Plymouth County Sheriff's Department Joseph D. McDonald, Jr. Sheriff	Policy **605**	Number of Pages **8**
	Related Standards *MGL: c.37; c.111§3,5,6,7,70,109,110,111,112; c.111c; c. 111d§6; c. 124, §1 (d&q); c. 127, § 1A&33* *103 CMR:918.04; 932.06 & .10; 940.02* *105 CMR 300* *ACA : 4-ALDF-14, 15, 16, 17, 18* *28 CFR 115*	

AIDS SUPERVISION, EDUCATION & TESTING AND COMMUNICABLE DISEASES

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APPROVED: Lawrence T. Soffredini *DATE:* 7/12/21

Health Authority

APPROVED: *DATE:* 9-8-2021

Joseph D. McDonald Jr.
Sheriff

I. GENERAL INFORMATION

A. Definitions

Acquired Immune Deficiency Syndrome (AIDS) - A communicable disease which attacks a person's immune system and can be contracted through contact with body fluids infected with HIV / AIDS

Bloodborne Pathogens - Pathogenic micro-organisms in human blood which can cause disease in humans.

Consent - A voluntary and capable agreement to sanction or participate in a particular act.

Employee - Any person paid salary or compensation by the Plymouth County Sheriff's Department, or appointed by the Sheriff as a Plymouth County Deputy Sheriff.

Health Services Unit - The area (s) of the institution, and personnel assigned thereto, which carries out medical department functions.

Human Immunodeficiency Virus (HIV) - The communicable virus which causes AIDS.

Infectious Disease - Disorders caused by organisms — such as bacteria, viruses, fungi or parasites.

Medical Screening - A term used synonymously with Receiving Screening is, the inquiry and observation of a newly committed inmate required to be conducted on all inmates upon arrival at the institution.

1. Inquiry into:

    a. Current illness and health problems including dental problems, communicable diseases and other infectious diseases;
    b. Medications taken and special health requirements;
    c. Use of alcohol and other drugs which includes types used, mode of use, date and time of last use, and a history of problems which may have occurred after ceasing use (e.g. convulsions);
    d. Past and present treatment or hospitalization for mental disturbances or suicide;
    e. Other health problems designated by a physician;

2. Observations of:

    a. Behavior indicating state of consciousness, mental status, appearance, conduct, tremor, or sweating;
    b. Body deformities, ease of movement; and
    c. Conditions of the skin, including trauma markings, rashes, bruises, lesions, jaundice, infestations, or other indications of drug use; and

3. Disposition of inmate of:

    a. General population;
    b. General population and prompt referral to appropriate health care services;
    c. Referral to an appropriate health care service on an emergency basis.

Occupational Exposure - Skin, eye, mucous membrane, or parental contact with blood or other potentially infectious materials that may result from the performance of one's duties.

Other Potentially Infectious Materials - Any other human bodily fluid that is contaminated with blood.

Universal Precautions - An approach to infection control which provides that all human blood and certain human body fluids are treated as if known to be infectious.

Exposure of Concern- The Department of Public Health limits exposures of concern capable of transmitting infectious disease dangerous to the public to:

1. Puncture wounds from used needles, glass, other sharp objects contaminated with human blood, and human bites

2. Blood or blood contact with open wounds, including open cuts, sores, rashes, abrasions or condition which interrupt skin integrity

3. Mucous membrane contact, as with CPR, eye splashing with infected fluids, i.e., blood, urine, feces and oral and nasal secretions

4. Inhalation exposure consisting of close, face-to-face contact with a person who has coughed and/or sneezed on another person

B. HIV / Aids Coordinator

The Sheriff has contracted an HIV / AIDS Coordinator whose duties include oversight of the facility's HIV / AIDS awareness and counseling program for inmates.

C. Appointment Of Designated Employee

The Sheriff has appointed a designated employee whose duties include providing clinical guidance and support for staff who believe and/or report possible unprotected exposures of concern to potentially infectious material (Attachment)

D. Emergency Spill Kits

Emergency Spill Kits that contain items needed to clean spills of potentially infectious materials have been placed throughout the facility. Such kits are available for immediate use by staff and others tasked with the cleanup of such spills.

E. Bio-hazardous Waste

Waste, which may pose a potential hazard to human health or the environment, will be properly treated, stored, transported and disposed.

F. UNIVERSAL PRECAUTIONS

Universal precautions will be strictly enforced at all times at the PCCF. Shift Commanders and Health Services Unit staff will be cognizant of the manner in which spills are cleaned, and will ensure staff are properly equipped and protected when cleaning spills that may contain any potentially infectious material.

II. GENERAL PRECAUTIONS BY EMPLOYEES

When responding to confrontational situations, medical emergencies, or at other times when staff could be exposed to contact with blood or other body fluids, staff should take the following universal precautions:

A. Be careful to avoid sharp objects during searches and in emergency situations involving weapons.

B. Wear protective gloves when searching, and in emergency situations.

C. Use mechanical resuscitation equipment or barrier protective devices when administering CPR.

D. Immediately, wash with soap and hot water after contact with blood, saliva or other body fluids.

E. Bites, cuts, scratches and abrasions should be immediately cleaned and reported for medical attention.

F. Blood or other potentially infectious body fluids on any surface are to be cleaned by staff utilizing universal precautions including, but not limited to:

1. Protective gloves,
2. 1:10 solution of bleach and water, or by another disinfectant approved by Medical Unit staff,
3. Including showers used by inmates who have lacerations, wounds or visible blood.
4. When directed by the Medical Unit, staff will use an Emergency Spill Kit.

G. Clothing that has been exposed to blood, urine, or other bodily fluid will be removed, placed in a water soluble bag and washed in water at a minimum temperature of 180° F or above, and dried.

H. Containment footgear must be cleaned with a disinfectant approved by Health Services Unit staff.

I. Health Services Unit contaminated waste, and waste from clean-up of spills, will be disposed in accordance with applicable procedures listed within this document.

III. GENERAL PRECAUTIONS BY INMATES

The HIV / AIDS Coordinator will ensure that all inmates at the PCCF receive AIDS information during their orientation. Protective measures to guard against unprotected exposure in a correctional setting will be addressed, including avoiding such behaviors that can result in unprotected exposure.

IV. ADMISSION PROCEDURES

A. As a matter of practice, Transportation Officers and Booking Officers will use universal precautions at all times whenever dealing with inmates.

B. If Transportation Officers are informed by the court, the inmate / detainee, or another credible source that the inmate has or may have Tuberculosis (TB), Transportation Officers will report that information to the Booking Officer upon admission.

C. Booking Officers will note on the Booking Officer Questionnaire that an inmate / detainee has or may have Tuberculosis (TB), and will immediately notify the Health Services Unit.

V. MEDICAL SCREENING OF INMATES

A. When medical screening indicates the possibility of communicable disease, the licensed facility Physician will order treatment as ~~may be~~ necessary.

B. Inmates who have confirmed cases of communicable disease and who represent high risk of infection to staff and others will be hospitalized when necessary at the direction of the licensed facility physician.

C. Inmate victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

VI. INFECTION CONTROL PROGRAM: HIV

To establish guidelines for assisting HIV infected inmates that comply with CDC standards of care:

A. Written consent will be obtained from the inmate prior to obtaining a blood sample for HIV testing.

B. Inmates requesting testing for HIV will have pre- and post-test counseling made available.

C. Usual laboratory determinations will be utilized to confirm the HIV positive status of a tested inmate to reduce the incidence of false positive reports.

D. Inmates who are HIV positive will not be segregated from general population inmates unless medically indicated.

E. In accordance with the community standards of care, confidentiality regarding the HIV / AIDS status of an inmate will be maintained within the control of the Health Services Unit.

F. Medical Records will not be marked to distinguish HIV status of inmate.

G. Educational programs will be offered to the healthcare and correctional staff, as well as the inmates, regarding appropriate protection and other information regarding the disease.

VII. INFECTION CONTROL PROGRAM: TUBERCULOSIS

To provide inmates with screening and treatment of tuberculosis.

A. The *TUBERCULIN SCREENING EXAMINATION* form is utilized and completed by the medical officers in the electronic medical record at the time of Medical Screening.

1. The Medical Officers will complete a brief symptom check and inquire about current and/or past treatment for TB during the Medical Screening.
2. The Medical Officers will document a more in depth symptom check and record a PPD implant date/signature or date of the last chest X-ray (and result if known) utilizing the Tuberculin Screening Examination Form.

B. If the inmate indicates that he has had a previous positive PPD test, one of the following should occur:

1. ***If the PPD is positive, the Medical Officer will follow protocol for ordering a chest x-ray***.

   a. The Medical Officer will make the appropriate referrals for a follow up with the Infectious Disease Management Nurse and the Licensed Medical Provider.

   b. The Tuberculin Examination Screening Form is to be used during the Annual PPD/TB Screening Procedures for inmates who have had a previous >10mm induration with a negative Chest X-ray.

   c. The medical staff will review x-ray findings as soon as possible and will decide if the inmate needs to see a physician. All x-ray findings are reviewed by the M.D. before being placed in the medical record.

C. Diagnostic protocol

1. Testing procedure:

   - Complete the tuberculin screening examination form.
   - Determine if the inmate requires a PPD to be planted.
   - If so, gather the necessary supplies.

2. Explain test

3. Perform test during medical screening.

4. A Medical Officer will read the PPD in 48-72hrs and document the result in the electronic medical record on the Tuberculin Screening Examination form.

5. Evaluation of results:

10mm or more	- Exposure to TB. - Set up appointment at appropriate hospital for complete work-up for TB. Follow recommended specimen collection procedures and drug therapy regime if ordered.
5 to 9mm	- Deemed positive if the individual is immuno-compromised (ie; H.I.V., receiving chemotherapy, organ transplant recipients)
0 to 4mm	- Negative.

6. Recent converter - One who has increased from below 10mm to over 10mm, or anyone who has increased 6mm from last testing.

VIII. TESTING OF EMPLOYEES FOR INFECTIOUS DISEASES

A. Any employee who suspects an exposure of concern to an infectious disease should complete Infectious Disease Exposure Report Form (Attachment), and present him/herself to the Health Services Unit for evaluation.

B. Any employee who suspects an exposure of concern to an infectious disease will be informed by the Health Services Unit staff of precautions and treatment which should be pursued, including the following:

1. The employee will be strongly encouraged to report to the Beth Israel Deaconess Hospital Plymouth for confidential testing, counseling and support services;

2. The employee will be encouraged to contact his/her personal physician for medical follow-up;

3. The employee will be advised about immediate medical precautions necessary to prohibit transmission of the infectious disease to others.

C. Test results will be confidential between the inmate and health care provider (s), and employee and health care provider(s).

1. Any notices to individual(s) who may have been exposed will be made in such a manner so as to assure that the notice is conveyed only to those individual(s). The Plymouth County Sheriff's Department will control information sent to laboratories using a number system, rather than identification of samples by name, to ensure confidentiality.

2. The identity of persons diagnosed as having an infectious disease dangerous to the public as defined in this policy will be released neither orally, nor in writing to any person who has sustained unprotected exposure from an inmate / patient or employee / patient. The patient's name will be kept confidential in accordance with MGL Chapter 111, Section 70F.

3. Inmates who are transferred must complete a written Authorization For Medical Release of Information (Attachment) in order that confidential health records regarding HIV/AIDS tests, results, treatment, etc. can be transferred to the receiving agency on a Medical Report (refer to Attachment).

IX. USE OF FORCE

A. In all cases involving use of force, staff will exercise caution against exposure to infection and follow the general precautions listed within this document.

B. In the event of an assault or use of force which results in bleeding by an inmate and / or employee, medical examinations will be conducted immediately or as soon as practical due to security concerns.

C. When use of force can be reasonably be anticipated, and a delay in its application will not increase the danger to employees or others, such as with forced cell moves, it is recommended that employees utilize such protective clothing and equipment as may be appropriate including, but not limited to helmet with visor, jumpsuit, gloves, and body shield.

D. After force has been used against an inmate, the inmate will be examined by a medical staff member as soon as possible. The Medical Officer conducting the evaluation will document such in a written Incident Report.

E. After force has been used against an inmate, medical attention and evaluation will be afforded to all staff members involved in the incident. The Medical Officer conducting the evaluation will document such in a written Incident Report.

X. CLEANUP OF POTENTIALLY INFECTIOUS MATERIAL

Any area, equipment, clothing, etc., contaminated by a spill of blood or other potentially infectious material that can be cleaned and decontaminated will be done so in accordance with the procedures in Universal Precautions.

XI. DISPOSAL OF POTENTIALLY INFECTIOUS MATERIAL

A. All potentially hazardous medical waste is disposed into a 6ml red bag.

B. At the originating site, a staff member or trained worker will close the red bag and deliver the red bag to medical to be placed in the secured bio-hazard locker.

C. Needles and syringes will be disposed of into a "SHARPS" container.

D. When a "SHARPS" container is full, it will be sealed and stored in the secured bio-hazard locker / room.

E. All containers and red bags will have the "Hazardous Material" label affixed to them.

1. All containers and red bags will be packaged into a receptacle for shipment. The receptacle will be properly identified as to "Hazardous Material" and sealed.

2. The Biohazard log will be prepared and updated by designated Medical Staff. All receipts and manifests from the hazardous waste disposal vendor will be signed and logged.

3. Upon delivery, a copy of the manifest will be signed by the vendor, brought back to the PCCF and delivered to the Health Services Unit for retention on file.

XII. COMMUNICABLE DISEASES

The licensed facility physician, with the approval of the Superintendent, has developed and implemented a protocol for the diagnosis and treatment of communicable diseases at the PCCF. Medical Officers will refer to this protocol whenever inmates or staff are suspected of having an infectious disease, or whenever inmates or staff are reasonably suspected to have suffered an exposure of concern.

XIII. REPORTABLE DISEASES, ILLNESSES & INJURIES

Certain diseases, illnesses and injuries are required by law to be reported to the Massachusetts Department of Public Health and / or the local Board of Health. The Health Services Administrator or designee will ensure that each such instance of disease, illness or injury is properly reported according to List of Reportable Diseases.

XIV. APPLICABILITY

This policy applies to all department employees and inmates.

XV. RESPONSIBLE STAFF

The Superintendent and the Health Services Administrator or their designee(s) will be responsible for implementing and monitoring this policy.

XVI. ATTACHMENT LIST

The following attachments are included with this document.

1. Appointment of Designated Employee
2. CONFIDENTIAL Inmate HIV/AIDS Test Consent Form
3. Infectious Disease Exposure Report Form
4. Authorization For Medical Release of Information (CorEMR Form)
5. Medical Report (CorEMR Form)
6. Universal Precautions
7. Health Services Unit Triage Protocol, Communicable Diseases
8. Massachusetts Department of Public Health List of Reportable Diseases
9. Hazardous Exposure Instructions
10. HIV Anti-body Testing
11. Counseling and Testing Program for HIV Anti-body Screening
12. Report of Infectious Diseases
13. Instructions for Completing the Adult HIV / AIDS Confidential Case Report
14. 105 CMR 300.00 Reportable Diseases, Surveillance and Isolation and Quarantine Requirements
15. COVID-19 Screening
16. CPS Clinical Guideline for COVID-19 / Coronavirus

The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Department
Plymouth County Correctional Facility

26 Long Pond Road
Plymouth, MA 02360
Telephone: (508) 830-6200
Fax: (508) 830-6201
www.pcsdma.org

Joseph D. McDonald, Jr.
Sheriff

Gerald C. Pudolsky
Special Sheriff

Accredited by:
American Correctional Association

TO: Health Services Administrator Kendra Brooks

FROM: Superintendent Antone Moniz

DATE: July 6, 2021

SUBJ: **Appointment as Designated Employee**

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1. You are hereby notified that effective this date, and with the approval of the licensed facility physician, I have appointed you the Designated Employee for the Plymouth County Correctional Facility.

