record (the Visit Identification Number);
(8) Emergency department facility identification number;
(9) Projected payor source;
(10) Date and time of emergency department visit (first documented time);
(11) Mode of transport to the emergency department;
(12) PreMIS identification number, if transported by EMS;
(13) Chief complaint;
(14) Initial temperature reading and route;
(15) Initial systolic and initial diastolic blood pressure;
(16) Triage Notes (brief description of patient's/family's self-reported illness episode, including symptoms, duration of symptoms, and reasons for visit [in addition to Chief Complaint] as presented by the patient or family to the triage nurse upon arrival at the emergency department) – this element is optional;
(17) Initial emergency department acuity assessment;
(18) Coded cause of injury (ICD-9-CM, if injury related to diagnosis);
(19) Emergency department procedures, up to ten (CPT or ICD-9-CM or ICD-10-CM);
(20) Emergency department disposition;
(21) Emergency department disposition diagnosis description; and
(22) Emergency department disposition diagnosis codes, one primary and up to ten additional (ICD-9-CM or ICD-10-CM).

History Note: *Authority G.S. 130A-480;*
Eff. January 1, 2005.

10A NCAC 41A .0106 REPORTING OF HEALTH-CARE- ASSOCIATED INFECTIONS

(a) The following definitions apply throughout this Rule:

(1) "Hospital" means any facility designated as such in G.S. 131E-76(3).
(2) "National Healthcare Safety Network" is an internet-based surveillance system managed by the Centers for Disease Control and Prevention. This system is designed to be used for the direct, standardized reporting of healthcare quality information, including health care-associated infections, by health care facilities to public health entities.
(3) "Health care-associated infection" means a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) with no evidence that the infection was present or incubating at the time of admission to the health care setting.
(4) "Electronic surveillance system" means an electronic platform which has the ability to collect, manipulate, store, analyze or transmit electronic health data which may be used for surveillance of health care-associated infections.

(5) "Denominator or summary data" refers to referent or baseline data required to generate meaningful statistics for communicating health care-associated infection rates.

(6) "The Centers for Medicare and Medicaid Services - Inpatient Prospective Payment System (CMS – IPPS) rules" are regulations promulgated for the disbursement of operating costs by the Centers for Medicare and Medicaid Services for acute care hospital stays under Medicare Part A based on prospectively set rates for care.

(b) Hospitals shall electronically report all health care-associated infections required by Paragraph (c) of this Rule through the National Healthcare Safety Network and shall make the data available to the Department. Hospitals also shall:

(1) Report all specified health care-associated infections within 30 days following the end of every calendar month during which the infection occurred;

(2) Report all required health care-associated infection denominator or summary data for healthcare-associated infections within 30 days following the end of every calendar month; and

(3) Comply with all reporting requirements for general participation in the National Healthcare Safety Network.

(c) Except as provided in rules of this Section, hospitals shall report the healthcare-associated infections required by the Centers for Medicare and Medicaid Services listed in the CMS-IPPS rules beginning on the dates specified therein. The CMS-IPPS rules are hereby incorporated by reference including subsequent amendments and editions. A current copy of the CMS-IPPS rules may be obtained through the CMS-IPPS website at http://www.cms.gov/AcuteInpatientPPS/. A copy of the current CMS-IPPS rules, applicable to this section, is available for inspection in the Division of Public Health, 225 N. McDowell Street, Raleigh NC 27601.

(d) Beginning October 1, 2012 and quarterly thereafter, the Department shall release reports to the public on health care-associated infection(s) in North Carolina.

History Note: *Authority G.S. 130A-150;*
Temporary Adoption Eff. November 30, 2011.

CHAPTER 41 – HEALTH: EPIDEMIOLOGY

SUBCHAPTER 41A – COMMUNICABLE DISEASE CONTROL

SECTION .0200 - CONTROL MEASURES FOR COMMUNICABLE DISEASES

10A NCAC 41A .0201 CONTROL MEASURES - GENERAL

(a) Except as provided in Rules of this Section, the recommendations and guidelines for testing, diagnosis, treatment, follow-up, and prevention of transmission for each disease and condition specified by the American Public Health Association in its publication, Control of Communicable Diseases Manual shall be the required control measures. Control of Communicable Diseases Manual is hereby incorporated by reference including subsequent amendments and editions. Guidelines and recommended actions published by the Centers for Disease Control and Prevention shall supercede those contained in the Control of Communicable Disease Manual and are likewise incorporated by reference, including subsequent amendments and editions. Copies of the Control of Communicable Diseases Manual may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldora, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. Copies of Centers for Disease Control and Prevention guidelines contained in the Morbidity and Mortality Weekly Report may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 for a total cost of three dollars and fifty cents ($3.50) each. Copies of both publications are available for inspection in the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915.

(b) In interpreting and implementing the specific control measures adopted in Paragraph (a) of this Rule, and in devising control measures for outbreaks designated by the State Health Director and for communicable diseases and conditions for which a specific control measure is not provided by this Rule, the following principles shall be used:

(1) control measures shall be those which can reasonably be expected to decrease the risk of transmission and which are consistent with recent scientific and public health information;
(2) for diseases or conditions transmitted by the airborne route, the control measures shall require physical isolation for the duration of infectivity;
(3) for diseases or conditions transmitted by the fecal-oral route, the control measures shall require exclusions from situations in which transmission can be reasonably expected to occur, such as work as a paid or voluntary food handler or attendance or work in a day care center for the duration of infectivity;
(4) for diseases or conditions transmitted by sexual or the blood-borne route, control measures shall require prohibition of donation of blood, tissue, organs, or semen, needle-sharing, and sexual contact in a manner likely to result in transmission for the duration of infectivity.

