Department of Health and Mental Hygiene

Board of Health

Notice of Public Hearing and Opportunity to Comment
on Proposed Amendments to Article 11 and 13 of the New York City Health Code

What are we proposing? The Department of Health and Mental Hygiene (the Department) is proposing that the Board of Health (the Board) amend Articles 11 (Reportable Diseases and Conditions) and 13 (Laboratories) of the New York City Health Code (Health Code) to enhance certain reporting and disease control requirements.

When and where is the hearing? The Department will hold a public hearing on the proposed Health Code amendments from 10 a.m. to 12 p.m. on October 25, 2016. The hearing will be at:

New York City Department of Health and Mental Hygiene
Gotham Center
42-09 28th Street, 14th Floor, Room 14-43
Long Island City, NY 11101-4132
This location has the following accessibility options available:
☒Wheelchair Accessible; ☒Blind or Low Vision Accessible

How do I comment on the proposed amendments to the Health Code? Anyone can comment on the proposed amendments by:

- **Website.** You can submit comments to the Department through the NYC rules website at http://rules.cityofnewyork.us

- **Email.** You can email written comments to resolutioncomments@health.nyc.gov

- **Mail.** You can mail written comments to:
  New York City Department of Health and Mental Hygiene
  Gotham Center, 42-09 28th Street, CN 31
  Long Island City, NY 11101-4132

- **Fax.** You can fax written comments to New York City Department of Health and Mental Hygiene at 347-396-6087.

- **Speaking at the hearing**. Anyone who wants to comment on the proposed amendments at the public hearing must sign up to speak. You can sign up before the hearing by calling Svetlana Burdeynik at 347-396-6078. You can also sign up in the hearing room before or during the hearing on October 25, 2016. You can speak for up to five minutes.

Is there a deadline to submit written comments? Written comments must be received on or before 5:00 p.m. on October 25, 2016.

Do you need assistance to participate in the hearing? You must tell us if you need a reasonable accommodation of a disability at the Hearing. You must tell us if you need a sign language interpreter. You can tell us by mail at the address given above. You may also tell us by telephone at 347-396-6078. You must tell us by October 11, 2016.

Can I review the comments made on the proposed amendments? You may review the comments made online at http://rules.cityofnewyork.us/ on the proposed amendments by going to the website at http://rules.cityofnewyork.us/. All written comments and a summary of the oral comments received by the Department will be made available to the public within a reasonable period of time by the Department's Office of the General Counsel.

What authorizes the Board to make these amendments? Section 558 of the City Charter authorizes the Board to adopt and amend the Health Code and to include in the Health Code all matters to which the authority of the Department extends. Section 556 of the Charter provides the Department jurisdiction to supervise clinical laboratories and the reporting and control of communicable diseases.

Where can I find the Health Code and the Department's rules? The Health Code and the rules of the Department of Health and Mental Hygiene are in Title 24 of the Rules of the City of New York.

What rules govern the rulemaking process? The Board must meet the requirements of §1043 of the City Charter when creating or changing the Health Code. This notice is made according to the requirements of City Charter §1043.

Statement of Basis and Purpose

The Department's Division of Disease Control conducts disease surveillance and control activities for most of the diseases listed in Article 11 (Reportable Diseases and Conditions) of the Health Code. The Division of Disease Control also enforces Article 13 (Clinical Laboratories) of the Health Code, which regulates the manner in which laboratory tests must be performed and the reporting of test results. In addition, the Department is required to comply with various provisions of Part 2 of the New York State Sanitary Code, found in Title 10 of the New York Codes, Rules and Regulations, with respect to control of communicable diseases.

To conduct more effective, timely, and complete disease surveillance and control, the Department is proposing that the Board amend Health Code Articles 11 and 13 as follows:

Hepatitis D and E and Other Suspected Infectious Viral Hepatitides Reporting

The Department is requesting that the Board remove hepatitis D and E and "other suspected infectious viral hepatitides" from Health Code §11.03(a)'s list of reportable diseases and amend §13.03(b)(3), regarding reportable laboratory findings, to remove references to these infections. The New York State Sanitary Code does not require reporting of either hepatitis D or E, nor do a majority of United States jurisdictions.

