IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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MEMORANDUM

Date: May 13, 2024

TO: Hospital Infection Preventionist, Local Health Departments, Laboratories and Healthcare Providers

FROM: Communicable Disease Section

RE: Amended Communicable Disease Code

77 Ill. Administrative Code, Part 690 Control of Notifiable Diseases and Conditions Code was amended effective February 27, 2024. The code defines what diseases and conditions are reportable to public health and the timeframes and methods in which they should be submitted, in addition to general reporting requirements. The purpose of this memo is to highlight some of the changes, especially as they relate to reporting of communicable diseases. As you may notice, the name was changed from Communicable Diseases to Notifiable Diseases to align with the language used by the CDC and most other states, as well as to allow for reporting of conditions of public health concern that may not be communicable.

The other major change was in the **timeframe for reporting Class II diseases**. It has been changed from as soon as possible but within seven days to as soon as possible but within three days (see Section 690.100). Measles was changed to a Class 1a disease reportable immediately with the Section renamed to "Measles, Suspect, Probable or Confirmed (Reportable by telephone immediately, within three hours, upon initial clinical suspicion or laboratory test)" to reenforce the urgent need for reporting the disease upon clinical suspicion.

New diseases added as reportable conditions include Acute Flaccid Myelitis, Cronobacter, including *C. sakazakii* and *C. malonaticus*, in infants younger than 12 months of age, Melioidosis due to *Burkholderia pseudomallei*, Multi-drug Resistant Organisms (MDROs) and Respiratory Syncytial Virus (RSV) Infection (Laboratory Confirmed Testing via ELR only, Pediatric Deaths and ICU Admissions). No diseases were repealed in this rule change process, however, Section 690.451 (Hepatitis B) was amended to remove Hepatitis D as reportable in this section.

Significant changes were made to **COVID-19** reporting rules, largely to synergize reporting and analysis of respiratory viruses with a focus on monitoring disease severity. Case-based reporting of all COVID cases is no longer required by providers and other reporters. COVID-19, RSV and seasonal influenza are reportable by providers only with ICU admissions or pediatric deaths. New I-NEDSS modules for reporting these new respiratory conditions will be available by May 18, 2024. Additionally, the Respiratory Unit has updated guidance on the IDPH CD WebPortal on ICU and pediatric death case definitions. COVID-19 was removed from the Novel Coronavirus Section. Laboratories will continue to report positive SARS-CoV-2 testing via ELR; reporting of negative results is no longer required.

Additionally, laboratories are to start sending Influenza and RSV positive results via ELR. Point of Care testing for COVID-19 is no longer reportable.

Invasive Group A Streptococcus (GAS) is reportable only in person exposed while admitted to the hospital or residing in a congregate setting. Outbreaks of invasive GAS (two or more cases in 21-day period) and non-invasive GAS (10 or more epi-linked cases in 10-day time period) are still reportable as well.

Carbapenem-resistant Enterobacterales (CRE) and ***Candida auris*** are now reportable under a new section for Multi-drug Resistant Organisms. Under Section 690.1510, new entities required to report these organisms include dialysis centers, specialized mental health rehabilitation facilities, and other high-risk health care facilities serving high-risk populations. These entities may also have their laboratories report on their behalf. Direct provider reporting of *C. auris* to the Extensively Drug-Resistant Organism (XDRO) Registry will open soon; until then, reports should continue to be submitted via I-NEDSS. The following health care facilities are now required to query new admissions or implement automated alerts from the XDRO registry: Hospitals, long-term acute care hospitals, skilled nursing and intermediate care facilities, and dialysis centers.

Laboratory requirements in many disease sections were amended to clarify reporting and testing requirement, especially when specimens or isolates are needed for further testing at IDPH or CDC Laboratories. Additionally, negative laboratory reporting is now required for Hepatitis B and Hepatitis C.

Nearly every Section within the rules has been amended to **clarify reporting and investigation procedures.** To highlight a few that relate to providers:

Section 690.200 a) 5) E) details **what information is to be reported** as specified below:

> *The reporter shall provide, when available, disease or condition, name, age, date of birth, sex, race, ethnicity, address (including zip code), email address and telephone number (if available) of the case, and name and telephone number of the attending medical provider. When requested, on paper forms provided by the Department or electronically through EDSS or AIMS, clinical and laboratory findings in support of the diagnosis, epidemiological facts relevant to the source of the infection or condition, and possible hazard of transmission of the infection or condition shall also be reported.*

The above language, coupled with 690.200 d) 8) (below), requires providers to furnish LHDs access to the above information within the timeframe of that reportable condition.

> *To prevent the spread of a disease or condition, the Department, local boards of health, and local health authorities, and other State agencies involved with direct care and service provisions to individuals shall have emergency access to medical or health information or records or data…*

As we advance toward **electronic case reporting**, the following language was added in Section 690.200 a) 5) C):

> *Providers shall establish a data linkage and submit electronic case report data through the Association of Public Health Laboratories Informatics Messaging Service (AIMS) platform in*

accordance with CMS Promoting Interoperability standards.

Section 690.565, Outbreaks of Public Health Significance, has been renamed "Any Suspected or Confirmed Outbreak of a Disease of Known or Unknown Etiology that may be a Danger to the Public Health, Whether the Disease, Infection, Microorganism, or Condition is specified in the Rule (Including, but Not Limited to, Foodborne, Healthcare-associated, Zoonotic Disease or Waterborne Outbreaks). In addition to expanding to stress the importance of reporting any type of suspect condition above the expected number, a greater emphasis was placed on healthcare associated infections.

In 690.30, General Procedures, in the section where restrictions for persons with fever, diarrhea and vomiting are addressed, new language has been added to restrict person with jaundice from working:

> *g) Persons with jaundice and the onset of jaundice within seven calendar days shall not work as health care workers, food handlers or in sensitive occupations until seven days after the jaundice ceases, unless the employee provides written documentation from a health care provider that the jaundice is not caused by the hepatitis A virus or other fecal-orally transmitted infection. If the case is confirmed as hepatitis A and jaundice is not present, the health care worker, food handler or person in a sensitive occupation shall be restricted from work for two weeks from the start of the clinical symptoms.*

In Part D (Disease-specific sections), language regarding infection control protocols for control of cases or contacts has been removed and replaced by a blanket statement in 690.100:

> *Appropriate infection control standards shall be implemented for cases and contacts per existing infection control standard precautions and transmission-based protocols.*

An updated Illinois Reportable Disease poster can be found on the DPH Website, Infectious Disease Reporting page, at the bottom under Publications. If you have any questions about the amended rules, please contact your Local Health Department.