(c) Persons with congenital rubella syndrome, tuberculosis, and carriers of Salmonella typhi and hepatitis B who change residence to a different local health department jurisdiction shall notify the local health director in both jurisdictions.

(d) Isolation and quarantine orders for communicable diseases and communicable conditions for which control measures have been established shall require compliance with applicable control measures and shall state penalties for failure to comply. These isolation and quarantine orders may be no more restrictive than the applicable control measures.

(e) An individual enrolled in an epidemiologic or clinical study shall not be required to meet the provisions of 10A NCAC 41A .0201 - .0209 which conflict with the study protocol if:
(1) the protocol is approved for this purpose by the State Health Director because of the scientific and public health value of the study, and
(2) the individual fully participates in and completes the study.

(f) A determination of significant risk of transmission under this Subchapter shall be made only after consideration of the following factors, if known:
(1) The type of body fluid or tissue;
(2) The volume of body fluid or tissue;
(3) The concentration of pathogen;
(4) The virulence of the pathogen; and
(5) The type of exposure, ranging from intact skin to non-intact skin, or mucous membrane.

(g) The term "household contacts" as used in this Subchapter means any person residing in the same domicile as the infected person.

History Note: *Authority G.S. 130A-135; 130A-144;*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. February 1, 1990; November 1, 1989; August 1, 1988;
Recodified Paragraphs (d), (e) to Rule .0202; Paragraph (i) to Rule .0203 Eff. June 11, 1991;
Amended Eff. April 1, 2003; October 1, 1992; December 1, 1991; August 1, 1998;
Emergency Amendment Eff. January 24, 2005;
Emergency Amendment Expired on April 16, 2005.

10A NCAC 41A .0202 CONTROL MEASURES – HIV

The following are the control measures for the Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection:
(1) Infected persons shall:
(a) refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure;
(b) not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;

(c) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;
(d) have a skin test for tuberculosis;
(e) notify future sexual intercourse partners of the infection;
(f) if the time of initial infection is known, notify persons who have been sexual intercourse and needle partners since the date of infection; and,
(g) if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

(2) The attending physician shall:
(a) give the control measures in Item (1) of this Rule to infected patients, in accordance with 10A NCAC 41A .0210;
(b) If the attending physician knows the identity of the spouse of an HIV-infected patient and has not, with the consent of the infected patient, notified and counseled the spouse, the physician shall list the spouse on a form provided by the Division of Public Health and shall mail the form to the Division. The Division shall undertake to counsel the spouse. The attending physician's responsibility to notify exposed and potentially exposed persons is satisfied by fulfilling the requirements of Sub-Items (2)(a) and (b) of this Rule;
(c) advise infected persons concerning clean-up of blood and other body fluids;
(d) advise infected persons concerning the risk of perinatal transmission and transmission by breastfeeding.

(3) The attending physician of a child who is infected with HIV and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the following circumstances:
(a) If the child is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child's parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee.
(i) If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee.
(ii) If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.
(b) If the child is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:
(i) notify the parents;
(ii) notify the committee;
(iii) assist the committee in determining whether an adjustment can be made to the student's school program to eliminate significant risks of transmission;
(iv) determine if an alternative educational setting is necessary to protect the public health;
(v) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by school personnel; and
(vi) consult with the superintendent or private school director to determine which school personnel directly involved with the child need to be notified of the HIV infection in order to prevent transmission and

ensure that these persons are instructed regarding the necessity for protecting confidentiality.

(c) If the child is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.

(4) When health care workers or other persons have a needlestick or nonsexual non-intact skin or mucous membrane exposure to blood or body fluids that, if the source were infected with HIV, would pose a significant risk of HIV transmission, the following shall apply:

(a) When the source person is known:

(i) The attending physician or occupational health care provider responsible for the exposed person, if other than the attending physician of the person whose blood or body fluids is the source of the exposure, shall notify the attending physician of the source that an exposure has occurred. The attending physician of the source person shall discuss the exposure with the source and, unless the source is already known to be infected, shall test the source for HIV infection without consent unless it reasonably appears that the test cannot be performed without endangering the safety of the source person or the person administering the test. If the source person cannot be tested, an existing specimen, if one exists, shall be tested. The attending physician of the exposed person shall be notified of the infection status of the source.

(ii) The attending physician of the exposed person shall inform the exposed person about the infection status of the source, offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred, and, if the source person was HIV infected, give the exposed person the control measures listed in Sub-Items (1)(a) through (c) of this Rule. The attending physician of the exposed person shall instruct the exposed person regarding the necessity for protecting confidentiality.

(b) When the source person is unknown, the attending physician of the exposed persons shall inform the exposed person of the risk of transmission and offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred.

(c) A health care facility may release the name of the attending physician of a source person upon request of the attending physician of an exposed person.

(5) The attending physician shall notify the local health director when the physician, in good faith, has reasonable cause to suspect a patient infected with HIV is not following or cannot follow control measures and is thereby causing a significant risk of transmission. Any other person may notify the local health director when the person, in good faith, has reasonable cause to suspect a person infected with HIV is not following control measures and is thereby causing a significant risk of transmission.