2. You will be guided in the performance of your duties, and will become thoroughly familiar with Sheriff's Department Policy and PCCF 605, AIDS Supervision, Education & Testing & Communicable Diseases, including all of its attachments and protocols, and other applicable laws, codes, policies and procedures.

3. You will acknowledge this appointment by affixing your signature and the date to this document, retaining a copy for your files, and returning the original to me.

Acknowledged: Kendra Brooks HSA Date: 6 July 2021

PLYMOUTH COUNTY
SHERIFF'S DEPARTMENT

PLYMOUTH COUNTY
CORRECTIONAL FACILITY

CONFIDENTIAL

INMATE HIV / AIDS TEST CONSENT FORM
PCCF 605: ATTACHMENT 2

Date: _____

Name: _____ ID #: _____
(Print Name)

I, _____ , do hereby state that I have
(Name of subject being counseled)
received information from the Plymouth County Sheriff's Department concerning the disease AIDS.

This information was communicated to me by AIDS Counselor, _____
(Counselor's Name)

_____ _____
Inmate Signature Witness Signature

_____ , do hereby state that I have with the
(Name of subject being counseled)

AIDS Counselor, _____ , about the disease and the test for the
(Counselor's Name)
AIDS antibody. I understand that the test is not one hundred percent accurate. I further request and Understand that I will receive counseling from the AIDS counselor regarding the test results.

_____ _____
Inmate Signature Witness Signature

I, _____ ,do hereby authorize the testing laboratory
(Name of subject being counseled)

_____ , to release the confidential results of the blood test for the
(Name of Testing Laboratory)
AIDS antibody to the Plymouth County Sheriff's Department Health Services Unit, the facility AIDS Counselor, The Assistant Superintendent, and the Director of Programs, and ADS of Classification.

_____ _____
Inmate Signature Witness Signature

PLYMOUTH COUNTY SHERIFF'S DEPARTMENT
INFECTIOUS DISEASE EXPOSURE REPORT FORM
Standard of the Occupational Safety and Health Act, 29 CFR 1910.1030 – Occupational Exposure to Bloodborne Pathogens

EMPLOYEE INFORMATION (please print)

Exposed Employee Name: _____ SS#: _____

Department: _____ Title: _____

EXPOSURE INCIDENT INFORMATION (please print)

Date: _____ Time: _____ Location of Incident: _____

Type of incident: (burn, fall, puncture, machinery, auto) Please be specific. _____

What were you exposed to: ☐Blood ☐Feces ☐Saliva ☐Sputum ☐Sweat ☐Tears ☐Urine ☐Vomitus ☐Other:

What part(s) of your body became exposed? Please be specific: _____

Did you have any open cuts, sores or rashes that became exposed? Please be specific. _____

How did exposure occur? Please be specific: _____

Who was notified of the incident? _____ Tel#: _____

PRE-EXPOSURE INFORMATION (please print)

Were you wearing personal protective equipment? ☐Yes ☐No

If answer is "Yes", please describe in detail: _____

What engineering or work practice controls were in place? _____

Were you trained in OSHA Standard 29 CFR 1910.1030 or the Department's Exposure Control Plan? ☐Yes ☐No

EMPLOYEE SIGNATURE: _____ DATE: _____

White – Medical Officer Yellow – Employee P605 A03 063021

Authorization for Release of Medical Info

Inmate ID: 000000
SSN: 000-00-0000
DOB: 04/05/1989

Preview Patient #000000

Plymouth County Sheriff's Department
26 Long Pod Road
Plymouth, MA 02360

Telephone (508) 830-6200
Fax (508) 830-6358

To:	

Subject: AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR PCCF

In order to be properly treated for medical infirmities, I hereby authorize you to forward any and all medical records pertaining to me to:	
to familiarize this provider with my medical history, and to assist them in continuing my treatment. I was a patient and/or inmate at your facility on or about:	
and was treated for:	
I request:	☐ Complete Records ☐ Discharge Summary ☐ Outpatient Records ☐ Pathology ☐ HIV ☐ Abstract ☐ History & Physical ☐ X-Rays ☐ Physical Therpy ☐ Hepatitis ☐ Face Sheet ☐ Consults ☐ Laboratory ☐ Emergency Report ☐ Other, as specified
Patient's Signature	
Staff/Witness	
I also wish to have any confidential records which hare kept in my medical record released to the above part (Please check those that apply)	☐ Psychological or psychiatric impairment ☐ Aquired Immunodeficiency Virus (AIDS) ☐ Test of infection with Human Immunodeficiency Virus (HIV) ☐ Drug and/or alcohol abuse ☐ Sickle Cell Anemia
Patient's Signature	
Staff / Witness	

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records, social service agency, any employee or retail business establishment, including as officers, employees, or related personnel, both individually and collectively, from any and all liability for damage of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, I understand that this authorization is valid until my release from supervision or one year from date above, whichever comes first, at which time this authorization to use or

disclose information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health informatio, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contract.

For Health Services Dept. Use

Copied by:	
Date Sent:	
Sent to:	

Medical Report

Preview Patient #000000

Inmate ID:	000000	**Location:**	Location
DOB:	04/05/1989	**Ethnicity:**	Ethnicity
Age:	32	**Race:**	Race
Height:	-	**Interviewer:**	Title Last, First (07/06/2021 1310)
Weight:	-		
Agency:	County		

Recommended Housing:	
	☐ Contagious Disease ☐ Alcohol Detoxification ☐ Drug Detoxification ☐ Suicide Precaution ☐ Other
	☐ Cardiac ☐ Double-Bag Trash & Laundry ☐ Give Additional Fluids at Meal ☐ Diabetic - Allow approved snacks from Kitchen ☐ Special Diet

Activity Instructions

	☐ Strict bedrest ☐ Visits - Non-contact ☐ No exercise ☐ No work ☐ No shower - tub bath only ☐ No outdoor reck-dec ☐ No weights/gym

Allow

	☐ Appliances: Cane, crutches; other: ☐ Special therapy: ☐ Tub soaks ☐ Other
Inmate/Detainee denies the need for assistance with ADL's?	○ Yes ○ No (see note) ○ Not applicable
NOTES	
Status Review Date	
Release Date	

Distribution:
1 - Individual Institutional Case File
1 - Inmate's Unit Officer

UNIVERSAL PRECAUTIONS : POLICY 605: ATTACHMENT 6

PROCEDURE FOR CLEANUP OF BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIAL

Any area, equipment, clothing, etc., contaminated by a spill of blood or other potentially infectious material, which can be cleaned and decontaminated, will be done so in accordance with the following procedures. At all times, employees will observe universal precautions:

UNIVERSAL PRECAUTIONS

TASK OR ACTIVITY	DISPOSABLE GLOVES	GOWN	MASK	PROTECTIVE EYEWEAR
Bleeding Control with spurting blood	**Yes**	**Yes**	**Yes**	**Yes**
Emergency childbirth	**Yes, if splashing is likely**	**Yes, if splashing is likely**	**Yes**	**Yes**
Blood Drawing	**At Certain Times**	**No**	**No**	**No**
Starting an (IV) Intravenous Line	**Yes**	**No**	**No**	**No**
Endotracheal intubation	**Yes, esophageal obturator use**	**No, unless splashing is likely**	**No, unless splashing is likely**	**No, unless splashing is likely**
Oral / Nasal suctioning, manually cleaning airway	**Yes**	**No**	**No**	**No**
Handling & cleaning instruments with microbial contamination	**Yes**	**No, unless splashing is likely**	**No**	**No**
Measuring Blood Pressure	**No**	**No**	**No**	**No**
Measuring Temperature	**No**	**No**	**No**	**No**
Giving an injection	**No**	**No**	**No**	**No**

1. Wear latex gloves if possible when handling blood and other fluids requiring "universal precaution" or soiled items. Pull gloves off inside out; wash your hands with soap and water.

2. IMMEDIATELY thoroughly wash your hands or other skin surfaces after contact with blood or other fluids which require "universal precautions".

3. Clean up any blood spills or fluids with "universal precautions" Use disinfectant, as premixed.

4. Avoid needle stick injuries.

5. Be very careful when disposing of used needles.

UNIVERSAL PRECAUTIONS : POLICY 605: ATTACHMENT 6

6. Wear protective clothing or other gear when there is a chance of being splashed with blood or other fluids that require "universal precautions".

A. Determine Category of Spill - The staff person responding to an incident or report of spill will assess the category of the spill as MINOR, MEDIUM or MEGA:

CATEGORY	AMOUNT	EXAMPLE
MINOR	Droplets & up to 3oz : (up to 3 shot glasses)	Bloody Nose / Small Laceration
MEDIUM	3 to 8 oz : (up to 1 single serving, facility milk carton)	Stab Wound, Large Laceration, Bloody Fecal Matter
MEGA	Over 8 oz	Hemorrhaging, Gun Shot Wound, Cut Wrists, Childbirth Deliveries, Vomiting with Quantities of Blood

B. Control Further Contamination - A staff person will be posted in the affected area, as needed, to ensure containment of the spill, and to prevent the accidental spread of the contaminant to persons, or tracking throughout the institution.

C. Report Spill To Central Control

The staff person assessing the spill will immediately report it to Central Control and the Shift Commander. Central Control, per order of the Shift Commander, will make the following notifications, as appropriate:

CATEGORY	NOTIFY
MINOR	SHIFT COMMANDER
MEDIUM	SHIFT COMMANDER
MEGA	SHIFT COMMANDER & HEALTH SERVICES UNIT STAFF

D. Medical Unit Responsibilities

When notified by Central Control and/or the Shift Commander or a MEGA spill, a Medical Officer will be required to report to the spill site to provide direction, and to advise staff regarding cleanup procedures.

E. Cleaning Responsibilities

Properly trained facility staff, to include inmate workers, will be responsible for cleaning up spills of blood and other potentially infectious materials according to the procedures herein which will be strictly followed:

UNIVERSAL PRECAUTIONS : POLICY 605: ATTACHMENT 6

1. Universal Precautions

   a. Facility staff that clean spills of blood or other potentially infectious materials will:

      1. Respond to each spill site with an Emergency Spill Kit.
      2. When advised and directed by Health Services Unit staff, Emergency Spill Kit(s) will be used.

   b. In all cases, universal precautions will be used, and will include, but not be limited to:

      1. Latex gloves,
      2. Spray container of 1:10 bleach / or disinfectant solution,
      3. Paper towels, and plastic leak proof bags marked "CAUTION - CONTAMINATED TRASH".

2. Emergency Spill Kits

   Emergency Spill Kits will be maintained in areas designated by the licensed facility physician. Each kit contains the following equipment:

QUANTITY	ITEM	SPECIAL INSTRUCTIONS
One	Gown	With the opening in the back, close the Velcro neck, and tie the waist
One	Mask With Eyeshield	Place gray foam strip against forehead; pull mask down over nose & mouth w/blue portion of mask facing outward. Wrap straps around each ear. Eyeshield may be unsnapped & removed if necessary
Two	Booties	Pull over shoes
One	Bonnet	Pull over head / cover hair
Two	Gloves	Use over latex gloves
One	CPR Shield	Facilitates performing CPR w/out danger of back flow contamination of the rescuer
Two	Towels	Used to wipe up spills
Two	Biohazard Bags	One 3-gallon, and 1 ten-gallon marked plastic bag (English & Spanish) for contaminated waste or other contaminated items
One	Premisorb	Absorbent that gels and deodorizes spills. Follow directions for use (attached)
One	Dust Pan & Brush	Used to sweep up spills once gelled, glass or other debris
One	Calvicide	Disinfectant/cleaner used to disinfect area after cleaned
Two	Sanidex	Towelettes used to wipe hands after cleaning a spill, after all protective clothing is removed, and after **biohazard** bag is sealed

UNIVERSAL PRECAUTIONS : POLICY 605: ATTACHMENT 6

3. Special Precautions For Broken Glass

Broken glass that may be contaminated with blood or other potentially infectious material, will not be handled, even when wearing gloves! Rather, glass will be cleaned up using other means, such as broom and dust pan, tweezers, etc.

4. Cleanup Procedures

CATAGORY	EQUIPMENT	PROCEDURE
MINOR & MEDIUM	**Universal Precautions**	1. Inspect gloves to ensure there are no tears or defects 2. Wearing gloves, spray the affected area 3. Wait 1 minute; wipe w/paper towels 4. Repeat steps 1-3 until thoroughly cleaned 5. Place dirty towels in marked plastic bag 6. Carefully remove gloves & place in marked plastic bag 7. Seal the bag; place bag in trash out-of-reach of inmates 8. Wash hands w/warm water & soap universal precautions
MEGA	**Universal Precautions** Mop & Bucket	1. Inspect gloves to ensure there are no tears or defect 2. Follow up clean-up directions given by Health Services Unit staff 3. Keep mop-heads in bucket containing 1:10 bleach or disinfectant solution 4. Carefully, remove protective equipment & place in plastic bag marked "CAUTION-CONTAMINATED LAUNDRY" 5. Carefully remove protective clothing & place in plastic bag marked "CAUTION CONTAMINATED LAUNDRY" 6. Carefully remove gloves & place in place in plastic bag marked "CAUTION- CONTAMINATED LAUNDRY" 7. Wash hands and any other exposed areas with warm water and soap

* Single-use, disposable items, e.g. mask, paper suit, etc. should be placed in containers marked for contaminated trash, and should not be reused. Only equipment such as plastic glasses, face shields, handcuffs, etc., should be decontaminated.

UNIVERSAL PRECAUTIONS : POLICY 605: ATTACHMENT 6

5. Decontamination Procedures

Facility staff, and / or inmates, who perform decontamination functions will ensure universal precautions are followed at all times.

ITEM	PROCEDURE
Contaminated 1:10 Solution Or Disinfectant	Dispose via slop sink or flush in toilet
Slop Sink Or Toilet	Rinse with 1:10 solution or disinfectant
Mop Head	Rinse with 1:10 solution or disinfectant and repeat until all traces of contaminant
Mop Handle	Rinse with 1:10 solution or disinfectant
Clothing	Launder normally with detergent in washing machine; heavily soiled items should be washed separately; dry cleanables can be dry cleaned as normal
Eye Protection	Rinse with 1:10 solution or disinfectant until clean
Handcuffs	Rinse with 1:10 solution or disinfectant until clean

Questions concerning decontamination of equipment and clothing should be referred to the Health Services Unit or the Shift Commander.

Note: **If it is determined that a bleach solution should be used instead of the available disinfectant in the facility, the Shift Commander is to be notified and will authorize the bleach to be brought into the area / unit for clean up. Immediately after the cleaning is complete, the bleach will be returned to the Shift Commander for storage in Central Control.**

COMMUNICABLE DISEASES

(1) COMMUNICABLE DISEASES
(2) HIV
(3) GONORRHEA
(4) PEDICULOSIS
(5) SCABIES
(6) SYPHILIS
(7) TUBERCULOSIS
(8) HEPATITIS
(9) UNPROTECTED EXPOSURE AND INFECTIOUS DISEASE REPORTING LAW/REGULATIONS MGL c.111, s.111C AND 105 CMR ET. SEQ.
(10) POLICY REGARDING DETAINEES SUSPECTED OF HAVING A COMMUNICABLE DISEASE
(11) MEDICAL ISOLATION

(1) COMMUNICABLE DISEASES

(a) Diagnosis and treatment of a communicable disease will be based on the recommendation of an appropriate Healthcare Professional (ie; M.D., N.P., P.A.)