Hepatitis D and E and "other suspected infectious viral hepatitides" were added to the list of reportable diseases in 2005, largely due to outbreaks of hepatitis D and E observed abroad. After 10 years of surveillance, the Department has determined that these viruses no longer need to be monitored. Hepatitis D is uncommon in the United States. It is an "incomplete virus" in that it can replicate in the presence of hepatitis B virus; thus, hepatitis D is usually detected in connection with hepatitis B infection or outbreak and need not be separately reported. Since hepatitis D cannot be transmitted in the absence of the hepatitis B virus, hepatitis B immunization and treatment are the best approaches to reduce hepatitis D incidence. There were only 21 reports of hepatitis D in New York City from 2013 to 2015.

Hepatitis E outbreaks have not occurred in New York City. Most hepatitis E cases are linked to foreign travel and most persons infected with the virus recover completely. There is no specific vaccine or antiviral therapy for acute hepatitis E. In addition, hepatitis E cases are often misreported, for reasons including the high false-positive rate of hepatitis E tests. Of 86 hepatitis E cases reported 2006-2009, 67 percent were determined not to be actual cases and 89 percent of confirmed cases had a history of foreign travel. For these reasons, and to redirect Department resources to address more urgent public health threats, the Department stopped routine investigation of hepatitis E cases in 2010.

Any novel strains of viral hepatitis are reportable as part of providers' obligation to report unusual manifestations of disease and any newly apparent or emerging disease under Health Code §11.03(c)(1). Thus, it is unnecessary and redundant to have a separate reporting requirement for these hepatitis strains.

Zika Reporting

Pursuant to Health Code §11.03(a), all confirmed cases and carriers of an acute arboviral infection must be reported to the Department within 24 hours. Although Zika virus is currently reportable as an acute arboviral infection, the Department is requesting that the Board amend Health Code §11.03(a) to expressly include Zika virus in the list of named acute arboviruses for clarity. For reportable conditions, the Department can monitor New Yorkers to ascertain where the infection was acquired, helping the Department implement prevention strategies. The Department can also investigate to promptly recognize novel forms of transmission, including by local mosquitos.

Tuberculosis Reporting for Children Less Than Five Years of Age

Children less than five years of age infected with tuberculosis (TB) are at increased risk for progressing to active disease and developing life-threatening forms of the disease, such as disseminated TB and TB meningitis. For this reason, the Health Code requires providers to report a positive reaction to the purified protein derivative Mantoux test or other recognized TB diagnostic test for this age group.

The Department is requesting that the Board amend Health Code §11.03(a) and §11.21, regarding tuberculosis reporting, to further augment the reporting requirements for children less than five years of age to require providers to submit qualitative and quantitative test results and radiology reports where there is a positive test for TB infection, and report initiation of treatment for TB infection. This information will enable the Department to help ensure that providers have ruled out active TB disease and

that they initiate appropriate treatment in patients. Further, requiring routine submission of radiology reports will save the Department time and resources currently spent to obtain such reports.

In addition, the Department is requesting that §13.03(b)(1) of the Health Code, regarding laboratory reporting of tuberculosis, be amended to require laboratories to report positive results for TB infection obtained from a blood-based test (e.g., interferon-gamma release assays) or other laboratory test when performed on children less than five years of age. Currently, only providers submit positive TB test results for this age group. Requiring reporting by both laboratory and providers will help ensure the Department is made aware of all children less than five years of age with a positive test for TB infection.

Immunization Reporting

The Department is requesting that Health Code §11.07(a)(3) be amended to allow for adult patients' non-written consent for immunization reporting (currently, consent must be in writing). State Public Health Law § 2168 was amended in 2013, with the support of the Department, to similarly allow non-written consent for reporting to the State-run registry, and subparagraph 2168(3)(b)(i) allows non-written consent for reporting to the City registry. Written consent is a barrier to immunization reporting and eliminating this requirement will help increase provider reporting.