(6) When the local health director is notified pursuant to Item (5) of this Rule, of a person who is mentally ill or mentally retarded, the local health director shall confer with the attending mental health physician or mental health authority and the physician, if any, who notified the local health director to develop a plan to prevent transmission.

(7) The Division of Public Health shall notify the Director of Health Services of the North Carolina Department of Correction and the prison facility administrator when any person confined in a state prison is determined to be infected with HIV. If the prison facility administrator, in consultation with the Director of Health Services, determines that a confined HIV infected person is not following or cannot follow prescribed control measures, thereby presenting a significant risk of HIV transmission, the administrator and the Director shall develop and implement jointly a plan to prevent transmission, including making recommendations to the unit housing classification committee.

(8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.

(9) Local health departments shall provide counseling and testing for HIV infection at no charge to the patient. Third party payors may be billed for HIV counseling and testing when such services are provided and the patient provides written consent.

(10) HIV pre-test counseling is not required. Post-test counseling for persons infected with HIV is required, must be individualized, and shall include referrals for medical and psychosocial services and control measures.

(11) A local health department or the Department may release information regarding an infected person pursuant to G.S. 130A-143(3) only when the local health department or the Department has provided direct medical care to the infected person and refers the person to or consults with the health care provider to whom the information is released.

(12) Notwithstanding Rule .0201(d) of this Section, a local or state health director may require, as a part of an isolation order issued in accordance with G.S. 130A-145, compliance with a plan to assist the individual to comply with control measures. The plan shall be designed to meet the specific needs of the individual and may include one or more of the following available and appropriate services:

(a) substance abuse counseling and treatment;

(b) mental health counseling and treatment; and

(c) education and counseling sessions about HIV, HIV transmission, and behavior change required to prevent transmission.

(13) The Division of Public Health shall conduct a partner notification program to assist in the notification and counseling of partners of HIV infected persons.

(14) Every pregnant woman shall be offered HIV testing by her attending physician at her first prenatal visit and in the third trimester. The attending physician shall test the pregnant woman for HIV infection, unless the pregnant woman refuses to provide informed consent pursuant to G.S. 130A-148(h). If there is no record at labor and delivery of an HIV test result during the current pregnancy for the pregnant woman, the attending physician shall inform the pregnant woman that an HIV test will be performed, explain the reasons for testing, and the woman shall be tested for HIV without consent using a rapid HIV test unless it reasonably appears that the test cannot be performed without endangering the safety of the pregnant woman or the person administering the test. If the pregnant woman cannot be tested, an existing specimen, if one exists that was collected within the last 24 hours, shall be tested using a rapid HIV test. The attending physician must provide the woman with the test results as soon as possible. However, labor and delivery providers who do not currently have the capacity to perform rapid HIV testing are not required to use a rapid HIV test until January 1, 2009.

(15) If an infant is delivered by a woman with no record of the result of an HIV test conducted during the pregnancy and if the woman was not tested for HIV during labor and delivery, the fact that the mother has not been tested creates a reasonable suspicion pursuant to G.S. 130A-148(h) that the newborn has HIV infection and the infant shall be tested for HIV. An infant born in the previous 12 hours shall be tested using a rapid HIV test. However, providers who do not currently have the capacity to perform rapid HIV testing shall not be required to use a rapid HIV test until January 1, 2009.

(16) Testing for HIV may be offered as part of routine laboratory testing panels using a general consent which is obtained from the patient for treatment and routine laboratory testing, so long as the patient is notified that they are being tested for HIV and given the opportunity to refuse.

History Note: *Authority G.S. 130A-135; 130A-144; 130A-145; 130A-148(h);*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. February 1, 1990; November 1, 1989; June 1, 1989;

Temporary Amendment Eff. January 7, 1991 for a period of 180 days to expire on July 6, 1991;
Amended Eff. May 1, 1991;
Recodified from 15A NCAC 19A .0201 (d) and (e) Eff. June 11, 1991;
Amended Eff. August 1, 1995; October 1, 1994; January 4, 1994; October 1, 1992;
Temporary Amendment Eff. February 18, 2002; June 1, 2001;
Amended Eff. November 1, 2007; April 1, 2005; April 1, 2003.

10A NCAC 41A .0203 CONTROL MEASURES - HEPATITIS B

(a) The following are the control measures for hepatitis B infection. The infected persons shall:

(1) refrain from sexual intercourse unless condoms are used except when the partner is known to be infected with or immune to hepatitis B;

(2) not share needles or syringes;

(3) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;

(4) if the time of initial infection is known, identify to the local health director all sexual intercourse and needle partners since the date of infection; and, if the date of initial infection is unknown, identify persons who have been sexual intercourse or needle partners during the previous six months;

(5) for the duration of the infection, notify future sexual intercourse partners of the infection and refer them to their attending physician or the local health director for control measures; and for the duration of the infection, notify the local health director of all new sexual intercourse partners;

(6) identify to the local health director all current household contacts;

(7) be tested six months after diagnosis to determine if they are chronic carriers, and when necessary to determine appropriate control measures for persons exposed pursuant to Paragraph (b) of this Rule;

(8) comply with all control measures for hepatitis B infection specified in Paragraph (a) of 10A NCAC 41A .0201, in those instances where such control measures do not conflict with other requirements of this Rule.