(b) Refer to Department of Public Health Manual "Communicable Diseases", and List of Reportable Diseases (POLICY / PROCEDURE 605).

(c) Medical isolation when indicated (see Section (11)).

(2) HIV

(a) Policy

(i) Inmates who have or who are reasonably suspected of having an infectious disease will not be denied rights or services because of their medical condition.

(ii) Employees of the Sheriff's Department who have, who are reasonably suspected, or who may have been exposured to an infectious disease will not be denied employment or benefits.

(b) Diagnostic Protocol

(i) Confidential HIV testing of inmates will be done only upon written request by the inmate, after education and counseling.

(ii) Confidential HIV testing of employees who may have been exposured to an infectious disease during their normal duties may be done at the Beth Israel Deaconess Hospital Plymouth only upon request by the employee. Such testing will remain completely confidential between the employee and Beth Israel Deaconess Hospital Plymouth Staff.

COMMUNICABLE DISEASES

(3) GONORRHEA

(a) Policy

(i) If inmate reports symptoms clinically consistent with Gonorrhea such as: a burning sensation when urinating, a white, yellow or green discharge from the penis, or painful or swollen testicles. Rectal infections may either cause no symptoms or cause the following symptoms in both men and women: discharge, anal itching, soreness, bleeding, or painful bowel movements.

(ii) No food handling until diagnosed and treated by a medical provider. Do not clear inmate to work in the kitchen.

(iii) Refer inmate to be seen by medical provider.

(iv) Refer to Department of Public Health Manual, Division of Venereal Diseases.

(b) Diagnostic Protocol

(i) Examination by medical provider.

(ii) Diagnosis by culture of infected site or urinalysis and urine culture.

(iii) Treatment designated by Department of Public Health, when ordered by medical provider.

(4) PEDICULOSIS (BODY LICE)

(a) In the HSU, give patient a bottle of RID or the equivalent and instruct the patient to follow the instructions on the bottle.

(b) Care of clothing

(i) Instruct the officer that after-a shower, the resident should have a clean set of bed linen and clothing issued. Notify laundry.

(ii) Wash clothing and linens in hot water and machine dry on high heat.

(5) SCABIES

(a) After diagnosis by the physician or Nurse Practitioner, instruct the patient to:

(i) While in the HSU, apply Permetherin lotion to the body from neck to toes;

(ii) Leave medication on the body for twelve (12) to twenty-four (24) hours;

COMMUNICABLE DISEASES

(iii) Thereafter, wash skin via a hot shower;

(iv) Return to sick call in one (1) week for re-treatment, following the steps listed in i-iii above

(b) Care of clothing

(i) Instruct the officer that after showering, the resident should have a clean set of bed linen and clothing issued. Notify laundry.

(ii) Wash clothing and linens in hot water and machine dry on high heat.

(6) SYPHILIS

(a) Policy

(iii) If inmate reports symptoms clinically consistent with syphilis such as: painless sore on genitals, anus or in mouth (primary stage), or a rough, red or reddish brown rash to feet and/or hands, or mucous membrane lesions in mouth, vagina, or anus (secondary stage) with or without fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue.

(iv) No food handling until diagnosed and treated by medical Provider. Do not clear inmate to work in the kitchen.

(iii) Refer inmate to be seen by medical provider.

(iv) Refer to Department of Public Health Manual, Division of Venereal Diseases.

(b) Diagnostic protocol

(i) Examination by medical provider.

(ii) Medical Provider will order appropriate serology.

(iii) Treatment designated by Department of Public Health, when ordered by medical provider.

(7) TUBERCULIN SCREENING EXAMINATION

(a) This form will replace all other forms currently being used to document administration and reading of PPD's and screening of inmates for tuberculosis.

(b) The *TUBERCULIN SCREENING EXAMINATION* form is to be completed electronically in the electronic medical record at the time of the Medical Intake Screening.

COMMUNICABLE DISEASES

The Medical Officer will complete the Symptom Evaluation section:

i. If the inmate is identified or self identifies as HIV positive, a Chest x-ray will be scheduled, a PPD plant will not be completed.

(c) The Medical Officer will then document the Current TB Testing that is done.

i. PPD implant date, location and signature
ii. Date of last chest X-ray and result (if known).
iii. If the inmate/detainee is transferred from another facility and has documentation of a recent PPD test (within the last year) the Medical Officer will check the Not Planted box and enter the information in the note box.
iv. If the inmate/detainee requires a chest x-ray the Medical Officer will check the Not Planted box and proceed to the Chest x-ray section of the form to document that they have scheduled a chest x-ray to be done. The Medical Officer must also complete a Physicians Order form.
v. When the date planted section is filled out, it automatically generates a task 2 days out on the PPDs to be read task line to ensure the PPD test is read within 48-72 hours. It also automatically generates a task 365 days out on the Infectious Disease Annual PPD task line to ensure the inmate is scheduled for an annual PPD test.

(d) If the inmate indicates that he has had a previous positive PPD test, one of the following should occur:

i. If the individual is an INS detainee, with previously documented positive status within the last year, schedule a Chest X-Ray (fill out X-ray requisition, and complete the Physicians Order form.
ii. If the individual is a County/Federal inmate, with previous documented positive status within the last year. The document must be placed in the medical chart and a chest x-ray will not be required.
iii. If the individual is a County/Federal inmate, without any previous documented positive status within the last year, a chest x-ray will be required.
iv. When the date ordered section is filled out, it automatically generates a task for 355 days out on the Infectious Disease Annual PPD x-ray task line.

(e) The Clerk-Typist will generate a daily list of PPD results that need to be read.

ii. The list will be placed on the proper med cart for each inmate who needs to have a PPD read.
iii. The Medical Officer will put results on the list.
iv. After completion of med pass, the Medical Officer will document the results of the PPD read in the inmate's electronic medical chart.
v. ***If the PPD is positive,(>5mm induration for ICE detainee and >10mm induration for inmate) the Medical Officer will schedule a Chest X-ray and complete a Physicians Order form.***

COMMUNICABLE DISEASES

(f) The Symptom Checklist is to be used during the Annual PPD/TB Screening Procedures for inmates who have had a previous >10mm induration with a negative Chest X-ray and ICE detainees who have had a previous >5mm induration with a negative chest x-ray.

(8) HEPATITIS

(a) Policy

(i) Inmates who have or who are reasonably suspected of having an infectious disease will not be denied rights or services because of their medical condition.

(ii) Employees of the Sheriff's Department who have, who are reasonably suspected, or who may have been exposured to an infectious disease will not be denied employment or benefits.

(b) Diagnostic Protocol

(i) Confidential HCV testing of inmates will be done only upon written request by the inmate, after education and counseling.

(ii) Confidential HCV testing of employees who may have been exposured to an infectious disease during their normal duties may be done at the Beth Israel Deaconess Hospital Plymouth only upon request by the employee. Such testing will remain completely confidential between the employee and Beth Israel Deaconess Hospital Plymouth Staff.

(c) Inmates diagnosed with chronic Hepatitis C (HCV) will be followed by the infectious disease Physician in the infectious disease clinic. Treatment of HCV is determined and ordered by the infectious disease physician.

(d) Inmates wishing to receive the Hepatitis B vaccine can request the vaccine by written request through the sick call process.

(i) Inmates suspected of having Hepatitis B will be referred to the medical provider for initial treatment in consultation with the infectious disease Physician. Hepatitis B cases should be reported to the Department of Public Health.

(e) All inmates and detainees are offered the Hepatitis A vaccine at the time of Medical Intake Screening.

(i) Inmates suspected of having Hepatitis A will be referred to the medical provider for initial treatment in consultation with the infectious disease Physician. Inmates with symptoms of Hepatitis A or diagnosed with Hepatitis A will require medical isolation until no longer considered infectious. They should also not be allowed to work in the kitchen. If an inmate is symptomatic and a kitchen worker, the Department of Public Health should be consulted for infection control purposes. All cases of Hepatitis A are require to be reported to the Department of Public Health.

COMMUNICABLE DISEASES

(9) EXPOSURE OF CONCERN AND COMMUNICABLE DISEASE REPORTING LAW/REGULATIONS MGL c.111, s.111C AND 105 CMR ET.SEQ.

(a) Communicable diseases that are a risk to public health include all those listed in POLICY / PROCEDURE 605, and require reporting to the Massachusetts Department of Public Health, or the local Board of Health pursuant to MGL Chapter 111, Section 6.

(b) An inmate exposure to blood borne pathogens will be evaluated and managed according to the current Center for Disease Control (CDC) and Massachusetts department of Public Health (DPH) guidelines for non-occupational exposures to HIV, Hepatitis B and Hepatitis C viruses.

(c) An exposure of concern is capable of transmitting an infectious disease in the following ways:

(i) Blood-to-blood contact with open wounds including open cuts, sores, rashes, abrasions, or other conditions which interrupt skin integrity

(ii) Inhalation exposure by close, face-to-face contact with a patient who has coughed and/or sneezed on an individual

(iii) Mucous membrane contact with potentially infectious body fluids (blood, genital secretions, saliva, urine or feces).

(iv) Puncture wounds resulting from used needles, glass and other sharp objects contaminated with blood, or body fluids.

(d) Policy and Procedure

(i) Any employee who suspects exposure to an infectious disease will complete the Infectious Disease Exposure Report Form (POLICY / PROCEDURE 605), and present him/herself to the Medical Unit for evaluation and first aid.

(ii) The employee who has sustained the exposure will be instructed to seek medical care at Beth Israel Deaconess Plymouth Hospital emergency room or occupation health.

(iii) The employee will be instructed to contact his/her personal physician for medical follow-up.

(v) Notices to the individual(s) who have been exposed to infectious disease(s) will be made confidentially.

(vi) The identity of the individual diagnosed as having an infectious disease dangerous to the public health as defined in these regulations will not be released either orally or in writing to any individual(s) who have sustained the unprotected exposure. The patient's name will be kept confidential in accordance with MGL Chapter 111, Section 70F. Reporting

COMMUNICABLE DISEASES

requirements pursuant to MGL Chapter 111, Section 6 will be effected by the Medical Administrator.

(vii) The individual with an infectious disease will be informed that others have been notified of his disease and that his name has been kept confidential.

(viii) The Medical Unit will clearly document that notification to the appropriate individuals has been made, as required.

(ix) The Medical Director / Physician will determine and advise the Medical Administrator whether or not the reported unprotected exposure is capable of transmitting such a disease.

(xii) The information as to the identity of the individual infected and the individual exposed will be held confidential, except in accordance with MGL Chapter 111, Section 6.

(xiii) The infected inmate will be informed of his diagnosis of an infectious disease dangerous to the public health, prior to informing the individual who has sustained an unprotected exposure. The exposed individual(s) will be informed orally within forty-eight (48) hours, and in writing within seventy-two (72) hours.

(xiv) Notwithstanding the provisions of any general or special law to the contrary, no doctor, administrator, official or representative will be held jointly or severally liable either as an institution or personally for reporting pursuant to the requirements, if such report was made in good faith. (MGL Chapter 111, Section 111C).

(e) References

Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR 2001; 50(No. RR-11): [1-43].

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Last update 2019

The National Institute for Occupational Safety and Health (NIOSH) Blood Borne Infectious Disease: HIV/AIDS, Hepatitis B and Hepatitis C:http://www.cdc.gov/niosh/topics/bbp/guidelines.html

(10) POLICY REGARDING INMATES / DETAINEES SUSPECTED OF HAVING A COMMUNICABLE DISEASE

(a) Identify the problem via:

COMMUNICABLE DISEASES

(I) Receipt of a Medical Intake Screening Form and/or

(ii) Inmate / Detainee complaint and / or

(iii) Documented evidence from court / family doctor / outside clinic

(b) Notify Medical Officer On-duty and/or Medical Administrator.

(c) Medical Officer will follow-up and have the inmate/ detainee evaluated by a physician within twenty-four (24) hours or sooner if deemed necessary; lab work as ordered by the physician.

(i) No inmate / detainee will be moved on "word-of-mouth" or their own "say-so". It will be a physician's decision to initiate medical isolation or move the person to either the Beth Israel Deaconess Hospital Plymouth, Lemuel Shattuck Hospital, or another appropriate facility.

(ii) The Health Services Unit Staff will maintain medical isolation until level of isolation/precautions is determined by physician or medical provider.

(d) Unless otherwise advised, the patient is to be isolated in a single cell.

(I) Use double plastic bags for trash and laundry.

(iii) Notify Laundry Officer.

(iii) Wear disposable gloves when appropriate. Wash hands after contact.

(iv) No sharing of personal items,

(v) Continue isolation until transferred out or cleared. In some cases, the inmate / detainee should not leave the cell for any reason. If in doubt, check with the Medical Officer.

(e) On release, or for daily cleaning of cell, use bleach (one (1) part to ten (10) parts water); wear gloves and air out the cell two (2) to four (4) hours before re-use.

(f) Each transportation vehicle will be supplied with a set of disposable gloves and face masks for use by officers.

(11) MEDICAL ISOLATION

(a) All inmates placed in medical isolation by the Health Services Unit Staff will be released when deemed non-communicable by the physician

(b) Earlier release will be determined by the Health Services Unit Staff depending on the circumstances.

COMMUNICABLE DISEASES

(c) During the medical isolation period, an inmate will be allowed showers, exercise and visits, unless specific restrictions are imposed for the welfare of the inmate concerned. Restrictions will be specified regarding medical isolation and/or treatment based on an individual cases by case basis. (Refer to POLICY / PROCEDURE 605). Questions should be directed to the Medical Supervisor or Medical Officer On-duty.

(d) After an inmate has been moved to a facility for any emergency evaluation, he will be placed in medical isolation until seen by the Health Services Unit Staff. This includes inmates returned from Lemuel Shattuck, Bridgewater State Hospital, and any other outside medical facility.

APPROVED: Kyndra Brooks HSA ***DATE:*** 7/12/21
Health Services Administrator

APPROVED: Laurence Baker, MD 7/12/21 ***DATE:***
Health Authority

COMMUNICABLE AND OTHER INFECTIOUS DISEASES REPORTABLE IN MASSACHUSETTS BY HEALTHCARE PROVIDERS*

*Reportable infectious diseases and conditions are not limited to those designated below.
This list includes *only* those which are *primarily* reportable by clinicians.
A full list of reportable diseases in Massachusetts is detailed in 105 CMR 300.100.

☎ REPORT IMMEDIATELY BY PHONE!

This includes both suspected and confirmed cases.

All cases should be reported to your local board of health;

if unavailable, call the Massachusetts Department of Public Health:
Telephone: (617) 983-6800 Confidential Fax: (617) 983-6813

• REPORT PROMPTLY (WITHIN 24 HOURS)

This includes suspected and confirmed cases.