Isolation of Suspected and Confirmed Varicella Cases

The Department is requesting that the Board amend Health Code §11.17(a), regarding control and isolation of certain diseases, to require isolation of patients with suspected or confirmed varicella in hospitals and other clinical facilities, as is required for other communicable diseases that pose a significant threat to public health. Since varicella can be spread by air, isolation is important to reduce the risk of transmission in healthcare facilities. As a recent example, in June 2016, a one-year-old baby developed varicella infection after being exposed to patients with varicella at a medical facility.

Syphilis Testing and Reporting

The Department is requesting that the Board amend Health Code §13.03(b)(2) to require laboratories to report indeterminate syphilis test results and, where a result is indeterminate, perform a second test on the same specimen and report the result of that test. If the result of the second test is also indeterminate, the laboratory would not be required to perform additional testing. While many laboratories already report indeterminate test results, it is not explicitly required in the Health Code. The amendment will provide for more complete reporting.

In 2015, there were 1,968 indeterminate syphilis test results reported to the Department. The standard approach to resolving an indeterminate test is for a laboratory to retest the same specimen with the same or an alternate diagnostic test or for a healthcare provider to collect another specimen from the patient and test that specimen. To help ensure prompt initiation of treatment of individuals with syphilis, the Department classifies indeterminate test results as positive. This results in the initiation of case investigation and field activities, which include Department staff contacting providers, laboratories, patients, and sex partners of patients.

Requiring laboratories to routinely perform a second syphilis test at the time an indeterminate result is obtained will enable prompt treatment initiation and reduce the risk of disease progression and transmission if the test is positive. The Department will also be able to focus its resources on those New Yorkers with confirmed infections or exposure to infected persons.

Other minor language changes that have no bearing on provider reporting obligations were made to simplify and clarify §13.03(b)(2).

Enteric Disease Testing and Isolate Submission

The Department is requesting that the Board amend Health Code §13.03(b) to require laboratories to perform culture testing on all specimens that are found to be positive by a culture-independent diagnostic test (CIDT) for certain enteric bacterial pathogens (*Campylobacter*, *Listeria monocytogenes*, *Salmonella*, *Shigella*, *Vibrio*, and *Yersinia*). Culture testing involves a laboratory using a specimen to grow the pathogen; a sample of the pathogen grown by culture is termed an "isolate." The Department is also requesting that laboratories submit all resulting isolates to the Department. For Shiga toxin-producing *Escherichia coli* (STEC), laboratories would be required to submit Shiga toxin-positive broth and stool or an isolate.

Laboratories are increasingly using CIDTs and not performing culture testing. At least two New York City laboratories can no longer perform bacterial culture on stool specimens, and several New York City laboratories have limited capabilities. The Department and other public health agencies in the United States rely on testing isolates of enteric pathogens to detect and manage outbreaks. Isolates of enteric pathogens undergo testing at the Department laboratory by methods such as pulsed-field gel electrophoresis, colloquially known as 'DNA fingerprinting.' The Department combines the results of 'DNA fingerprinting' with patient interviews and environmental investigation to confirm and remediate sources of food contamination. CIDTs do not yield isolates for such testing.

The Centers for Disease Control and Prevention encourages laboratories to culture enteric specimens with a positive CIDT result (*Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention. Bacterial Enteric Infections Detected by Culture-Independent Diagnostic Tests — FoodNet, United States, 2012–2014. *MMWR*. 2015;64(09):252-257). The Association of Public Health Laboratories (APHL) recommends that "all public health departments establish legal requirements for the submission of enteric bacterial disease isolates and/or clinical specimens by hospital and clinical laboratories. . . ." APHL's position is based in part on its finding that "[t]he rapidly increasing availability of CIDTs for foodborne pathogens poses serious challenges for public health and is threatening to derail current laboratory-based surveillance systems" (APHL Position Statement: Establishing Legal Requirements for the Submission of Enteric Disease Isolates and/or Clinical Material to Public Health Laboratories, Approved by Membership February 2015). Requiring laboratories to perform culture testing and submit resulting isolates is consistent with the APHL recommendation.

Statutory Authority

The authority for these proposed amendments is found in Sections 556 and 558 of the New York City Charter (the "Charter"). Sections 558(b) and (c) of the Charter empower the Board (the "Board") to amend the Health Code and to include all matters to which the Department's authority extends. Section 1043 grants the Department rule-making authority.