(b) The following are the control measures for persons reasonably suspected of being exposed:

(1) when a person has had a sexual intercourse exposure to hepatitis B infection, the person shall be tested;

(2) after testing, when a susceptible person has had sexual intercourse exposure to hepatitis B infection, the person shall be given a dose appropriate for body weight of hepatitis B immune globulin and hepatitis B vaccination as soon as possible; hepatitis B immune globulin shall be given no later than two weeks after the last exposure;

(3) when a person is a household contact, sexual intercourse or needle sharing contact of a person who has remained infected with hepatitis B for six months or longer, the partner or household contact, if susceptible and at risk of continued exposure, shall be vaccinated against hepatitis B;

(4) when a health care worker or other person has a needlestick, non-intact skin, or mucous membrane exposure to blood or body fluids that, if the source were infected with the hepatitis B virus, would pose a significant risk of hepatitis B transmission, the following shall apply:

(A) when the source is known, the source person shall be tested for hepatitis B infection, unless already known to be infected;

(B) when the source is infected with hepatitis B and the exposed person is:

(i) vaccinated, the exposed person shall be tested for anti-HBs and, if anti-HBs is unknown or less than 10 milli-International Units per ml, receive hepatitis B vaccination and hepatitis B immune globulin as soon as possible; hepatitis B immune globulin shall be given no later than seven days after exposure;

(ii) not vaccinated, the exposed person shall be given a dose appropriate for body weight of hepatitis B immune globulin immediately and begin vaccination with hepatitis B vaccine within seven days;

(C) when the source is unknown, the determination of whether hepatitis B immunization is required shall be made in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention guidelines. Copies of the Control of Communicable Diseases Manual may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldora, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. Copies of Center for Disease Control and Prevention guidelines contained in the Morbidity and Mortality Weekly Report may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 for a cost of three dollars fifty cents ($3.50) each. Copies of both publications are available for inspection in the General Communicable Disease Control Branch, Cooper Memorial Health Building, 225 N. McDowell Street, Raleigh, North Carolina 27603-1382.

(5) infants born to HBsAg-positive mothers shall be given hepatitis B vaccination and hepatitis B immune globulin within 12 hours of birth or as soon as possible after the infant is stabilized. Additional doses of hepatitis B vaccine shall be given in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention Guidelines. The infant shall be tested for the presence of HBsAg and anti-HBs within three to nine months after the last dose of the regular series of vaccine; if required because of failure to develop immunity after the regular series, additional doses shall be given in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention guidelines. Copies of the Control of Communicable Diseases Manual may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldora, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. Copies of Center for Disease Control and Prevention guidelines contained in the Morbidity and Mortality Weekly Report may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 for a cost of three dollars fifty cents ($3.50) each. Copies of both publications are available for inspection in the General Communicable Disease Control Branch, Cooper Memorial Health Building, 225 N. McDowell Street, Raleigh, North Carolina 27603-1382;

(6) infants born to mothers whose HBsAg status is unknown shall be given hepatitis B vaccine within 12 hours of birth and the mother tested. If the tested mother is found to be HBsAg-positive, the infant shall be given hepatitis B immune globulin as soon as possible and no later than seven days after birth;

(7) when an acutely infected person is a primary caregiver of a susceptible infant less than 12 months of age, the infant shall receive an appropriate dose of hepatitis B immune globulin and hepatitis vaccinations in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention Guidelines. Copies of the Control of Communicable Diseases Manual may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldora, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. Copies of Center for Disease Control and Prevention guidelines contained in the Morbidity and Mortality Weekly Report may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 for a cost of three dollars fifty cents ($3.50) each. Copies of both publications are available for inspection in the General Communicable Disease Control Branch, Cooper Memorial Health Building, 225 N. McDowell Street, Raleigh, North Carolina 27603-1382.

(c) The attending physician shall advise all patients known to be at high risk, including injection drug users, men who have sex with men, hemodialysis patients, and patients who receive multiple transfusions of blood products, that they should be vaccinated against hepatitis B if susceptible. The attending physician shall also recommend that hepatitis B chronic carriers receive hepatitis A vaccine (if susceptible).

(d) The following persons shall be tested for and reported in accordance with 10A NCAC 41A .0101 if positive for hepatitis B infection:

(1) pregnant women unless known to be infected; and

(2) donors of blood, plasma, platelets, other blood products, semen, ova, tissues, or organs.

(e) The attending physician of a child who is infected with hepatitis B virus and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the circumstances.

(f) If the child referred to in Paragraph (e) of this Rule is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child's parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee. If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee. If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.

(g) If the child referred to in Paragraph (e) of this Rule is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:

(1) notify the parents;

(2) notify the committee;

(3) assist the committee in determining whether an adjustment can be made to the student's school program to eliminate significant risks of transmission;

(4) determine if an alternative educational setting is necessary to protect the public health;

(5) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by school personnel; and

(6) consult with the superintendent or private school director to determine which school personnel directly involved with the child need to be notified of the hepatitis B virus infection in order to prevent transmission and ensure that these persons are instructed regarding the necessity for protecting confidentiality.

(h) If the child referred to in Paragraph (e) of this Rule is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.