⇨🖃 Isolates should be submitted to the State Public Health Laboratory

- ☎ Anthrax ⇨🖃
- ☎ Any case of an unusual illness thought to have public health implications
- ☎ Any cluster/outbreak of illness, including but not limited to foodborne illness
- ☎ Botulism ⇨🖃
- • Brucellosis ⇨🖃
- ☎ Cholera
- • Chikungunya virus
- • Creutzfeldt-Jakob disease (CJD) and variant CJD
- ☎ Diphtheria
- • Encephalitis, any cause
- ☎ Foodborne illness due to toxins (including mushroom toxins, ciguatera toxins, scombrotoxin, tetrodotoxin, paralytic shellfish toxin and amnesic shellfish toxin, staphylococcus enterotoxin and others)
- • Hansen's disease (leprosy)
- ☎ Hemolytic uremic syndrome
- ☎ Hepatitis A (IgM+ only)
- • Hepatitis B in pregnant women
- • Hepatitis syndrome, acute possibly infectious
- ☎ Influenza, pediatric deaths (<18 years old) ⇨🖃
- ☎ Infection due to novel influenza A viruses ⇨🖃
- • Jamestown Canyon virus
- • Lymphocytic choriomeningitis
- • Malaria
- ☎ Measles ⇨🖃
- • Meningitis, bacterial, community acquired
- • Meningitis, viral (aseptic), and other infectious (non-bacterial)
- ☎ Meningococcal disease, invasive (*Neisseria meningitidis*) ⇨🖃
- • Mumps ⇨🖃
- • Pertussis
- ☎ Plague ⇨🖃
- ☎ Polio
- • Powassan
- ☎ Pox virus infections in humans, including variola (smallpox), monkeypox, vaccinia, and other orthopox or parapox viruses
- ☎ Rabies in humans
- ☎ Respiratory infection thought to be due to any novel coronavirus including SARS and MERS
- • Reye syndrome
- • Rickettsialpox
- • Rocky Mountain spotted fever
- ☎ Rubella
- ☎ Tetanus
- • Toxic shock syndrome
- • Trichinosis
- ☎ Tuberculosis ⇨🖃
- • Evidence of tuberculosis infection
- • Tularemia ⇨🖃
- ☎ Typhoid fever ⇨🖃
- • Typhus
- • Varicella (chickenpox)
- ☎ Viral hemorrhagic fevers

Animal bites should be reported **immediately** to the designated local authority.

Important Note: MDPH, its authorized agents, and local boards of health have the authority to collect pertinent information on all **reportable diseases, including those not listed on this page, as part of epidemiological investigations (M.G.L. c. 111, s. 7).**

COMMUNICABLE AND OTHER INFECTIOUS DISEASES REPORTABLE IN MASSACHUSETTS

*Reportable infectious diseases and conditions are not limited to those designated below.
This list includes *only* those which are *primarily* reportable by clinicians.
A full list of reportable diseases in Massachusetts is detailed in 105 CMR 300.100.

Reportable Diseases Primarily Detected Through Laboratory Testing

Please work with the laboratories you utilize to assure complete reporting.

- Anaplasmosis
- Amebiasis
- Babesiosis
- Campylobacteriosis
- Cholera
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- ☎ Eastern equine encephalitis ⇨🖹
- Ehrlichiosis
- *Escherichia coli* O157:H7 ⇨🖹
- Enteroviruses (from CSF)
- Giardiasis
- Glanders ⇨🖹
- ☎ Group A streptococcus, invasive
- Group B streptococcus, invasive in patients <1 year old
- ☎ *Haemophilus influenzae*, invasive ⇨🖹
- ☎ Hantavirus
- Hepatitis B
- Hepatitis C
- Hepatitis D
- Hepatitis E
- Influenza (⇨🖹 if antiviral resistant)
- Legionellosis ⇨🖹
- Listeriosis ⇨🖹
- Lyme disease
- Melioidosis ⇨🖹
- Norovirus
- Pneumococcal disease, invasive (*Streptococcus pneumoniae*) in patients <18 years old ⇨🖹
- Pneumococcal disease, invasive, penicillin-resistant
- Salmonellosis ⇨🖹
- Shiga toxin-producing organisms ⇨🖹
- Shigellosis ⇨🖹
- *Staphylococcus aureus,* methicillin-resistant (MRSA), invasive
- ☎ *Staphylococcus aureus,* vancomycin-intermediate (VISA) and vancomycin-resistant (VRSA) ⇨🖹
- Psittacosis
- Q fever
- Toxoplasmosis
- Typhus
- Vibriosis ⇨🖹
- West Nile ⇨🖹
- Yellow fever
- Yersiniosis ⇨🖹
- Zika

Report Directly to the Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences

305 South Street, Boston, MA 02130
Tel: (617) 983-6801 Confidential Fax: (617)983-6813

Sexually Transmitted Infections

- Chancroid
- Chlamydial infections (genital)
- Gonorrhea ⇨🖹
- Gonorrhea resistant to Ceftriaxone ⇨🖹
- Herpes, neonatal (onset within 60 days after birth)
- HIV infection and AIDS
  - ☎ Acute HIV infection
- Lymphogranuloma venereum
- Ophthalmia neonatorum
- Pelvic inflammatory disease
- Syphilis

⇨🖹 Isolates should be submitted to the State Public Health Laboratory

The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Department
Plymouth County Correctional Facility

26 Long Pond Road
Plymouth, MA 02360
Telephone: (508) 830-6200
Fax: (508) 830-6201
www.pcsdma.org

Joseph D. McDonald, Jr.
Sheriff

Gerald C. Pudolsky
Special Sheriff

Accredited by:
American Correctional Association

Hazardous Exposure Instructions

To: Exposed and Assessed Subject

From: PCCF Medical Unit

Subject: Instructions regarding follow-up to an Exposure

You have been assessed by Medical Personnel regarding your exposure and are advised of the following:

1.) You are advised to present yourself to the Emergency Room at Beth Israel Plymouth Hospital for treatment, confidential testing and counseling.

2.) You may opt to see your primary physician within 72 hours.

3.) Follow all orders rigidly and without fail.

Receiving Signature: _____ Date: _____

Medical Officer's Signature: _____ Date: _____

These instructions are consistent with Policy and Procedure 605. (PCCF 605 Section VII)

APPROVED: _____ ***DATE:*** 8.9.21

Jorge R. Veliz, M.D.
Health Authority

Pf605at9 063021

The Commonwealth of Massachusetts
County of Plymouth
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PLYMOUTH COUNTY CORRECTIONAL FACILITY

HIV ANTIBODY TESTING

1. You will be given your results in writing in two weeks.
2. You will be asked if you would like to see your test results you are not required to get your test results. You may use a follow-up visit as a time to re-evaluate whether it is advisable for you to receive your test results.
3. You should present this form when receiving test results at a follow-up visit.
4. If you are released to another facility, a counselor can call Lisa or Vicky at 508-830-6206.
5. If you are released to the street before you receive your test results, call Lisa or Vicky at 508-830-6206 (two weeks after the test was given).

Appointment / Sample Code: _____

Pre-Test Counselor: _____

The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Department
Plymouth County Correctional Facility

26 Long Pond Road
Plymouth, MA 02360
Telephone: (508) 830-6200
Fax: (508) 830-6201
www.pcsdma.org

Joseph D. McDonald, Jr.
Sheriff

Gerald C. Pudolsky
Special Sheriff

COUNSELING AND TESTING PROGRAM FOR HIV ANTIBODY SCREENING

Confidential Informed Consent Form

I understand that testing for HIV antibody is voluntary and strictly confidential. Although I will be asked to give my name and other information for identification, only the code number that I have been given will be used to identify my blood sample and the necessary forms which accompany the specimen to the lab in order to protect my confidentiality.

I understand the benefits and risks of testing and the meaning of a negative, positive and indeterminate test result as explained to me by the HIV counselor.

I am aware that I may experience increased anxiety in the course of having this procedure, or while waiting for the test results. I acknowledge that I may be made more anxious knowing test results.

I understand that if my blood test is positive, I will be offered counseling and referral for further health care and assistance in notifying my partners.

I understand that my test results will become part of my medical file here at the Plymouth County Correctional Facility.

It is my personal decision to have this test. I realize that the results will not necessarily answer all my questions about HIV / AIDS.

I agree that in order to receive my test results, I must return to see the HIV Counselor for my post-test counseling session. I also understand that I have a choice about being informed of the test results, and that I can re-evaluate my decision at any time.

Date: _____

Signature of Inmate: _____

Signature of Witness: _____

Plymouth County Sheriff's Department
26 Long Pond Road
Plymouth, MA 02360

Tel: (508) 830-6200
Fax (508) 830-6358

Report of Infectious Disease

Patient Information

Last Name_____First_____M.I._____

Date of Birth_____I.D.#_____

Diagnosis Date

Date Reported_____

Physician _____

Comments:

HIV/AIDS Surveillance

Instructions for Completing the Adult HIV/AIDS Confidential Case Report

- Starting January 1, 2007, HIV infection cases must be reported by name to the Massachusetts HIV/AIDS Surveillance Program at the MDPH. This is the same way that AIDS cases have been reported to MDPH since 1983.
- All patients diagnosed with HIV infection who are receiving medical care at your facility should be reported by name starting January 1, 2007. If individuals have been previously reported using the code, the Department expects these individuals to be re-reported by name prior to December 31, 2007 (12 month period).
- This reporting change also serves as a reminder to review your facility's current HIV testing and care consent forms to be certain they are accurate about reporting by name to MDPH.
- State regulations (105 CMR 300) identify AIDS and HIV as reportable diseases and mandate that health care providers licensed by the Commonwealth and facilities licensed by the Department (hospitals, clinics or nursing homes) report HIV and AIDS cases. Because persons with HIV infection may receive treatment from different health care providers, the primary medical care provider and/or the facility where care is provided are considered the principal source of HIV case reports. Facilities with large HIV case loads should develop a coordinated reporting plan and designate an individual responsible for reporting. Patients who are not Massachusetts residents are not reportable. Likewise, providers and facilities located outside Massachusetts are not subject to the reporting regulation.

This document provides detailed instructions and guidance for completing the form. Following is a breakdown of all information called for on the form according to sections. Please fill in the form as completely as possible.

DATE FORM COMPLETED

Fill in completely.

DIAGNOSIS STATUS AT REPORT

Check off HIV Infection or AIDS in the top right corner of the form.

I. HEALTH DEPARTMENT USE ONLY

To be filled in by Massachusetts Department of Public Health personnel.

II. FOR HIV & AIDS - MUST BE COMPLETED - ESSENTIAL INFORMATION

This information must be filled in for HIV infection and AIDS cases. Completion of the code section of the case report form is required to facilitate linkage of cases reported by name to cases previously reported under the code-based HIV reporting system and to assure an accurate count of those HIV cases previously reported by code for Federal auditing purposes.

To create the code, follow the steps listed below carefully.

Name-related Fields

Use the first two letters of the first name and the number of letters in the last name as the name

appears on the medical record.

First names: DO NOT use a nickname unless it represents the patient's name of record. If the first name of record is an initial only, disregard it and enter the first two letters of the next name in sequence.

Example: T. Walter Smith=WA5

Last names: Please ignore hyphens, apostrophes, spaces or periods that occur in the last name. When last names are hyphenated or contain two elements that are not stand-alone names (St. James, De Leone) include all the letters in the count. When individuals have multiple surnames not connected by hyphens, use only the final one in sequence for the count.

Example 1: John Doe=JO3

Example 2: Linda D'Agostino=LI9

Example 3: Bill McCarthy=BI8

Example 4: Jane O'Brien=JA6

Example 5: Al Smith-Jones=AL10

Example 6: Susan St. James=SU7

Example 7: Anna Maria Lopez Sanchez=AN7

Example 8: G. Gordon Liddy=GO5

Gender: Check the appropriate box.

Month/Date/Year of Birth: Fill in numbers corresponding to the month, day, and year of birth in the designated boxes (Jan= 01, Feb=02, etc.)

Example: June 8,1955=060855

Last 4 Digits of Social Security Number: If the social security number is available, write in the LAST four digits in the designated boxes. These digits are randomly assigned and do not identify an individual. If a social security number is not available, enter "9999."

Zip Code: Enter the five digit zip code of the patient's current residence. If the patient has a street address but no recorded zip code, enter "99999." If a patient is homeless, enter "88888."

III. DEMOGRAPHIC INFORMATION

Complete all relevant items. "Residence at diagnosis" refers to location where person was living at the time they were diagnosed with AIDS or tested positive for HIV infection; provide zip code if known. This zip code may be different from the "zip code of residence" in section II.

IV. FACILITY OF DIAGNOSIS

Complete all relevant items. Under "facility type", please use *Other* to identify a Counseling and

Testing site that is NOT affiliated with one of the other individual selections.

V. PATIENT HISTORY

Check off either "Yes" "No" or "Unk." for EVERY item.

VI. LABORATORY DATA

Fill in the relevant boxes for all test results available.

CLINICAL RECORD REVIEWED

Please check "yes" or "no." A "yes" indicates that a medical record was reviewed to complete the form. A "no" answer indicates that another clinical source, such as a demographic information database, was consulted.

VII. AIDS DEFINING CONDITIONS

This section lists AIDS indicator diseases and should be filled out for **AIDS cases only.**

VIII. TREATMENT/SERVICES REFERRALS

Complete all relevant items.

Note: Partner notification assistance is available from the Massachusetts Department of Public Health. Call (617) 983-6940.

IX. COMMENTS

Include any relevant information not collected in the above sections.

BOX AT THE BOTTOM OF SIDE TWO

Complete provider name and address information is essential in the event the Massachusetts Department of Public Health needs to follow up on a case. **Note:** This information will not be transmitted to the Centers for Disease Control and Prevention.

Once form is completed, please mail it an envelope marked "confidential" to MHASP - Room 241, Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130.

If you have questions about the HIV/AIDS Confidential Case Report form, call (617) 983-6560.

105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS

Section

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300.200: Isolation and Quarantine Requirements
300.210: Procedures for Isolation and Quarantine

300.001: Purpose

The purpose of 105 CMR 300.000 is to list diseases dangerous to the public health as designated by the Department of Public Health and to establish reporting, surveillance, isolation and quarantine requirements. 105 CMR 300.000 is intended for application by local boards of health, hospitals, laboratories, physicians and other health care workers, veterinarians, education officials, recreational program health service providers, food industry officials, and the public.

300.020: Definitions

Airborne Precautions. Measures designed to reduce the risk of transmission of infectious agents that may be suspended in the air in either small particle aerosols or dust particles (*i.e.* droplet nuclei <= 5 microns). Patients in health care facilities must be given a private room with special air handling and ventilation (negative pressure with respect to the rest of the facility), and an appropriate level of respiratory protection is necessary when entering the patient's room.

300.020: continued

Board of Health or Local Board of Health. The appropriate and legally designated health authority of the city, town, or other legally constituted governmental unit within the Commonwealth having the usual powers and duties of the board of health or health department of a city or town.

Carrier. An individual who can tolerate an infection so as not to become ill, yet is able to transmit the disease-causing organism to cause infection and illness in others.

Case or Patient. One who is ill, infected, injured or diagnosed with a reportable disease or injury.

Cluster. *See* 105 CMR 300.020: Outbreak or Cluster.

Communicable. Ability of an infection to be transmitted from one person or animal to another.

Contact. A person who has been in such association with an infected person or animal or with a contaminated environment as to have had exposure capable of transmitting the infection to that person.

Contact Precautions. Measures designed to reduce the risk of transmission of infectious agents that can be spread through direct contact with the patient or indirect contact with potentially infectious items or surfaces. Gloves and gowns are required for all patient contact and contact with the patient's environment; strict hand hygiene practices must also be applied.