Section 556 of the Charter provides the Department with jurisdiction to protect and promote the health of all persons in the City of New York.

Statement pursuant to Charter §1043

This proposal was not included in the Department's Regulatory Agenda for FY 2017 in part because of an administrative oversight and in part because the need for the proposal was not known at the time the Regulatory Agenda was promulgated.

The proposal is as follows:

Note: Matter in brackets [ ] is to be deleted. Matter <u>underlined</u> is new.

"Shall" and "must" denote mandatory requirements and may be used interchangeably unless otherwise specified or unless the context clearly indicates otherwise.

RESOLVED, that subdivision (a) of section 11.03 of Article 11 of the New York City Health Code, set forth in Title 24 of the Rules of the City of New York, be amended to read as follows:

§11.03 Diseases and conditions of public health interest that are reportable.

(a) Cases and carriers affected with any of the following diseases and conditions of public health interest, and persons who at the time of their death were apparently so affected, shall be reported to the Department as specified in this article:

Amebiasis
Anaplasmosis (Human granulocytic anaplasmosis)
Animal bite, or exposure to rabies
Anthrax
Arboviral infections, acute (including but not limited to the following viruses: [Chikungunyavirus,] chikungunya virus, Zika virus, dengue virus, Eastern equine encephalitis virus, Jamestown Canyon virus, Japanese encephalitis virus, La Crosse virus, Powassan virus, Rift Valley fever virus, St. Louis encephalitis virus, Western or Venezuelan equine encephalitis virus, West Nile virus and yellow fever)
Babesiosis
Botulism (including infant, foodborne and wound botulism)
Brucellosis (undulant fever)
Campylobacteriosis
Chancroid
Chlamydia trachomatis infections
Cholera
Creutzfeldt-Jakob Disease
Cryptosporidiosis
Cyclosporiasis
Diphtheria
Drownings, defined as the process of experiencing respiratory impairment from submersion/immersion in liquid whether resulting in death or not
Ehrlichiosis (Human monocytic ehrlichiosis)
Encephalitis

Escherichia coli 0157:H7 infections

Falls from windows in multiple dwellings by children sixteen (16) years of age and under

Food poisoning occurring in a group of two or more individuals, including clusters of diarrhea or other gastrointestinal symptoms; or sore throat which appear to be due to exposure to the same consumption of spoiled, contaminated or poisonous food, or to having eaten at a common restaurant or other setting where such food was served. Also includes one or more suspected cases of neurologic symptoms consistent with foodborne toxin-mediated, including but not limited to botulism, combroid or ciguatera fish poisoning, or neurotoxic or paralytic shellfish poisoning.

Giardiasis

Glanders

Gonococcal infection (gonorrhea)

Granuloma inguinale

Hantavirus disease

Hemolytic uremic syndrome

Hemophilus influenzae (invasive disease)

Hepatitis A; B; and C [D ("Delta Hepatitis"); E; and other suspected infectious viral hepatitides]

Herpes simplex virus, neonatal infections (in infants 60 days or younger)

Hospital associated infections as defined in Title 10 New York Codes, Rules and Regulations (NYCRR) Section 2.2 (New York State Sanitary Code) or its successor law, rule or regulation

Influenza, novel strain with pandemic potential

Influenza, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)

Influenza-related deaths of a child less than 18 years of age

Legionellosis

Leprosy

Leptospirosis

Listeriosis

Lyme disease

Lymphocytic choriomeningitis virus

Lymphogranuloma venereum

Malaria

Measles (rubeola)

Melioidosis

Meningitis, bacterial causes (specify type)

Meningococcal, invasive disease

Monkeypox

Mumps

Norovirus, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)

Pertussis (Whooping cough)

Plague

Poisoning by drugs or other toxic agents, including but not limited to lead poisoning consisting of a blood lead level of 10 micrograms per deciliter or higher (see also §11.09(a) of this Code); carbon monoxide poisoning and/or a carboxyhemoglobin level above 10%; and including confirmed or suspected pesticide poisoning as demonstrated by:

(1) Clinical symptoms and signs consistent with a diagnosis of pesticide poisoning; or

(2) Clinical laboratory findings of blood cholinesterase levels below the normal range; or

(3) Clinical laboratory findings or pesticide levels in human tissue above the normal range.