History Note: *Authority G.S. 130A-135; 130A-144*
Eff. February 1, 1990;
Amended Eff. October 1, 1990;
Recodified from 15A NCAC 19A .0201(i) Eff. June 11, 1991;
Amended Eff. August 1, 1998; October 1, 1994;
Temporary Amendment Eff. February 18, 2002;
Amended Eff. April 1, 2003.

10A NCAC 41A .0204 CONTROL MEASURES - SEXUALLY TRANSMITTED DISEASES

(a) Local health departments shall provide diagnosis, testing, treatment, follow-up, and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale. These services shall be provided upon request and at no charge to the patient.

(b) Persons infected with, exposed to, or reasonably suspected of being infected with gonorrhea, chlamydia, non-gonococcal urethritis, and mucopurulent cervicitis shall:

(1) Refrain from sexual intercourse until examined and diagnosed and treatment is completed, and all lesions are healed;

(2) Be tested, treated, and re-evaluated in accordance with the STD Treatment Guidelines published by the U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required control measures for testing, treatment, and

follow-up for gonorrhea, chlamydia, nongonococcal urethritis, and mucopurulent cervicitis, and are incorporated by reference including subsequent amendments and editions. A copy of this publication is on file for public viewing with the and a copy may be obtained free of charge by writing the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915, and requesting a copy. However, urethral Gram stains may be used for diagnosis of males rather than gonorrhea cultures unless treatment has failed;

(3) Notify all sexual partners from 30 days before the onset of symptoms to completion of therapy that they must be evaluated by a physician or local health department.

(c) Persons infected with, exposed to, or reasonably suspected of being infected with syphilis, lymphogranuloma venereum, granuloma inguinale, and chancroid shall:

(1) Refrain from sexual intercourse until examined and diagnosed and treatment is completed, and all lesions are healed;

(2) Be tested, treated, and re-evaluated in accordance with the STD Treatment Guidelines published by t h e U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required control measures for testing, treatment, and follow-up for syphilis, lymphogranuloma venereum, granuloma inguinale, and chancroid, except that chancroid cultures are not required;

(3) Give names to a disease intervention specialist employed by the local health department or by the Division of Public Health for contact tracing of all sexual partners and others as listed in this Rule:

(A) for syphilis:

(i) congenital - parents and siblings;

(ii) primary - all partners from three months before the onset of symptoms to completion of therapy and healing of lesions;

(iii) secondary - all partners from six months before the onset of symptoms to completion of therapy and healing of lesions; and

(iv) latent - all partners from 12 months before the onset of symptoms to completion of therapy and healing of lesions and, in addition, for women with late latent, spouses and children;

(B) for lymphogranuloma venereum:

(i) if there is a primary lesion and no buboes, all partners from 30 days before the onset of symptoms to completion of therapy and healing of lesions; and

(ii) if there are buboes all partners from six months before the onset of symptoms to completion of therapy and healing of lesions;

(C) for granuloma inguinale - all partners from three months before the onset of symptoms to completion of therapy and healing of lesions; and

(D) or chancroid - all partners from ten days before the onset of symptoms to completion of therapy and healing of lesions.

(d) All persons evaluated or reasonably suspected of being infected with any sexually transmitted disease shall be tested for syphilis, encouraged to be tested confidentially for HIV, and counseled about how to reduce the risk of acquiring sexually transmitted disease, including the use of condoms.

(e) All pregnant women shall be tested for syphilis, chlamydia and gonorrhea at the first prenatal visit. All pregnant women shall be tested for syphilis between 28 and 30 weeks of gestation and at delivery. Hospitals shall determine the syphilis serologic status of the mother prior to discharge of the newborn so that if necessary the newborn can be evaluated and treated as provided in (c)(2) of this rule. Pregnant women 25 years of age and younger shall be tested for chlamydia and gonorrhea in the third trimester or at delivery if the woman was not tested in the third trimester.

(f) Any woman who delivers a stillborn infant shall be tested for syphilis.

(g) All newborn infants shall be treated prophylactically against gonococcal ophthalmia neonatorum in accordance with the STD Treatment Guidelines published by the U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required prophylactic treatment against gonococcal ophthalmia neonatorum.

History Note: Authority G. S. 130A-135; 130A-144;

Eff. December 1, 1991;
Amended Eff. April 1, 2008; November 1, 2007; April 1, 2003; July 1, 1993.

10A NCAC 41A .0205 CONTROL MEASURES – TUBERCULOSIS

(a) The local health director shall investigate all cases of tuberculosis disease and their contacts in accordance with the provisions of the Control of Communicable Diseases Manual which is hereby incorporated by reference including subsequent amendments and editions. Copies of this publication may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldorf, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. A copy is available for inspection in the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931.

(b) The following persons shall be skin tested for tuberculosis and given appropriate clinical, microbiologic and x-ray examination in accordance with the "Diagnostic Standards and Classification of Tuberculosis in Adults and Children," published by the American Thoracic Society. The recommendations contained in this reference shall be the required control measures for evaluation, testing, and diagnosis for tuberculosis patients, contacts and suspects, except as otherwise provided in this Rule and are incorporated by reference including subsequent amendments and editions:

(1) Household and other high priority contacts of active cases of pulmonary and laryngeal tuberculosis. For purposes of this Rule, a high priority contact is defined in accordance with Centers for Disease Control and Prevention guidelines which are incorporated by reference in Rule .0201 of this Section. If the contact's initial skin test is negative (0-4mm), and the case is confirmed by culture, a repeat skin test shall be performed 8 to 10 weeks after the exposure has ended;

(2) Persons reasonably suspected of having tuberculosis disease;

(3) Inmates in the custody of, and staff with direct inmate contact in, the Department of Corrections upon incarceration or employment, and annually thereafter;

(4) Patients and staff in long term care facilities upon admission or employment. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months;

(5) Staff in adult day care centers providing care for persons with HIV infection or AIDS upon employment. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months; and

(6) Persons with HIV infection or AIDS.