Counseling. Process by which individuals and groups are advised as to how to promote, maintain and/or restore health. Methods and procedures used in counseling must take account of the ways in which people develop various forms of behavior, of the factors that lead them to maintain or to alter their behavior, and of the ways in which people acquire and use knowledge.

Date of Last Exposure. That point in time when exposure that would be expected to provide an opportunity for transmission of infection between a case or carrier and a susceptible person ends, or point in time when a case or carrier is no longer capable of transmitting illness or infection to others, whichever was more recent.

Department. The Massachusetts Department of Public Health.

Disease. An abnormal condition or functional impairment resulting from infection, metabolic abnormalities, physical or physiological injury or other cause, marked by subjective complaints, associated with a specific history, and clinical signs and symptoms, and/or laboratory or radiographic findings (compare 105 CMR 300.020: Illness).

Disease Event. An occurrence of a reportable disease or laboratory evidence of infection reported to a board of health or the Department and entered into the disease surveillance and case management system, MAVEN.

Disease Surveillance and Case Management System. MAVEN, a secure electronic system utilized by the Department and local boards of health to monitor or respond to diseases dangerous to the public health. MAVEN is maintained by the Department.

Droplet Precautions. Measures designed to reduce the risk of transmission of infectious agents via large particle droplets that do not remain suspended in air, usually generated by coughing, sneezing or talking. Masks must be used, but gowns, gloves and special air handling are not generally needed.

Enteric Precautions. Measures designed to prevent direct or indirect fecal-oral transmission of disease. Gowns must be worn if soiling is likely, and gloves must be worn for touching contaminated materials; strict hand hygiene practices must also be applied. Masks are not indicated.

Exposure. Proximity to, and or contact with, a source of an infectious agent with potential for acquisition of the infection.

300.020: continued

Food. Any raw, cooked or processed edible substance, ice, beverage, medications, or ingredient used or intended for use or for sale in whole or in part for human consumption *via* the alimentary tract.

Food Handler. Any person directly preparing or handling food. This could include the food handling facility owner, individual having supervisory or management duties, person on the payroll, family member, volunteer, person performing work under contractual agreement, or any other person working in a food handling facility. Food Handler also includes any person handling clean dishes or utensils. Any person who dispenses medications by hand, assists in feeding, or provides mouth care shall be considered food handlers for the purpose of 105 CMR 300.000. In health care facilities, this includes those who set up trays for patients to eat, feed or assist patients in eating, give oral medications or give mouth/denture care. In day care facilities, schools and community residential programs, this includes those who prepare food for clients to eat, feed or assist clients in eating, or give oral medications. Food Handler does not include individuals in private homes preparing or serving food for individual family consumption.

Food Handling Facility. Any fixed or mobile place, structure or vehicle, whether permanent, seasonal or temporary, in which food is prepared, processed, stored or held for sale, whether at retail or wholesale, or for service on the premises or elsewhere; or where food is served or provided to the public or segment of the public with or without charge. Food Handling Facility does not include private homes where food is prepared or served for individual family consumption.

Food Poisoning. Poisoning that results from eating foods contaminated with toxins. These toxins may occur naturally, as in certain mushrooms or seafoods; they may be chemical or biologic contaminants; or they may be metabolic products of infectious agents that are present in the food.

Health Care Provider. As defined in M.G.L. c. 111, § 1: "any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under the provisions of M.G.L. c. 112, or an intern, or a resident, fellow, or medical officer licensed under M.G.L. c. 112, § 9, or a hospital, clinic or nursing home licensed under the provisions of M.G.L. c. 111 and its agents and employees, or a public hospital and its agents and employees".

Health Care Worker. One who provides direct care to patients or who works in a setting where such care is provided.

Hepatitis Syndrome, Acute. Illness associated with symptoms, including but not limited to, jaundice, nausea, vomiting, abdominal pain, and laboratory evidence of liver damage or dysfunction occurring without identified cause or due to an unexpected or unusual cause.

Illness. An abnormal condition or functional impairment resulting from infection, metabolic abnormalities, physical or physiological injury or other cause, marked by subjective complaints and clinical signs (compare 105 CMR 300.020: Disease).

Immunity. Possession of protective antibodies or cellular components sufficient to protect from infection and/or illness following exposure to an infectious agent (*see* also 105 CMR 300.020: Resistance).

Incidence. A general term used to characterize the frequency of new occurrences of a disease, infection, or other event over a period of time and in relation to the population in which it occurs. Incidence is expressed as a rate, commonly the number of new cases during a prescribed time in a unit of population. For example, one may refer to the number of new cases of tuberculosis per 100,000 population per year.

Invasive Infection. Infection involving the bloodstream or internal organs, not including infection of the skin or mucous membranes. Invasive infection is usually established by the recovery of an etiologic agent from a usually sterile body fluid or tissue.

300.020: continued

Isolation. Separation, for the period of communicability, of infected persons from others in such places and under such conditions as will prevent the direct or indirect transmission of an infectious agent to susceptible people or to those who may spread the agent to others. Isolation applies also to animals (compare 105 CMR 300.020: Quarantine).

Laboratory. A facility or place, however named, the purpose of which is to make biological, serological, chemical, immuno-hematological, cytological, pathological, or other examinations of materials derived from a human body. Laboratory includes laboratories in hospitals and other facilities.

MAVEN. The Massachusetts Virtual Epidemiologic Network, the Department's infectious disease surveillance and case management system.

Novel Influenza A Viruses. A strain of influenza A that substantially differs antigenically from circulating or recently circulating influenza A viruses.

Outbreak or Cluster. The occurrence in a community, facility, workplace or region of cases of an illness clearly in excess of the number of cases usually expected. The number of cases indicating an outbreak or cluster will vary according to the infectious agent or the site conditions/hazards, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. Outbreaks or clusters are therefore identified by significant increases in the usual frequency of the disease in the same area, among the specified population, at the same season of the year.

Personal Surveillance. The practice of close medical or other supervision of contacts without restricting their movements in order to promote prompt recognition of infection or illness.

Point of Care Testing. Testing done at or near the site of patient care by use of a test cleared by the federal Food and Drug Administration for such use.

Prophylaxis. The administration of a drug or biologic agent to prevent the development of an infection or disease, or limit the progression of an infection.

Quarantine. Restricting the freedom of movement of well persons or domestic animals who have been exposed to a communicable disease for a period of time relating to the usual incubation period of the disease, in order to prevent effective contact with those not so exposed (compare 105 CMR 300.020: Isolation).

Report of a Disease. An official notice that shall include contact information for the clinician responsible for reporting the disease and full personal demographic, clinical, epidemiologic and laboratory information on the case, to the appropriate authority of the occurrence of a specified disease in people or animals, directly by telephone, in writing, by facsimile, or by electronic means. Content of reports to the Department shall be defined on a disease by disease basis. Also *see* 105 CMR 300.170 for laboratory reports.

Resistance. The sum total of body mechanisms which interpose barriers to the progress of invasion or multiplication of infectious agents or to damage by their toxic products.

(1) Immunity is that resistance usually associated with possessing antibodies or cells having a specific activity against the etiologic agent of an infectious disease. Passive immunity is attained either naturally by maternal transfer or artificially by introducing specific protective antibodies. Passive immunity is of brief duration. Active immunity is attained by infection, with or without symptoms, or by introducing certain fractions or products of the infectious agent or the agent itself in a killed, modified or variant form.

(2) Natural resistance is the ability to resist disease independently of antibodies or a specific cellular response. It commonly rests in anatomic, cellular or physiologic characteristics of the host. It may be genetic or acquired, permanent or temporary.

300.020: continued

Respiratory Hygiene/Cough Etiquette. Measures to prevent the transmission of all respiratory infections, that includes covering of the nose/mouth when coughing or sneezing, use and safe disposal of tissues and hand hygiene.

Risk. The probability of an individual developing a given disease or experiencing a change in health status over a specific period of time.

Spinal Cord Injury. The occurrence of an acute traumatic lesion of neural elements in the spinal canal (spinal cord or *cauda equina*) resulting in temporary or permanent sensory deficit, motor deficit, or bowel or bladder dysfunction.

Standard Precautions. Refers to consistent and prudent preventive measures to be used at all times regardless of patient's infection status. The Department adopts, by reference, as standard precautions for infection control, the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, published by the U.S. Centers for Disease Control and Prevention and its Healthcare Infection Control Practices Advisory Committee.

Surveillance of Disease. Monitoring the occurrence and spread of disease and indications of such occurrence and spread.

Susceptible. A person or animal not possessing resistance to a pathogenic agent. Such a person or animal is liable to contract a disease if or when significantly exposed to such agent.

Suspect Case. A person or animal with clinical and/or laboratory evidence suggestive of the existence of a disease or condition dangerous to the public health but prior to the confirmation of such a diagnosis.

Traumatic Amputation. An unintentional severing of some or all of a body part.

Traumatic Brain Injury. An occurrence of injury to the head, arising from blunt or penetrating trauma or from acceleration-deceleration forces, with one or more of the following conditions attributed to the injury: decreased level of consciousness, amnesia, skull fracture, or objective evidence of a neurological or neuropsychological abnormality or diagnosed intracranial lesion.

Tuberculosis.

(1) Active Tuberculosis. A disease that is caused by *Mycobacterium tuberculosis* or other members of the *Mycobacterium tuberculosis* complex family in any part of the body and that is in active state as determined by either:

(a) a positive diagnostic test for tuberculosis on any human specimen and the person has not completed the appropriate prescribed course of medication for active tuberculosis disease;

(b) radiographic, current clinical, or laboratory evidence sufficient to support a clinical diagnosis of tuberculosis for which treatment is indicated.

(2) Tuberculosis Infection (also known as Latent Tuberculosis Infection). Condition in which living *tubercle bacilli* are present in an individual, without producing clinically active disease. Infected individuals usually have a positive tuberculin skin test or laboratory test for tuberculosis infection (such as an interferon release assay or IGRA), but are not infectious.

Unusual Illness. An illness, by any indication, occurring for the first time or under rare circumstances, or an illness associated with signs and symptoms not otherwise expected to occur based on the known or presumed etiology of the illness.

Work-related Disease. A disease or condition which is believed to be caused or aggravated by conditions in the individual's workplace.

Work-related Serious Traumatic Injury to a Person Younger Than 18 Years Old. An injury to a person younger than 18 years old which:

300.020: continued

(1) results in death, hospitalization, or, in the judgment of the treating physician, results in significant scarring or disfigurement, permanent disability, significant loss of consciousness, or loss of a body part or bodily function; or which
(2) the physician determines is less significant but is of the same or similar nature to injuries previously sustained at the same place of employment.

Zoonotic. Infectious disease of animals that can be transmitted to humans.

300.100: Diseases Reportable to Local Boards of Health

Cases or suspect cases of the diseases listed as follows shall be reported by household members, physicians and other health care providers as defined by M.G.L. c. 111, § 1, and other officials designated by the Department, by telephone, in writing, by facsimile or other electronic means, as deemed acceptable by the Department, including transmission from electronic health records, immediately, but in no case more than 24 hours after diagnosis or identification, to the board of health in the community where the case is diagnosed or suspect case is identified. When available, full demographic, clinical and epidemiologic information, as defined by the Department, must be included for each report. The local board of health's responsibility, upon receipt of a report, is set forth in 105 CMR 300.110 and 300.160. Physicians and other health care providers shall also report the diseases listed as follows when identified to be present through point of care testing.

Anthrax
Arbovirus infection, including but not limited to, infection caused by:
chikungunya virus, dengue, eastern equine encephalitis virus, Jamestown Canyon virus, West Nile virus, yellow fever virus, and Zika virus
Botulism
Brucellosis
Cholera
Creutzfeldt-Jakob disease or variant Creutzfeld-Jakob disease
Diphtheria
Foodborne illness due to toxins (including mushroom toxins, ciguatera toxins, scombrotoxin, tetrodotoxin, paralytic shellfish toxin and amnesic shellfish toxin, staphylococcus enterotoxin, and others) Encephalitis, any cause
Hansen's disease (leprosy)
Hemolytic uremic syndrome (HUS)
Hepatitis A
Hepatitis B
Hepatitis C
Hepatitis D
Hepatitis E
Hepatitis syndrome, acute
Lymphocytic choriomeningitis
Malaria
Measles
Meningitis, bacterial, community-acquired
Meningitis, viral (aseptic) or other infectious (non-bacterial)
Meningococcal disease, invasive infection (with N. meningitidis)
Mumps
Pertussis
Plague
Poliomyelitis
Powassan
Pox virus infections in humans, including variola (smallpox), monkeypox, vaccinia, and other orthopox or parapox viruses
Rabies in humans
Respiratory infection thought to be due to any novel coronavirus, including but not limited to severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS)

300.100: continued

Reye syndrome
Rickettsialpox
Rocky Mountain spotted fever
Rubella
Tetanus
Toxic shock syndrome
Trichinosis
Tularemia
Typhoid Fever
Typhus
Varicella (chickenpox)
Viral hemorrhagic fevers, including but not limited to infection caused by Ebola virus, Marburg virus and other filoviruses, arenaviruses, bunyaviruses and flaviviruses

The following diseases shall also be reported to the local board of health. These diseases are often primarily ascertained through laboratory testing and reported to the Department pursuant to 105 CMR 300.170 through 300.174. If reported to the Department pursuant to 105 CMR 300.170 through 300.175, this may serve in *lieu* of direct reporting to local boards of health:

Anaplasmosis
Amebiasis
Babesiosis
Campylobacteriosis
Cryptosporidiosis
Cyclosporiasis
Ehrlichiosis
Giardiasis
Glanders
Group A streptococcus, invasive infection
Group B streptococcus, invasive infection in children younger than one year old
Haemophilus influenzae, invasive infection
Hantavirus infection
Influenza
Legionellosis
Listeriosis
Lymphocytic choriomeningitis virus infection
Lyme disease
Melioidosis
Noroviruses infection
Psittacosis
Q Fever
Salmonellosis
Shigellosis
Shiga toxin-producing organisms isolated from humans, including enterohemorrhagic *E. coli* (EHEC)
Streptococcus pneumoniae, invasive infection in individuals younger than 18 years old
Vibriosis (non-Cholera)
Yersiniosis

300.110: Case Reports by Local Boards of Health

Each local board of health shall report to the Department the occurrence or suspected occurrence of any disease reported to the board of health, pursuant to 105 CMR 300.100. When available, the case's full demographic, clinical and epidemiologic information, as defined by the Department, must be included for each report. Each local board of health shall utilize the secure electronic disease surveillance and case management system (MAVEN) designated and maintained by the Department. Each case shall be reported immediately, but no later than 24 hours after receipt by the local board of health.

300.120: Confidentiality

(A) All confidential personally identifying information, whether kept in an electronic system or paper format, including but not limited to, reports of disease, records of interviews, written or electronic reports, statements, notes, and memoranda, about any individual that is reported to or collected by the Department or local boards of health pursuant to 105 CMR 300.000, shall be protected by persons with knowledge of this information. Except when necessary for the Commonwealth's or local jurisdiction's disease investigation, control, treatment and prevention purposes, or for studies and research authorized by the commissioner pursuant to M.G.L. c. 111, § 24A, the Department and local boards of health shall not disclose any personally identifying information without the individual's written consent. Only those Department and local board of health employees who have a specific need to review personal data records for lawful purposes of the Department or local board of health shall be entitled access to such records. The Department and local boards of health shall ensure that all paper records and electronic data systems relating to information that is reported to or collected by the Department or local boards of health pursuant to 105 CMR 300.000 are kept secure and, to the greatest extent practical, kept in controlled access areas.