Poliomyelitis

Psittacosis

Q fever

Rabies

Respiratory syncytial virus, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)

Ricin poisoning

Rickettsialpox

Rocky Mountain spotted fever

Rotavirus, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)

Rubella (German measles)

Rubella syndrome, congenital

Salmonellosis

Severe or novel coronavirus

Shiga toxin-producing *Escherichia coli* (STEC) (which includes but is not limited to *E. coli* O157:H7)

Shigellosis

Smallpox (variola)

Staphylococcal enterotoxin B poisoning

Staphylococcus aureus, methicillin-resistant, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)

Staphylococcus aureus, vancomycin intermediate and resistant (VISA and VRSA)

Streptococcus, Group A (invasive infections)

Streptococcus, Group B (invasive infections)

Streptococcus pneumoniae invasive disease

Syphilis, all stages, including congenital

Tetanus

Toxic shock syndrome

Trachoma

Transmissible spongiform encephalopathy

Trichinosis

Tuberculosis, as demonstrated by:

(1) Positive culture for *Mycobacterium tuberculosis* complex; or

(2) Positive DNA probe, polymerase chain reaction (PCR), or other technique for identifying [Mycobacterium tuberculosis] *Mycobacterium tuberculosis* from a clinical or pathology specimen; or

(3) Positive smear for acid-fast bacillus, with final culture results pending or not available, on either a microbacteriology or a pathology specimen; or

(4) Clinically suspected pulmonary or extrapulmonary (meningeal, bone, kidney, etc.) tuberculosis, such that the physician or other health care professional attending the [case] patient has initiated or intends to [initiate isolation] isolate the patient or initiate treatment for tuberculosis, or to continue or resume treatment for previously incompletely treated disease, or, if the patient is not available, that the physician or other health care professional would initiate isolation or treatment if the patient were available; or

(5) Biopsy, pathology, or autopsy findings in lung, lymph nodes or other tissue specimens, consistent with active tuberculosis disease including, but not limited to presence of acid-fast bacilli, caseating and non-caseating granulomas, caseous matter, tubercles and [fibre-caseous] fibro-caseous lesions; or

(6) Positive reaction to the purified protein derivative (PPD) Mantoux test, blood-based tests positive for tuberculosis infection, or other recognized diagnostic test positive for tuberculosis infection in a child less than five years of age, regardless of whether such child has had a BCG vaccination.

Tularemia

Typhoid fever

Vaccinia disease, defined as

(1) Persons with vaccinia infection due to contact transmission; and

(2) Persons with the following complications from smallpox vaccination: eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, myocarditis or pericarditis, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the vaccination site, and any other serious adverse events (i.e., those resulting in hospitalization, permanent disability, life-threatening illness or death)
Varicella, laboratory-confirmed (only required through the Department's electronic reporting mechanism set forth in §13.03(c) of this Code)
Vibrio species, non-cholera (including *parahaemolyticus* and *vulnificus*)
Viral hemorrhagic fever
Yersiniosis

RESOLVED, that paragraph (3) of subdivision (a) of section 11.07 of Article 11 of the New York City Health Code, set forth in Title 24 of the Rules of the City of New York, be amended to read as follows:

(3) Reports of an immunization administered to any individual age nineteen and above may be submitted to the Department provided that the person administering the immunization or the person in charge of the hospital, clinic or other institution where the immunization is administered, has obtained [written] consent to report such immunization from the person to whom such immunization information relates.

RESOLVED, that subdivision (a) of section 11.17 of Article 11 the New York City Health Code, set forth in Title 24 of the Rules of the City of New York, be amended to read as follows:

§11.17 Control measures; duty to isolate; and isolation, quarantine and examination orders.