A copy of "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" is available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website at http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/Maj_guide/cdc_ats_guidelines.htm.

(c) Treatment and follow-up for tuberculosis infection or disease shall be in accordance with "Treatment of Tuberculosis," published by the American Thoracic Society. The recommendations contained in this reference shall be the required control measures for testing, treatment, and follow-up for tuberculosis patients, contacts and suspects, except as otherwise provided in this Rule and are incorporated by reference including subsequent amendments and editions. Copies of this publication are available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website at http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/Maj_guide/cdc_ats_guidelines.htm.

(d) The attending physician or designee shall instruct all patients treated for tuberculosis regarding the potential side effects of the medications prescribed and prescribed medications, including instructions to promptly notify the physician or designee if side effects occur.

(e) Persons with active tuberculosis disease shall complete a standard multi-drug regimen, unless otherwise approved by the State Tuberculosis Medical Director or designee, and shall be managed using Directly Observed Therapy (DOT), which is the actual observation of medication ingestion by a health care worker (HCW).

(f) Persons with suspected or known active pulmonary or laryngeal tuberculosis who have sputum smears positive for acid fast bacilli are considered infectious and shall be managed using airborne precautions, including respiratory isolation, or isolation in their home, with no new persons exposed. These individuals

are considered noninfectious and use of airborne precautions, including respiratory isolation or isolation in their home, may be discontinued when:

(1) They have two consecutive sputum smears collected at least eight hours apart which are negative; and

(2) They have been compliant on tuberculosis medications to which the organism is judged to be susceptible and there is evidence of clinical response to tuberculosis treatment.

(g) Persons with suspected or known active pulmonary or laryngeal tuberculosis who are initially sputum smear negative do not require respiratory isolation once they have been started on tuberculosis treatment.

History Note: *Authority G.S. 130A-135; 130A-144;*
Eff. March 1, 1992;
Amended Eff. April 1, 2006; April 1, 2003; August 1, 1998; October 1, 1994;
Temporary Amendment Eff. August 1, 2011.

10A NCAC 41A .0206 INFECTION PREVENTION – HEALTH CARE SETTINGS

(a) The following definitions apply throughout this Rule:

(1) "Health care organization" means a hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home care agency; nursing home; local health department; community health center; mental health facility; hospice; ambulatory surgical facility; urgent care center; emergency room; Emergency Medical Service (EMS) agency; pharmacies where a health practitioner offers clinical services; or any other organization that provides clinical care.

(2) "Invasive procedure" means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(3) "Non-contiguous" means not physically connected.

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens. The health care organization shall designate one on-site staff member for each noncontiguous facility to direct these activities. The designated staff member in each health care facility shall complete a course in infection control approved by the Department. The Department shall approve a course that addresses:

(1) Epidemiologic principles of infectious disease;

(2) Principles and practice of asepsis;

(3) Sterilization, disinfection, and sanitation;

(4) Universal blood and body fluid precautions;

(5) Safe injection practices;

(6) Engineering controls to reduce the risk of sharp injuries;

(7) Disposal of sharps; and

(8) Techniques that reduce the risk of sharp injuries to health care workers.

(c) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens:

(1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;

(2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;

(3) Accessibility of infection control devices and supplies; and

(4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

(d) Health care workers and emergency responders shall, with all patients, follow Centers for Disease Control and Prevention Guidelines on blood and body fluid precautions incorporated by reference in 10A NCAC 41A .0201.
(e) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.
(f) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 15A NCAC 13B .1200 after use or sterilized prior to reuse.

History Note: *Authority G.S. 130A-144; 130A-145; 130A-147;*
Eff. October 1, 1992;
Amended Eff. January 1, 2010; December 1, 2003; July 1, 1994; January 4, 1994.