(B) Notwithstanding 105 CMR 300.120(A), the Department shall not disclose to the federal government, the Commonwealth or any of its political subdivisions or any agency, agent, or contractor of said Commonwealth or federal government, the identity of any individual with HIV or AIDS reported to the Department under 105 CMR 300.000.

300.131: Illness Believed to Be Due to Food Consumption

Every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence or suspected occurrence of case or cases of illness believed to have been due to the consumption of food, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located or the Department directly. If the Department is notified directly, it shall notify the local board of health within 24 hours.

300.132: Illness Believed to Be Transmissible Through Food

The manager or supervisor of any food handling facility, when he or she knows or has reason to believe that an employee has contracted any disease transmissible through food or has become a carrier of such disease, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located or the Department directly. If the Department is notified directly, it shall notify the local board of health within 24 hours.

300.133: Illness Believed to Be Unusual

In addition to the diseases listed in 105 CMR 300.100, every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence of a case or a suspect case of an unusual illness, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located or contact the Department directly. If the Department is notified directly, it shall notify the local board of health within 24 hours.

300.134: Illness Believed to Be Part of a Suspected or Confirmed Cluster or Outbreak

In addition to the diseases listed in 105 CMR 300.100, every person who is a health care provider or who is in a supervisory position at a school, day care, hospital, institution, clinic, medical practice, laboratory, labor or other camp who has knowledge of the occurrence of any suspected or confirmed cluster or outbreak of any illness, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located or contact the Department directly. If the Department is notified directly, it shall notify the local board of health within 24 hours.

300.135: Reporting of Pediatric Influenza Deaths, Severe and Unusual Illness Due to Influenza, Cases of Antiviral Treatment or Prophylaxis Failure, and Illnesses Believed to Be Due to Novel Influenza Viruses

(A) Health care providers shall report to the Department within 24 hours, in a form or manner deemed acceptable by the Department:

(1) All suspected and confirmed deaths due to influenza in pediatric patients and in pregnant women. Pediatric patients are defined as individuals younger than 18 years old;

(2) All suspect or confirmed human cases of influenza that are unusual or unusually severe, including but not limited to cases with encephalopathy, myocarditis or pericarditis;

(3) All cases of influenza suspected or proven to be a result of resistance to an influenza antiviral agent; and

(4) Suspect or confirmed cases of human infection due to influenza A viruses that are different from currently circulating human influenza H1 and H3 viruses. These viruses include those that are subtyped as non-human in origin and those that are unsubtypable with standard methods and reagents.

(B) The Department will notify the local board of health *via* MAVEN of all such reports.

300.136: Reporting of Infection or Suspected Infection Believed to Be Transmitted by a Transfused Blood Product or Transplanted Organ, Tissue or Tissue Product

In addition to the diseases listed in 105 CMR 300.100, every person who is a health care provider or who is in a supervisory position at a hospital, institution, clinic, medical practice, or laboratory, who has knowledge of the occurrence of a case or a suspect case of an infection or suspected infection that may be transmitted by a transfused blood product or transplanted organ, tissue, or tissue product, shall report the same immediately by telephone, by facsimile or other electronic means to the local board of health in the community in which the facility is located or contact the Department directly.

300.140: Reporting of Animal Diseases with Zoonotic Potential by Veterinarians

As required under M.G.L. c. 129, § 28 any veterinarian or local board of health with knowledge of the existence of a domestic animal affected with, or suspected to be affected with a contagious disease must report the disease to the Department of Agricultural Resources (DAR), Bureau of Animal Health. DAR will immediately notify the Department of any suspicion or occurrence of any such disease if it is potentially infectious to humans. Notwithstanding requirements to report such cases to DAR, veterinarians shall also report to the Department within 24 hours any case of anthrax, plague, West Nile virus infection, or Eastern equine encephalitis virus infection diagnosed in an animal. The Department will notify the local board of health of all such reports within 24 hours.

300.150: Declaring a Disease or Condition Immediately Reportable, under Surveillance and/or Subject to Isolation and Quarantine: Temporary Reporting, Surveillance and/or Isolation and Quarantine

In addition to the diseases and conditions listed in 105 CMR 300.000, the Commissioner, as necessary to reduce morbidity and mortality in the Commonwealth, shall require the reporting, authorize the surveillance and/or establish isolation and quarantine requirements, on a time-limited basis, of confirmed and suspect cases of diseases or conditions which are newly recognized or recently identified or suspected to be a public health concern. Such declarations shall be authorized for a period of time not to exceed 12 months. Such requirements for a particular disease or condition beyond this time period shall be continued pursuant to 105 CMR 300.000.

300.160: Diseases Reportable by Local Boards of Health to the Department

Whenever there shall occur in any municipality, report of a case or condition listed in 105 CMR 300.000, a case of unusual illness or cluster or outbreak of disease, including but not limited to suspected food poisoning, or an increased incidence of diarrheal and/or unexplained febrile illness, it shall be the duty of the local board of health to report immediately by secure electronic disease surveillance and case management system (MAVEN) designated and maintained by the Department and, if indicated by the Department, by telephone the existence of such an unusual disease, outbreak, cluster, or increased incidence of illness to the Department. Information contained in the report shall be defined by the Department and shall include when available full demographic, clinical, epidemiologic and laboratory information.

300.170: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Laboratories

In addition to the requirements of 105 CMR 300.100, 300.171, 300.180(A) and (C) all laboratories, including those outside of Massachusetts, performing examinations on any specimens derived from Massachusetts residents that yield evidence of infection due to the organisms listed below shall report such evidence of infection directly to the Department through secure electronic laboratory reporting mechanisms, or other method, as defined by the Department, within 24 hours. A laboratory contact must be included with each report in addition to the test results, source of specimen, date of specimen collection, case's full name, date of birth, sex, race and ethnicity, address, telephone number, and name of the ordering health care provider, when available. Upon receipt of a laboratory report, the Department shall notify the local board of health in the town in which the case resides within 24 hours *via* the MAVEN surveillance and case management system.

Anaplasma sp.
Arboviruses, including but not limited to, chikungunya virus, eastern equine encephalitis virus, dengue fever virus, Jamestown Canyon virus, West Nile virus, yellow fever virus, and Zika virus
Babesia sp.
Bacillus anthracis
Bordetella bronchiseptica
Bordetella holmseii
Bordetella parapertussis
Bordetella pertussis
Borrelia burgdorferi
Borrelia miyamotoi
Brucella sp.
Burkholderia mallei
Burkholderia pseudomallei
Campylobacter sp.
Chlamydophila psittaci
Clostridium botulinum
Clostridium difficile
Clostridium perfringens
Clostridium tetani
Corynebacterium diphtheriae
Coxiella burnetii
Cryptosporidium sp.
Cyclospora cayetanensis
Ehrlichia sp.
Entamoeba histolytica
Enteroviruses
Escherichia coli O157:H7
Francisella tularensis
Giardia sp.
Group A streptococcus, from a usually sterile site
Group B streptococcus, from a usually sterile site in children younger than one year old
Haemophilus influenzae, from a usually sterile site
Hantavirus
Hemorrhagic fever viruses, including but not limited to Ebola virus, Marburg virus, and other filoviruses, arenaviruses, bunyaviruses and flaviviruses
Hepatitis A virus
Hepatitis B virus
Hepatitis C virus
Hepatitis D virus
Hepatitis E virus
Evidence of human prion disease
Influenza A and B viruses
Legionella sp.
Listeria sp.

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Lymphocytic choriomeningitis virus
Measles virus
Mumps virus
Mycobacterium leprae
Mycobacterium tuberculosis, M. africanum, M. bovis
Neisseria meningitidis, from a usually sterile site
Noroviruses
Novel coronaviruses causing severe disease
Novel influenza A viruses
Plasmodium sp. including P. falciparum, P. malariae, P. ovale. P. vivax
Poliovirus
Powassan virus
Pox viruses, including but not limited to variola, vaccinia, and other orthopox and parapox viruses, but excluding molluscum contagiosum viruses
Rabies virus
Rickettsia akari
Rickettsia prowazekii
Rickettsia rickettsii
Rubella virus
Salmonella sp.
Shiga toxin
Shigella sp.
Simian herpes virus
Streptococcus pneumoniae, from a usually sterile site in individuals younger than 18 years old
Trichinella spiralis
Laboratory evidence of tuberculosis infection
Varicella zoster virus
Vibrio sp.
Yersinia pestis
Yersinia sp.

Evidence of infection due to the organisms listed as follows shall also be reported directly to the Department through secure electronic laboratory reporting mechanisms, or other method, as defined by the Department, within 24 hours. A laboratory contact must be included with each report in addition to the test results, source of specimen, date of specimen collection, case's full name, date of birth, sex, race and ethnicity, address, telephone number, and name of the ordering health care provider, when available.

Chlamydia trachomatis
Haemophilus ducreyi
Herpes simplex virus, neonatal infection (in child younger than 60 days old)
Human immunodeficiency virus (HIV)
Klebsiella granulomatis
Neisseria gonorrhoeae
Treponema pallidum

300.171: Reporting of Antimicrobial Resistant Organisms and Cumulative Antibiotic Susceptibility Test Results (Antibiograms)

(A) All Laboratories shall report results indicating antimicrobial resistance in the following organisms directly to the Department through secure electronic laboratory reporting mechanisms, or other method, as defined by the Department. Information shall include the name of a laboratory contact, the specified test results, date of specimen collection, source of specimen, and the case's full name, date of birth, sex, race and ethnicity, full address, telephone number, and name of the ordering health care provider, when available.

Carbapenemase-producing and/or carbapenem-resistant *Enterobacteriacea*
Neisseria gonorrhoeae resistant to ceftriaxone
Vancomycin-resistant *Staphylococcus aureus* (VRSA)
Vancomycin-intermediate *Staphylococcus aureus* (VISA)

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Invasive methicillin-resistant *Staphyloccus aureus* (MRSA)
Invasive penicillin-resistant *Streptococcus* pneumoniae
If antimicrobial resistance of an unexplained or novel nature is identified in any infectious organism, the laboratory must contact the Department within five business days.

(B) All hospitals shall report annual cumulative antibiotic susceptibility test results (antibiograms). This report shall include information specified by the Department and be sent in the manner deemed acceptable by the Department.

300.172: Submission of Selected Isolates and Diagnostic Specimens to the State Public Health Laboratory

All laboratories performing examinations on any specimens derived from Massachusetts residents shall submit the following directly to the State Public Health Laboratory for further examination.

Bacillus anthracis isolates and suspect isolates
Brucella sp. isolates and suspect isolates
Burkholderia mallei isolates and suspect isolates
Burkholderia pseudomallei isolates and suspect isolates
Carbapenem-resistant and carbapenemase producing *Enterobacteriacea* isolates
Campylobacter sp. isolates
Clostridium botulinum isolates and suspect isolates
Specimens obtained from human sources with indication or suspicion of eastern equine encephalitis (EEE) virus infection
Francisella tularensis isolates and suspect isolates
Haemophilus influenzae isolates from a usually sterile site
Influenza viruses diagnostic specimens or isolates known or suspected to contain antiviral resistant virus
Legionalla sp., isolates and suspect isolates
Listeria monocytogenes isolates
Specimens with indication or suspicion of measles virus infection
Specimens with indication or suspicion of mumps virus infection
Mycobacterium tuberculosis
Neisseria gonorrhoeae isolates
Neisseria meningitidis isolates from a usually sterile site
Salmonella sp. isolates
Shiga toxin producing organism isolates including *E. coli* O157, and any broths which test positive for shiga toxin producing organisms where the organism has not been isolated
Shigella sp. isolates
Staphylococcus aureus, vancomycin-intermediate and vancomycin-resistant isolates only
Streptococcus pneumoniae isolates from a usually sterile site and only from individuals younger than 18 years old
Vibrio sp. isolates
Specimens obtained from human sources with indication or suspicion of West Nile virus infection
Yersinia pestis isolates and suspect isolates
Yersinia sp. (non pestis) isolates
Organisms with antimicrobial resistance of a novel nature

300.173: Reporting of Certain Negative and Indeterminant Diagnostic Tests Associated with Ascertainment of Infection Status

For the purposes of accurately classifying cases of syphilis, viral hepatitis and tickborne diseases, all laboratories performing examinations on any specimens derived from Massachusetts residents shall report directly to the Department through secure electronic laboratory mechanisms, or other method, as defined by the Department, within 24 hours, negative results of the following specific laboratory tests:

(1) Any test for syphilis associated with a concurrent positive serologic test;
(2) Hepatitis C serologic and nucleic acid amplification tests;
(3) Any negative or indeterminate diagnostic test result for HIV infection associated with a concurrent positive test;

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(4) Any tests that are part of a panel of diagnostic tests for vector-borne infections that are associated with a concurrent positive result of one or more tests in the panel;
(5) Any tests that are part of a panel of diagnostic tests for viral hepatitis infections that are associated with a concurrent positive result of one or more tests in the panel.

300.174: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Point of Care Testing

Physicians and other healthcare providers using point of care tests for diagnosis of infectious diseases must report test results to the Department when they are indicative of an infectious disease reportable directly to the Department by laboratories (per 105 CMR 300.170) unless such point of care testing is subject to routine reflex testing by a supplementary or confirmatory testing the results of which would be reportable.

300.175: Potential Exposures to Certain Infectious Agents in Clinical Laboratories and Research Settings Reportable Directly to the Department

Any person who is in a supervisory position at a human or veterinary diagnostic or research laboratory located in Massachusetts who has knowledge that a human has had exposure to certain infectious agents in the laboratory, shall report the same immediately by telephone to the Department. These infectious agents include, but are not necessarily limited to, *Bacillus anthracis* (excluding Sterne strains), *Brucella suis*, *Brucella melitensis*, *Brucella abortus*, *Brucella canis*, *Brucella* sp. vaccine strains, *Burkholderia mallei*, *Burkholderia pseudomallei*, *Francisella tularensis*, *Neisseria meningitidis*, and *Yersinia pestis*

In addition, bites, scratches or contact with body fluids from macaque monkeys shall be reported in the same manner.

300.180: Diseases Reportable Directly to the Department

(A) Reporting of Suspect or Confirmed Active Tuberculosis Disease. Any health care provider, laboratory, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of confirmed tuberculosis or clinically suspected tuberculosis, as defined in 105 CMR 300.020, shall notify the Department within 24 hours by telephone, in writing, by facsimile or other electronic means, as defined by the Department. When available, full demographic, epidemiologic, clinical and laboratory information on the case, as defined by the Department shall be included in each report. Upon receipt of such notice, the Department shall notify the local board of health in the community where the case resides *via* MAVEN.

(B) Reporting of Tuberculosis Infection (also known as Latent Tuberculosis Infection). Any health care provider, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of tuberculosis infection as determined by skin test or other test for determining the presence of tuberculosis infection shall notify the Department in a written or electronic format as designated by the Department. A skin test for tuberculosis which meets criteria for indicating tuberculosis infection according to the published guidelines of the U.S. Centers for Disease Control and Prevention or the Department is itself reportable. When available, full demographic, epidemiologic, clinical and laboratory information on the case, as defined by the Department shall be included in each report.