(a) It shall be the duty of an attending physician, or a person in charge of a hospital, clinic, nursing home or other medical facility to isolate a case, carrier, suspect case or suspect carrier of diphtheria, rubella (German measles), influenza with pandemic potential, invasive meningococcal disease, measles, monkeypox, mumps, pertussis, poliomyelitis, pneumonic form of plague, severe or novel coronavirus, vancomycin intermediate or resistant Staphylococcus aureus (VISA/VRSA), smallpox, tuberculosis (active), vaccinia disease, viral hemorrhagic fever<u>, varicella,</u> or any other contagious disease that in the opinion of the Commissioner may pose an imminent and significant threat to the public health, in a manner consistent with recognized infection control principles and isolation procedures in accordance with State Department of Health regulations or guidelines pending further action by the Commissioner or designee.

RESOLVED, that subdivision (a) of section 11.21 of Article 11 of the New York City Health Code, set forth in Title 24 of the Rules of the City of New York, be amended by adding a new paragraph (5) to read as follows:

(5) *Reports for children less than five years of age*. When a child less than five years of age has a positive test for tuberculosis infection, the physician who attends the child, or the person in charge of a hospital, dispensary or clinic giving treatment to the child, must submit to the Department reports of all qualitative and quantitative diagnostic tests for tuberculosis infection for such child, including reports of all blood-based tests and purified protein derivative (PPD) Mantoux tests (including induration where a PPD is performed); all radiological examinations (including chest x-rays, computerized tomography scans, and magnetic resonance imaging scans); and initiation of treatment for latent tuberculosis infection, in a manner prescribed by the Department.

RESOLVED, that the section heading and subdivision (b) of section 13.03 of Article 13 of the New York City Health Code, set forth in Title 24 of the Rules of the City of New York, be amended to read as follows:

§13.03 Report of findings and submission of isolates.

* * *

(b)(1) With regard to tuberculosis, reports shall also include all laboratory findings which indicate presumptive or confirmed presence of tuberculosis, the results of smears found positive for acid fast bacilli (AFB), all results including negatives and species identification on samples which had positive smears, all blood-based or other laboratory test results positive for tuberculosis infection for children less than five years of age, all drug susceptibility testing results and all subsequent test results on samples collected within one year from any patient who had a previous positive AFB smear or a positive [M. tuberculosis] *Mycobacterium tuberculosis* complex test result (e.g., culture or NAA). Reports shall specify the laboratory methodology used and shall state if applicable whether the specimen was susceptible or resistant to each anti-tuberculosis drug at each concentration tested.

(2) With regard to syphilis, in addition to reporting any positive or reactive test results, any treponemal or non-treponemal results, whether qualitative or quantitative, [which are positive or reactive,] shall be reported to the Department [within 24 hours of obtaining any such positive or reactive results. In addition, any], and additional testing must be performed and the results reported, as follows:

(A) Any negative or non-reactive test results, or any quantitative results, on syphilis tests associated with [the aforementioned] positive or reactive results [, and performed by the same laboratory,] shall be separately reported to the Department [by the laboratory performing the associated syphilis tests within 24 hours of obtaining such results].

(B) Where the result of a syphilis test is indeterminate (including but not limited to a weakly reactive, minimally reactive, equivocal, and inconclusive test result), the laboratory must report the indeterminate test result to the Department. When a treponemal test result is indeterminate, the laboratory must perform, or refer the specimen to another laboratory for the performance of, a second treponemal test on the same specimen using an alternate treponemal test within 24 hours of obtaining the indeterminate result and report the results of that second test to the Department. Where the result of the second treponemal test is also indeterminate, whether performed by the same laboratory or a different laboratory, no additional treponemal test is required. In the case of an indeterminate non-treponemal test result, the laboratory must perform, or refer the specimen to another laboratory for the performance of, a second non-treponemal test on the same specimen using the same or an alternate non-treponemal test within 24 hours of obtaining the indeterminate result, and report the results of that second test to the Department. Where the result of the second non-treponemal test is also indeterminate, whether performed by the same laboratory or a different laboratory, no additional non-treponemal test is required.

(C) If a laboratory has been referred a specimen to perform only tests associated with a positive [syphilis] result or an indeterminate result (including but not limited to a weakly reactive, minimally reactive, equivocal, and inconclusive test result) obtained at the referring laboratory, and such associated syphilis tests have yielded only negative or non-reactive results, then [, notwithstanding anything to the contrary in subdivision (a) of this section,] only the referring laboratory shall report said negative or non-reactive results to the Department within 24 hours of obtaining the results from the testing laboratory.