10A NCAC 41A .0207 HIV AND HEPATITIS B INFECTED HEALTH CARE WORKERS
(a) The following definitions shall apply throughout this Rule:
(1) "Surgical or obstetrical procedures" means vaginal deliveries or surgical entry into tissues, cavities, or organs. The term does not include phlebotomy; administration of intramuscular, intradermal, or subcutaneous injections; needle biopsies; needle aspirations; lumbar punctures; angiographic procedures; endoscopic and bronchoscopic procedures; or placing or maintaining peripheral or central intravascular lines.
(2) "Dental procedure" means any dental procedure involving manipulation, cutting, or removal of oral or perioral tissues, including tooth structure during which bleeding occurs or the potential for bleeding exists. The term does not include the brushing of teeth.
(b) All health care workers who perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902..
(c) The State Health Director shall investigate the practice of any infected health care worker and the risk of transmission to patients. The investigation may include review of medical and work records and consultation with health care professionals who may have information necessary to evaluate the clinical condition or practice of the infected health care worker. The attending physician of the infected health care worker shall be consulted. The State Health Director shall protect the confidentiality of the infected health care worker and may disclose the worker's infection status only when essential to the conduct of the investigation or periodic reviews pursuant to Paragraph (h) of this Rule. When the health care worker's infection status is disclosed, the State Health Director shall give instructions regarding the requirement for protecting confidentiality.
(d) If the State Health Director determines that there may be a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel to evaluate the risk of transmission to patients, and review the practice, skills, and clinical condition of the infected health care worker, as well as the nature of the surgical or obstetrical procedures or dental procedures performed and operative and infection control techniques used. Each expert panel shall include an infectious disease specialist, an infection control expert, a person who practices the same occupational specialty as the infected health care worker and, if the health care worker is a licensed professional, a representative of the appropriate licensure board. The panel may include other experts. The State Health Director shall consider for appointment recommendations from health care organizations and local societies of health care professionals.
(e) The expert panel shall review information collected by the State Health Director and may request that the State Health Director obtain additional information as needed. The State Health Director shall not reveal to the panel the identity of the infected health care worker. The infected health care worker and the health care worker's attending physician shall be given an opportunity to present information to the panel. The panel shall make recommendations to the State Health Director that address the following:
(1) Restrictions that are necessary to prevent transmission from the infected health care worker to patients;

(2) Identification of patients that have been exposed to a significant risk of transmission of HIV or hepatitis B; and

(3) Periodic review of the clinical condition and practice of the infected health care worker.

(f) If, prior to receipt of the recommendations of the expert panel, the State Health Director determines that immediate practice restrictions are necessary to prevent an imminent threat to the public health, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require cessation or modification of some or all surgical or obstetrical procedures or dental procedures to the extent necessary to prevent an imminent threat to the public health. This isolation order shall remain in effect until an isolation order is issued pursuant to Paragraph (g) of this Rule or until the State Health Director determines the imminent threat to the public health no longer exists.

(g) After consideration of the recommendations of the expert panel, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require any health care worker who is allowed to continue performing surgical or obstetrical procedures or dental procedures to, within a time period specified by the State Health Director, successfully complete a course in infection control procedures approved by the Department of Health and Human Services, General Communicable Disease Control Branch, in accordance with 10A NCAC 41A .0206(e). The isolation order shall require practice restrictions, such as cessation or modification of some or all surgical or obstetrical procedures or dental procedures, to the extent necessary to prevent a significant risk of transmission of HIV or hepatitis B to patients. The isolation order shall prohibit the performance of procedures that cannot be modified to avoid a significant risk of transmission. If the State Health Director determines that there has been a significant risk of transmission of HIV or hepatitis B to a patient, the State Health Director shall notify the patient or assist the health care worker to notify the patient.

(h) The State Health Director shall request the assistance of one or more health care professionals to obtain information needed to periodically review the clinical condition and practice of the infected health care worker who performs or assists in surgical or obstetrical procedures or dental procedures.

(i) An infected health care worker who has been evaluated by the State Health Director shall notify the State Health Director prior to a change in practice involving surgical or obstetrical procedures or dental procedures. The infected health care worker shall not make the proposed change without approval from the State Health Director. If the State Health Director makes a determination in accordance with Paragraph (c) of this Rule that there is a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel in accordance with Paragraph (d) of this Rule. Otherwise, the State Health Director shall notify the health care worker that he or she may make the proposed change in practice.

(j) If practice restrictions are imposed on a licensed health care worker, a copy of the isolation order shall be provided to the appropriate licensure board. The State Health Director shall report violations of the isolation order to the appropriate licensure board. The licensure board shall report to the State Health Director any information about the infected health care worker that may be relevant to the risk of transmission of HIV or hepatitis B to patients.

History Note: *Authority G.S. 130A-144; 130A-145;*
Eff. October 1, 1992;
Amended Eff. April 1, 2003.

10A NCAC 41A .0208 CONTROL MEASURES -- SMALLPOX; VACCINIA DISEASE

(a) Guidelines and recommended actions for prevention of the spread of smallpox and for prevention of the spread of vaccinia published by the Center for Disease Control and Prevention (CDC) shall supercede those contained in the control of Communicable Disease Manual and are incorporated by reference, including subsequent amendments and editions. Copies of CDC guidelines contained in the Morbidity and Mortality weekly reports may be purchased from the Superintendent of Documents, US Government Printing Office, Washington DC 20402 for a total cost of three dollars and fifty cents ($3.50) each.

(b) The attending physician of a person vaccinated against smallpox shall report to the local health department the existence of any of the following:

(1) autoinnoculation;

(2) generalized vaccinia;

(3) eczema vaccinatum;

(4) progressive vaccinia; and

(5) post vaccination encephalitis.

The attending physician shall make the report to the local health department within 24 hours. The local health department shall notify the Division of Public Health within 24 hours.

(c) The physician responsible for vaccinating a person against smallpox and the physician diagnosing a person with vaccinia disease shall instruct the patient to follow CDC guidelines for the prevention of the spread of vaccinia adopted by reference in Paragraph (a) of this Rule. The patient shall follow these guidelines.

(d) The State Health Director or a local health director may use isolation authority pursuant to G.S. 130A-145 when necessary to prevent the spread of smallpox or vaccinia virus.

History Note: *Authority G.S. 130A-144;*
Temporary Adoption Eff. February 13, 2003;
Eff. August 1, 2004.