(C) Any health care provider, laboratory, board of health or administrator of a city, state or private institution or hospital who has knowledge of the diseases listed as follows shall notify the Department within 24 hours, by telephone, in writing, by facsimile or other electronic means, as defined by the Department. When available, full demographic, epidemiologic, and clinical and laboratory information on the case, as defined by the Department must be included in each report.

Acquired immunodeficiency syndrome (AIDS);
Chancroid;
Chlamydial infection;
Gonorrhea;
Granuloma inguinale;

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Herpes simplex infection, neonatal (onset within 60 days after birth);
Human immunodeficiency virus (HIV) infection;
Lymphogranuloma venereum;
Ophthalmia neonatorum caused by any agent;
Pelvic inflammatory disease of any etiology;
Syphilis.

(D) The following work-related diseases and injuries are reportable directly to the Department by physicians and other health care providers in a manner approved by the Department no later than ten days after diagnosis or identification. Said report must include, at a minimum, the reporter's name and address; the patient's name, address, telephone number, age and sex, race/ethnicity, if known; the employer's name and location where the occupational exposure or injury reportedly occurred; the diagnosis of the disease or description of the injury; the patient's occupation if known; and any other information as requested by the Department.

(1) Occupational Lung Disease.
  (a) Asbestosis;
  (b) Silicosis;
  (c) Beryllium disease;
  (d) Chemical pneumonitis;
  (e) Asthma caused by or aggravated by workplace exposures;
  (f) Other work-related lung disease;

(2) Work-related Heavy Metal Absorption.
  (a) Mercury (blood >15 mcg/L: urine > 35 mcg/grams creatinine);
  (b) Cadmium (blood > 5mcg/L: urine > 5 mcg/grams creatinine);
  (c) Other.

(3) Work-related Acute Chemical Poisoning.
  (a) Carbon monoxide poisoning;
  (b) Pesticide poisoning;
  (c) Other;
  (d) Work-related Carpal Tunnel Syndrome.

(E) Reporting of Work-related Traumatic Injuries to a Person Younger than 18 Years Old.

(1) By Health Care Facilities. Work-related traumatic injuries to persons younger than 18 years old that are treated in a hospital or other health care facility shall be reported by the person in charge of the facility or their designee. Health care facilities shall report these cases through computer generated reports on a regular basis no less than once every six months. Said reports shall include similar information to that required under 105 CMR 300.180(D).

(2) By Physicians and Other Health Care Providers. Serious work-related traumatic injuries to persons younger than 18 years old shall be reported to the Department by the physician or other health care provider who treats the minor, within ten days after the physician or health care provider initially treats the injury. Physicians and other health care providers may report all work-related traumatic injuries to persons younger than 18 years old. Said reports shall include similar information to that required under 105 CMR 300.180(D).

300.181: Reporting Work-related Disease Outbreaks

Any physician or other health care provider who shall have knowledge of a work-related disease outbreak, regardless of whether or not the disease is included on the reportable disease list, shall report it immediately by telephone, in writing, by facsimile, or other electronic means to the Department.

300.182: Joint Authority with Department of Labor and Workforce Development

The Department recognizes that the Department of Labor and Workforce Development also has the authority, pursuant to M.G.L. c.149, § 11, to require reporting of work-related diseases and conditions. In order to avoid duplicate reporting, the Department will, upon designation by the Department of Labor and Workforce Development, also serve as the agent of the Department of Labor and Workforce Development for collection of reports of work-related diseases and conditions required under M.G.L. c. 149, § 11.

300.190: Surveillance and Control of Diseases Dangerous to the Public Health

The Department and local boards of health are authorized to conduct surveillance activities necessary for the investigation, monitoring, control and prevention of diseases dangerous to the public health. Such activities shall include, but need not be limited to:

(A) Systematic collection and evaluation of morbidity and mortality reports.

(B) Investigation into the existence of diseases dangerous to the public health in order to determine the causes and extent of such diseases and to formulate prevention and control measures.

(C) Identification of cases and contacts.

(D) Counseling and interviewing individuals as appropriate to assist in positive identification of exposed individuals and to develop information relating to the source and spread of illness.

(E) Monitoring the medical condition of individuals diagnosed with or exposed to diseases dangerous to the public health.

(F) Collection and/or preparation of data concerning the availability and use of vaccines, immune globulins, insecticides and other substances used in disease prevention and control.

(G) Collection and/or preparation of data regarding immunity levels in segments of the population and other relevant epidemiological data.

(H) Ensuring that diseases dangerous to the public health are subject to the requirements of 105 CMR 300.200 and other proper control measures.

300.191: Access to Medical Records and Other Information

(A) The Department and local boards of health are authorized to obtain, upon request, from health care providers and other persons subject to the provisions of 105 CMR 300.000, medical records and other information that the Department or the local board of health deems necessary to carry out its responsibilities to investigate, monitor, prevent and control diseases dangerous to the public health.

(B) School nurses are authorized to obtain from health care providers the immunization records or other immunization related information required for school admission, without the authorization of the child's parent(s) or legal guardian(s), as necessary to carry out the immunization requirements of M.G.L. c. 76, § 15. Prior to requesting such records from the provider, school nurses shall make a good faith effort to obtain the information from the child's parent(s) or legal guardian(s) and shall notify them that the information will be obtained from the health care provider pursuant to 105 CMR 300.191 if it is not provided in a timely manner by the parent(s) or guardian(s). For purposes of the Health Insurance Portability and Accountability Act (HIPAA), school nurses are hereby designated as public health authorities and granted authority to obtain immunization information from health care providers in accordance with 105 CMR 300.000 in order to monitor and ensure compliance with the immunization requirements of M.G.L. c. 76, § 15.

300.192: Surveillance of Diseases Possibly Linked to Environmental Exposures

The Department is authorized to collect medical records and other identifiable information from health care providers and other persons subject to 105 CMR 300.000, and/or prepare data, as detailed in 105 CMR 300.190 and 300.191, on individuals evaluated for or diagnosed with the following diseases possibly linked to environmental exposures:

Amyotrophic lateral sclerosis (ALS);
Aplastic anemia;
Asthma;
Autism spectrum disorder (ASD);
Multiple sclerosis (MS);

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Myelodysplastic syndrome (MDS);
Scleroderma;
Systemic lupus erythematosus.

300.193: Surveillance of Injuries Dangerous to Public Health

The Department is authorized to collect medical records and other identifiable information from health care providers and other persons subject to 105 CMR 300.000, and/or prepare data, as detailed in 105 CMR 300.190 and 300.191, related to the following types of injuries or causes of injuries:

Any mode of transportation;
Assaults or homicides;
Drownings;
Falls;
Fires;
Machinery;
Poisoning, including, but not limited to, drug overdose;
Spinal cord injuries;
Strikes by/against another object or person;
Suffocation;
Suicides, attempted suicides, or self-inflicted wounds;
Traumatic amputations;
Traumatic brain injuries;
Weapons;
Work-related injuries.

300.200: Isolation and Quarantine Requirements

Upon the report of a case or suspected case of disease declared dangerous to the public health, the local board of health and the Department are authorized to implement and enforce the requirements outlined in 105 CMR 300.200. Minimum requirements for the isolation and quarantine of diseases dangerous to the public health are set forth in 105 CMR 300.200(A). Depending on the specific circumstances related to the exposure, case and/or contact with respect to any disease or condition listed in 105 CMR 300.200(A) or (B), additional control measures may be required.

(A) Diseases Reportable to Local Boards of Health.

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Amebiasis	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Anaplasmosis	No restrictions	No restrictions
Anthrax	For cutaneous anthrax, place on contact precautions until lesions are healed or free from anthrax bacilli.	No restrictions
Arbovirus infection	No restrictions	No restrictions
Babesiosis	No restrictions except for exclusion from blood donation.	No restrictions
B. miyamotoi	No restrictions	No restrictions

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Botulism	No restrictions	No restrictions
Brucellosis	No restrictions	No restrictions
Campylobacteriosis	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Cholera	After diarrhea has resolved, food handlers may only return to food handling duties after producing two negative stool specimens produced at least 24 hours apart. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Clostridium difficile	No restrictions	No restrictions
Severe infection due to novel coronaviruses	Isolate for duration of illness. Isolation beyond the resolution of symptoms may be required and will be determined by the Department based on the most current recommendations by the Centers for Disease Control and Prevention.	Asymptomatic contacts should practice personal surveillance for symptoms and should any occur within 14 days of the individual's last contact with the case, report them to their health care provider immediately. Febrile contacts or contacts with respiratory symptoms only, shall be treated the same as a case for 72 hours, after which further management shall be in consultation with the Department.
Creutzfeldt-Jakob disease or variant Creutzfeldt-Jakob disease	No restrictions	No restrictions
Cryptosporidiosis	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Cyclosporiasis	Food handlers may return to food handling duties after diarrhea has resolved. In certain situations however, food handlers may be required to produce one or two negative stool specimens before returning to food handling duties. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In certain outbreak situations, asymptomatic contacts who are food handlers may be required to produce one or two negative stool specimens prior to returning to food handling duties. Otherwise, no restrictions.

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Diphtheria	Maintain isolation until two successive pairs of nose and throat cultures (and cultures of skin lesions in cutaneous diphtheria) obtained greater than 24 hours apart and at least 24 hours after completion of antimicrobial therapy are negative. If there was no antimicrobial therapy, these two sequential pairs of cultures shall be taken after symptoms resolve and greater than two weeks after their onset. If an avirulent (nontoxigenic) strain is documented, isolation is not necessary.	All contacts (both symptomatic and asymptomatic) who are food handlers must be excluded from work until two successive pairs of nose and throat cultures obtained greater than two weeks after completion of antimicrobial prophylaxis (if any) and greater than 24 hours apart are negative. Symptomatic contacts who are not food handlers shall be considered the same as a case until their culture results are negative and they are cleared by the appropriate public health authority. Asymptomatic contacts who are not foodhandlers must be on appropriate antibiotics and personal surveillance.
Ehrlichiosis	No restrictions	No restrictions
Encephalitis, any case	No restrictions	No restrictions
Food poisoning and toxicity	No restrictions	No restrictions
Giardiasis	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case has been treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Glanders	No restrictions	No restrictions
Group A streptococcus, invasive infection	Persons with streptococcal pharyngitis or skin infections, with or without invasive disease, shall not return to school or child care until at least 24 hours after initiating antimicrobial treatment.	Personal surveillance and prophylaxis with an antimicrobial when appropriate. Otherwise, no restrictions.
Group B streptococcus, invasive infection	No restrictions	No restrictions
Haemophilus influenzae, invasive infection a) type B b) non type B	 Until 24 hours after initiating antimicrobial treatment. No restrictions	 Personal surveillance and prophylaxis with an appropriate antimicrobial when indicated by clinical situation of the contact or by potential for transmission. Otherwise, no restrictions. No restrictions
Hansen's disease	No restrictions if under medical care.	No restrictions
Hantavirus infection	No restrictions	No restrictions
Hemolytic uremic syndrome	After diarrhea has resolved, food handlers may only return to food handling duties after producing two negative stool specimens, produced at least 24 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts

Hepatitis A	Isolation until one week after onset of symptoms or for cases where the onset date is not known, one week past the date the specimen positive for IgM antibody to HAV was provided.	No restrictions except for susceptible food handlers, who shall be excluded from their occupations for 28 days unless they receive a prophylactic dose of immune globulin (IG) and/or hepatitis A vaccine within 14 days of exposure, or in accordance with the latest recommendations from the Department.
Hepatitis B	No restrictions except for exclusion from organ and blood donation. Case shall receive counseling to modify activities in order to prevent transmission.	Personal surveillance for high-risk contacts who should receive hepatitis B immune globulin (HBIG) and vaccine. Infants born to infected women should also receive HBIG and vaccine. Otherwise, no restrictions.
Hepatitis C	No restrictions except for exclusion from organ and blood donation. Case shall receive counseling to modify activities in order to prevent transmission.	Personal surveillance for high-risk contacts. Otherwise, no restrictions.
Hepatitis D	Same as co-infecting hepatitis B	Same as co-infecting hepatitis B
Hepatitis E	Isolation until one week after onset of symptoms, or for cases where the onset date is not known, one week past the date of the specimen positive for evidence of acute hepatitis E was provided.	No restrictions, except for susceptible food handlers, who shall be excluded from their occupations for 28 days.
Influenza	No restrictions	No restrictions
Legionellosis	No restrictions	No restrictions
Listeriosis	No restrictions	No restrictions
Lyme disease	No restrictions	No restrictions
Lymphocytic choriomeningitis virus infection	No restrictions, except for exclusion from organ and blood donation	No restrictions
Malaria	No restrictions except for exclusion from blood donation.	No restrictions
Measles	Through four days after onset of rash (counting the day of rash onset as day zero).	Contacts born in or after 1957, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work, classes or other public activities from the fifth through the 21st day after their exposure even if they receive immune globulin. If exposure was continuous and/or if multiple cases occur, susceptibles will be excluded through the 21st day after rash onset in the last case. Health care workers and inpatients, regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work (health care workers) or isolated with airborne precautions (inpatients) from the fifth day after their first exposure through the 21st day after their last exposure. These restrictions for health care workers and inpatients remain even if the contact received IG or was vaccinated post-exposure.
Melioidosis	No restrictions	No restrictions

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Meningitis a) bacterial, community-acquired	If infected with *H. influenzae* or *N. meningitidis*, droplet precautions until 24 hours after initiation of appropriate antibiotic therapy. Otherwise, no restrictions.	Personal surveillance and antibiotic prophylaxis, where appropriate, if case has *H. influenzae* or *N. meningitidis*. Otherwise, no restrictions.
b) viral (aseptic), and other non-bacterial	No restrictions	No restrictions
Meningococcal disease, invasive infection	Droplet precautions until 24 hours after initiation of appropriate antibiotic therapy. Otherwise, no restrictions.	Personal surveillance and antibiotic prophylaxis, where appropriate. Otherwise no restrictions.
Monkeypox	Until lesions have dried and crusts have separated. If no lesions, until seven days after onset of fever.	Personal surveillance. Otherwise no restrictions.
Mumps	Through five days after onset of gland swelling (counting the initial day of gland swelling as day zero).	Contacts born in or after 1957, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work, classes or other public activities from the 12th through the 25th day after their exposure. When multiple cases occur, susceptibles need to be excluded through 25 days after the onset of the last case. Health care workers, and inpatients, regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity will be excluded from work (health care workers) or isolated with droplet precautions (inpatients) from the 12th through the 25th date after their exposure.
Noroviruses	Food handlers must be excluded from food handing duties for either 72 hours past the resolution of symptoms or 72 hours past the date the specimen positive for norovirus was produced, which ever occurs last.	Contacts with diarrhea or vomiting who are food handlers shall be excluded from food handling duties for 72 hours past the resolution of symptoms.
Pertussis	Until 21 days from onset of cough or five days after initiation of appropriate antibiotic therapy.	If the contact is symptomatic, use same restrictions as for cases. If the contact is an asymptomatic healthcare worker not receiving antibiotic prophylaxis, exclude from the workplace for 21 days after last exposure or, if unknown, for 21 days after the onset of the last case in the setting. If the contact is asymptomatic, not a healthcare worker, and exposed within the last 21 days, s/he should receive antibiotic prophylaxis but no exclusion is generally required. In certain situations deemed to be high-risk, the public health authority may require exclusion of asymptomatic contacts not receiving antibiotic prophylaxis and/or other contacts, and/or may extend the exclusion period beyond 21 days up to a maximum of 42 days.