(D) If a laboratory obtains negative or non-reactive results or an indeterminate result (including but not limited to a weakly reactive, minimally reactive, equivocal, and inconclusive test result) on a specimen submitted for syphilis testing and refers a specimen for further syphilis testing to another laboratory, and such further syphilis tests yield positive or reactive results, then, [notwithstanding anything to the contrary in subdivision (a) of this section,] in addition to the testing laboratory reporting such positive or reactive results, the referring laboratory shall report both the negative or non-reactive results or indeterminate result obtained by it and also the positive or reactive results of any such further syphilis testing within 24 hours of obtaining the results from the testing laboratory.

(E) If a laboratory has been referred a specimen to perform only tests associated with an indeterminate result (including but not limited to a weakly reactive, minimally reactive, equivocal, and inconclusive test result) obtained at the referring laboratory, and such associated syphilis tests have yielded only indeterminate results, then, in addition to the testing laboratory reporting such indeterminate results, the referring laboratory shall report both the indeterminate result obtained by it and also the indeterminate results of such further syphilis testing within 24 hours of obtaining the results from the testing laboratory.

(3) With regard to hepatitis A, B, or C, [D, E or any other suspected infectious viral hepatitides,] reports shall also include the results of alanine aminotransferase testing (ALT) if performed on the same specimen that tests positive for any of the reportable viral hepatitides.

* * *

(4) If a culture-independent diagnostic test or other laboratory test demonstrates the possible presence of *Campylobacter*, *Listeria monocytogenes*, *Salmonella*, *Shigella*, *Vibrio*, or *Yersinia* in a patient specimen, the laboratory must perform, or refer the specimen to another laboratory for performance of, reflexive culture on the original specimen to isolate the organism. The laboratory that performed the reflexive culture must submit the resulting isolates to the Department in a manner and form prescribed by the Department. In the case of Shiga toxin-producing *Escherichia coli*, the laboratory must submit an isolate or a Shiga toxin-positive broth and stool to the Department in a manner and form prescribed by the Department.

NEW YORK CITY MAYOR'S OFFICE OF OPERATIONS
253 BROADWAY, 10th FLOOR
NEW YORK, NY 10007
212-788-1400

CERTIFICATION / ANALYSIS
PURSUANT TO CHARTER SECTION 1043(d)

RULE TITLE: Amendment of Reporting and Disease Control Requirements.

REFERENCE NUMBER: DOHMH-73

RULEMAKING AGENCY: Board of Health

I certify that this office has analyzed the proposed rule referenced above as required by Section 1043(d) of the New York City Charter, and that the proposed rule referenced above:

(i) Is understandable and written in plain language for the discrete regulated community or communities;

(ii) Minimizes compliance costs for the discrete regulated community or communities consistent with achieving the stated purpose of the rule; and

(iii) Does not provide a cure period because the violations pose significant risks to public health and safety.

/s/ Maurice A. Goldstein — *September 8, 2016*
Mayor's Office of Operations — Date

NEW YORK CITY LAW DEPARTMENT
DIVISION OF LEGAL COUNSEL
100 CHURCH STREET
NEW YORK, NY 10007
212-356-4028

CERTIFICATION PURSUANT TO

CHARTER §1043(d)

RULE TITLE: Amendment of Disease Reporting and Testing Requirements

REFERENCE NUMBER: 2016 RG 078

RULEMAKING AGENCY: Board of Health

I certify that this office has reviewed the above-referenced proposed rule as required by section 1043(d) of the New York City Charter, and that the above-referenced proposed rule:

(i) is drafted so as to accomplish the purpose of the authorizing provisions of law;

(ii) is not in conflict with other applicable rules;

(iii) to the extent practicable and appropriate, is narrowly drawn to achieve its stated purpose; and

(iv) to the extent practicable and appropriate, contains a statement of basis and purpose that provides a clear explanation of the rule and the requirements imposed by the rule.

/s/ STEVEN GOULDEN Date: September 7, 2016
Acting Corporation Counsel