10A NCAC 41A .0209 LABORATORY TESTING

All laboratories shall do the following:

(1) When Neisseria meningitidis is isolated from a normally sterile site, test the organism for specific serogroup or send the isolate to the State Laboratory of Public Health for serogrouping;

(2) When a stool culture is requested on a specimen from a person with bloody diarrhea, culture the stool for shiga-toxin producing Escherichia coli or send the specimen to the State Laboratory of Public Health;

(3) When Haemophilus influenzae is isolated, test the organism for specific serogroup or send the isolate to the State Laboratory of Public Health for serogrouping; and

(4) When Mycobacterium tuberculosis complex is isolated, test the organism for specific restriction fragment length polymorphism (RFLP) or send the isolate, or a subculture of the isolate, to the State Laboratory of Public Health for genotyping.

History Note: *Authority G.S. 130A-139;*
Eff. October 1, 1994;
Temporary Amendment Eff. February 18, 2002;
Amended Eff. April 1, 2004; April 1, 2003.

10A NCAC 41A .0210 DUTIES OF ATTENDING PHYSICIANS

Immediately upon making a diagnosis of or reasonably suspecting a communicable disease or communicable condition for which control measures are provided in Rule .0201, .0202 or .0203 of this Section, the attending physician shall instruct the patient and any other person specified in those control measures to carry out those control measures and shall give sufficiently detailed instructions for proper compliance, or the physician shall request the local health director to give such instruction. When making the initial telephone report for diseases and conditions required to be reported within 24 hours, the physician shall inform the local health director of the control measures given.

History Note: *Filed as a Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;*
Authority G.S. 130A-144;
Eff. March 1, 1988;
Recodified from 15A NCAC 19A .0202 Eff. June 11, 1991.

10A NCAC 41A .0211 DUTIES OF OTHER PERSONS

(a) The local health director may reveal the identity and diagnosis of a person with a reportable communicable disease or communicable condition or other communicable disease or communicable condition which represents a significant threat to the public health to those persons specified in Paragraph (b) when disclosure is necessary to prevent transmission in the facility or establishment for which they are responsible. The local health director shall ensure that all persons so notified are instructed regarding the necessity for protecting confidentiality.

(b) The following persons shall require that any person about whom they are notified pursuant to Paragraph (a) comply with control measures given by the local health director to prevent transmission in the facility or establishment:

(1) the principal of any private or public school;
(2) employers;
(3) superintendents or directors of all public or private institutions, hospitals, or jails; and
(4) operators of a child day care center, child day care home, or other child care providers.

(c) The provisions of Paragraphs (a) and (b) shall not apply with regard to gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, chlamydia, non-gonococcal urethritis, AIDS, and HIV infection. However, persons may be notified with regard to these diseases and conditions in accordance with 10A NCAC 41A .0201, .0202 or .0203 of this Section.

History Note: *Filed as a Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;*
Authority G.S. 130A-143; 130A-144;
Eff. March 1, 1988;
Amended Eff. June 1, 1989;
Recodified from 15A NCAC 19A .0203 Eff. June 11, 1991.

10A NCAC 41A .0212 HANDLING AND TRANSPORTATION OF BODIES

(a) It shall be the duty of the physician attending any person who dies and is known to be infected with HIV, plague, or hepatitis B or any person who dies and is known or reasonably suspected to be infected with smallpox, rabies, severe acute respiratory syndrome (SARS), or Jakob-Creutzfeldt to provide written notification to all individuals handling the body of the proper precautions to prevent infection. This written notification shall be provided to funeral service personnel at the time the body is removed from any hospital, nursing home, or other health care facility. When the patient dies in a location other than a health care facility, the attending physician shall notify the funeral service personnel verbally of the precautions required as soon as the physician becomes aware of the death. These precautions are noted in Paragraphs (b) and (c).

(b) The body of any person who died and is known or reasonably suspected to be infected with smallpox or severe acute respiratory syndrome (SARS) or any person who died and is known to be infected with plague shall not be embalmed. The body shall be enclosed in a strong, tightly sealed outer case which will prevent leakage or escape of odors as soon as possible after death and before the body is removed from the hospital room, home, building, or other premises where the death occurred. This case shall not be reopened except with the consent of the local health director. Nothing in this Paragraph shall prohibit cremation.

(c) Persons handling the body of any person who died and is known to be infected with HIV or hepatitis B or any person who died and is known or reasonably suspected to be infected with Jakob-Creutzfeldt or rabies shall be provided written notification to observe blood and body fluid precautions.

History Note: *Authority G.S. 130A-144; 130A-146;*
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Eff. March 1, 1988; Recodified from 15A NCAC 19A .0204 Eff. June 11, 1991;
Temporary Amendment Eff. November 1, 2003;
Amended Eff. April 1, 2004.

10A NCAC 41A .0213 CONTROL MEASURES -- SARS

Guidelines and recommended actions for prevention of the spread of Severe Acute Respiratory Syndrome (SARS) published by the Centers for Disease Control and Prevention (CDC) shall be the required control measures for SARS and are incorporated by reference, including subsequent amendments and editions. Copies of CDC guidelines contained in the Morbidity and Mortality weekly reports may be purchased from the Superintendent of Documents, US Government Printing Office, Washington DC 20402 for a total cost of three dollars and fifty cents ($3.50) each.