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Plague	For pneumonic plague, droplet precautions until 72 hours after initiation of appropriate antibiotic therapy. For bubonic plague, case shall be placed on contact precautions until 48 hours after initiation of effective therapy.	Contacts of cases of pneumonic plague should be provided prophylaxis and placed under personal surveillance for seven days; those who refuse prophylaxis shall be placed in quarantine and under personal surveillance for seven days.
Poliomyelitis	Place case on enteric precautions for six weeks after onset of symptoms or until poliovirus can no longer be recovered from feces (the number of negative specimens required will be determined by the Department on a case-by-case basis).	According to applicable Department guidelines, administer an appropriate preparation of polio virus vaccine if the immune status is unknown or incomplete. Otherwise, no restrictions.
Powassan	No restrictions	No restrictions
Psittacosis	No restrictions	No restrictions
Q Fever	No restrictions	No restrictions
Rabies- human	For duration of illness	Post-exposure prophylaxis of contacts when appropriate, using recommendations of the Department. Otherwise, no restrictions.
Reye Syndrome	No restrictions	No restrictions
Rickettsialpox	No restrictions	No restrictions
Rocky Mountain spotted fever	No restrictions	No restrictions
Rubella		
a) Congenital	Isolation from susceptible persons for the first year of life or until two cultures of clinical specimens (nasopharyngeal secretions or urine) obtained one month apart after age three months are negative for rubella virus.	No restrictions except for susceptibles, then same as for non-congenital rubella.
b) Non-Congenital	Until seven days after onset of rash (counting the day of rash onset as day zero).	Contacts born in or after 1957, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work, classes or other public activities from the seventh through the 23rd day after their last exposure. When multiple cases occur, susceptibles need to be excluded until 23 days after the onset of the last case.Health care workers inpatients, regardless of year of birth, who are not appropriately immunized or do not have laboratory evidence of immunity, will be excluded from work (health care workers) or isolated with droplet precautions (inpatients) from the seventh day after first exposure through the 23rd day after their last exposure.

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Salmonellosis a) Not including typhoid fever	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case was treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
b) S. typhi (typhoid fever)	Food handlers may only return to food handling duties after producing three consecutive negative stool specimens each produced no less than 48 hours apart and one month after onset of first symptoms. If one culture is positive, repeat cultures shall be collected at one month intervals until three consecutive negative cultures are obtained. If the case has been treated with an antimicrobial, the first stool specimen shall not be collected until 48 hours after cessation of therapy.	All food handlers, symptomatic or asymptomatic, who are contacts of a typhoid case shall be considered the same as a case and handled in the same fashion.
Shiga toxin-producing organisms, including *E. coli* O157:H7	After diarrhea has resolved, food handlers may only return to food handling duties after producing two negative stool specimens, produced at least 24 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Shigellosis	After diarrhea has resolved, food handlers may only return to food handling duties after producing two negative stool specimens produced at least 24 hours apart. If a case was treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.
Smallpox	In conjunction with public health authorities, place case(s) on highest level of isolation to prevent direct contact, droplet contact and airborne exposure until lesions have dried and crusts have separated.	Afebrile contacts shall be placed under fever surveillance (quarantine) for 18 days from the last contact or 14 days from successful vaccination (which ever comes first), with monitoring and recording of temperature twice daily (morning and evening). Febrile contacts with or without rash shall be considered the same as a case and handled in the same fashion (isolation). If no rash develops after five days and the fever is diagnosed as being caused by recent vaccination or some other non-smallpox etiology, contact may be released from isolation to home to continue fever surveillance for 18 days following their last contact with a case or 14 days following successful vaccination (whichever comes first).

300.200: continued

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Streptococcus pneumoniae, invasive infection	No restrictions	No restrictions
Tetanus	No restrictions	No restrictions
Toxic shock syndrome	No restrictions	No restrictions
Trichinosis	No restrictions	No restrictions
Tularemia	No restrictions	No restrictions
Typhus	No restrictions	No restrictions
Varicella (chickenpox)	If vesicles are present, until lesions have dried and crusted, or until no new lesions appear, usually by the fifth day (counting the day of rash onset as day zero). If no vesicles are present, until the lesions have faded (i.e. the skin lesions are in the process of resolving; lesions do not need to be completely resolved) or no new lesions appear within a 24-hour period, whichever is later.	Contacts in non-health care settings, who are not appropriately immunized or are without laboratory evidence of immunity or a reliable history of chickenpox, shall be excluded from school, work or other public activities from the eighth through the 21st days after their exposure to the case during the case's infectious period. If the exposure was continuous, contacts shall be excluded from the eighth through the 21st days after the case's rash onset. Neonates born to mothers with active varicella shall be isolated from susceptibles until 21 days of age. Health care workers who are not appropriately immunized or are without laboratory evidence of immunity shall be excluded from work (health care workers) or isolated with airborne precautions (inpatients) from the eighth day after their first exposure through the 21st day after the last exposure. In all settings, anyone receiving varicella zoster immune globulin (VZIG) or intravenous immune globulin (IVIG) shall extend their exclusion to 28 days post-exposure.
Vibriosis (non- Cholera)	Food handlers with diarrhea may return to work after diarrhea has resolved.	No restrictions
Viral hemorrhagic fevers	Place on hemorrhagic fever specific barrier precautions with airborne, contact, and droplet precautions, and double gloving, with strict hand hygiene, impermeable gowns, face shields, eye protection, and leg and shoe coverings until clinical illness has resolved.	Personal surveillance
Yersiniosis	After diarrhea has resolved, food handlers may only return to food handling duties after producing one negative stool specimen. If a case was treated with an antimicrobial, the stool specimen shall not be collected until at least 48 hours after cessation of therapy. In outbreak circumstances, two negative stool specimens produced at least 24 hours apart will be required prior to returning to food handling duties.	Contacts with diarrhea, who are food handlers, shall be considered the same as a case and handled in the same fashion. In outbreak circumstances, asymptomatic contacts who are food handlers shall be required to produce two negative stool specimens produced at least 24 hours apart prior to returning to food handling duties. Otherwise, no restrictions.

300.200: continued

(B) Diseases Reportable Directly to the Department of Public Health.

Disease	Minimum Period of Isolation of Patient	Minimum Period of Quarantine of Contacts
Tuberculosis a) Active tuberculosis: Pulmonary (also includes mediastinal, laryngeal, pleural, or miliary)	Clearance from isolation in the community requires one or more of the following: three appropriately collected and processed sputum smears that are collected in eight – 24 hour intervals (one of which should be an early morning specimen); or other FDA cleared/approved or generally accepted laboratory tests indicating tuberculosis is unlikely or infectiousness is unlikely, as per guidelines such as those of the CDC, the Advisory Council of the Elimination of Tuberculosis (ACET) or the American Thoracic Society (ATS); or until the patient has undergone a period of effective chemotherapy in accordance with current treatment standards, such as those of CDC, ACET or ATS, and there is demonstration of clinical improvement (*i.e.* decreasing cough, reduced fever, resolving lung infiltrates).	No restrictions of asymptomatic contacts required.
b) Active tuberculosis: Extra-pulmonary	No restrictions except for appropriate handling of infected fluids.	No restrictions
c) Latent TB infection	No restrictions	No restrictions

(C) Standard Precautions. In addition to the specific practices set out in 105 CMR 300.000, standard precautions should be followed when treating all patients and contacts. The Department adopts, by reference, as standard practice for infection control, the most current version of the guidelines on the prevention of transmission of infection published by the U.S. Centers for Disease Control and Prevention and its Healthcare Infection Control Practices Advisory Committee.

(D) Work-related Diseases and Injuries Reportable Directly to the Department of Public Health. As these diseases are not communicable, each case should be evaluated individually regarding a return to work.

300.210: Procedures for Isolation and Quarantine

(A) Scope.

(1) The Department through an authorized agent shall, and local boards of health are encouraged to strongly comply with the provisions of 105 CMR 300.210(B) through (I) when implementing isolation or quarantine.

(2) The procedures set forth in 105 CMR 300.210(B) through (I) are applicable to isolation and quarantine of persons in the population at large, but do not apply to persons in the custody of correctional facilities operated by the Department of Correction, persons in the custody of county houses of correction, persons in the custody of city or town jails, or to youth detained by or committed to the Department of Youth Services.

(3) Notwithstanding 105 CMR 300.210(A)(1) and (2), the Department and local boards of health shall follow the procedures set forth in M.G.L. c. 111, §§ 94A through 94H when isolating individuals with active tuberculosis who are unwilling or unable to accept proper medical treatment and who thereby pose a serious danger to public health.

300.210: continued

(B) General.

(1) Voluntary Compliance.

(a) Before using mandatory measures, the Department or local board of health shall educate the individual or group about the reasons and requirements for isolation or quarantine, and shall attempt to secure voluntary compliance.

(b) When an individual or group agrees to comply voluntarily with isolation or quarantine, no written or oral order shall be necessary.

(2) Least Restrictive Setting. Isolation or quarantine shall take place in the least restrictive setting that complies with the requirements of 105 CMR 300.200.

(3) Types of Orders. Orders for isolation and quarantine may include, but are not limited to, restricting individuals or groups from being present in certain places including but not limited to school or workplace; restriction to residence and/or workplace; and confinement in other private or public premises. Such other premises shall not include a jail, prison, or other correctional facility.

(4) Time Period of Order. An order that has not expired shall be rescinded when the individual or group no longer poses a serious danger to public health.

(C) Written Order.

(1) The Department or local board of health may issue a written order of isolation or quarantine to an individual or group of individuals as authorized by 105 CMR 300.000.

(2) A copy of the written order shall be provided to the individual to be isolated or quarantined. If the order applies to a group of individuals and it is impractical to provide individual copies, the order may be posted in a conspicuous place in the isolation or quarantine premises.

(D) Temporary Isolation or Quarantine through Oral Order.

(1) The Department or local board of health may temporarily isolate or quarantine an individual or group of people as authorized by 105 CMR 300.000 through an oral order only if delay in imposing the isolation or quarantine would pose a serious, imminent danger to the public health.

(2) The individual or group shall be orally informed that the order may be appealed by telephoning a specified health official issuing the order at a stated telephone number.

(3) If an oral order is issued, a written order shall be issued as soon as is reasonably possible, but in no event later than 24 hours following the issuance of the oral order.

(4) An individual or group subject to an oral order of isolation or quarantine may appeal the order by following the procedures specified in 105 CMR 300.210(F).

(E) Further Requirements.

(1) Contents of Written or Oral Order. The written or oral order of isolation or quarantine shall include the following.

(a) The identity of the individual or description of the group of individuals subject to isolation or quarantine;

(b) The date and time at which isolation or quarantine will commence and the duration of the isolation or quarantine period;

(c) The reason for which isolation or quarantine is being ordered;

(d) The place of isolation or quarantine;

(e) Any special instructions or precautions that should be taken;

(f) The legal authority under which the order is issued; and

(g) A statement advising the individual or group that the order may be appealed by contacting a designated health official at a telephone number stated in the order.

(2) If an individual or group is isolated or quarantined in a location other than their residences, the Department or local board of health must obtain an order of the Superior Court authorizing the isolation or quarantine as soon as practicable, but in no event later than ten days following the commencement of isolation or quarantine

(F) Appeal of Written or Oral Order.

(1) An individual or group subject to an order of isolation or quarantine may appeal the order by contacting a specified health official at a telephone number stated on the written order or provided orally at the time that the oral order is issued.

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(2) An individual or group subject to an order of isolation or quarantine may file a petition in Superior Court challenging the order at any time.

(3) Unless rescinded by order of the Department or local board of health or a court, the order for isolation or quarantine shall remain in force and effect until any appeal is finally determined.

(G) Enforcement of Written or Oral Order.

(1) The Department or local board of health shall take all reasonable measures to minimize the risk of exposure to disease of police officers and others assisting with enforcement of an isolation or quarantine order.

(2) If an order for isolation or quarantine is violated, the Department or local board of health may apply to a judge of the Superior Court for an order to enforce the isolation or quarantine in a manner that will protect the public health.

(H) Requirements for Isolation or Quarantine.

(1) The Department or local board of health shall ensure that the following requirements are met, whether an individual or group is isolated or quarantined in their residences or in a place other than their residences.

(a) The health status of isolated or quarantined individuals shall be monitored regularly to determine if they require continued isolation or quarantine.

(b) The needs of individuals isolated or quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, medication, competent medical care, and crisis counseling or other mental health services when needed.

(c) To the extent possible, cultural and religious beliefs and existing disabilities shall be considered in addressing the needs of individuals.

(2) The Department or local board of health shall ensure that the following requirements are met when an individual or group is isolated or quarantined in a place other than their residences.

(a) Isolated individuals shall be confined separately from quarantined individuals.

(b) If a quarantined individual subsequently acquires or is reasonably believed to have acquired a disease or condition for which isolation is necessary to protect the public health, he or she shall promptly be removed to isolation.

(c) Individuals isolated or quarantined shall be provided adequate clothing, food, shelter, and means of communication with persons outside isolation or quarantine.

(d) Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and shall be designed to minimize the likelihood of further transmission of infection or other harms to individuals isolated and quarantined.

(e) The Department or local board of health may authorize physicians, health care workers, mental health workers, personal care attendants, parents or guardians of minor children, and others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals. Individuals who use service animals shall be allowed to bring them into the isolation or quarantine premises.

(f) No individual other than an authorized individual shall enter isolation or quarantine premises. Any individual entering isolation or quarantine premises with or without authorization may be isolated or quarantined.

(I) Isolation or Quarantine of People in a Geographical Area.

(1) The Department or local board of health may order the isolation or quarantine of all people in a geographical area that poses a serious danger to public health, when such isolation or quarantine is reasonably believed to be necessary to prevent the immediate spread of a dangerous disease to people outside the area. Such isolation or quarantine shall be implemented by means of a written order as provided in 105 CMR 300.210(C).

(2) The Department or local board of health shall use all reasonable means of communication to inform individuals in the area of orders and instructions in effect during the period of isolation or quarantine of people in the area. At a minimum, such communication shall include posting notices in places where people in and approaching the area are reasonably likely to see them, and publishing a notice in a newspaper of general circulation in the area at least once each week during the isolation or quarantine period, which notices shall state the orders and instructions in force with a brief explanation of their meaning and effect.

300.210: continued

(3) The Department or local board of health shall terminate the isolation or quarantine of all people in an area when the area no longer poses a serious danger to public health.
(4) Any individual in the area subject to an order of isolation or quarantine may appeal the order as provided in 105 CMR 300.210(F).

REGULATORY AUTHORITY

105 CMR 300.000: M.G.L. c. 111, §§ 1, 3, 5, 6, 7, 94C, 109, 110, 110B, 111 and 112, and c. 111D, § 6.

COVID-19 Screening

Preview Patient #000000

Inmate ID:	000000	**Location:**	Location
DOB:	04/05/1989	**Race:**	Race
Age:	32	**Interviewer:**	Title Last, First (07/06/2021 1426)
Height:	-		
Weight:	-		
Agency:	County		

To be conducted at the time of intake, the patient must have a mask on. This form is subject to change as the CDC, MADPH, and ICE update screening recommendations. Please educate inmates/detainees on hygiene including hand washing, covering coughs, and requesting medical attention if ill.

1.	In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19) ?	○ Yes ○ No
2.	Do you have a cough and/or shortness of breath? If yes, please contact a medical provider for further direction.	○ Yes ○ No
3.	Do you have any of the following? * please include the duration of symptoms in the documentation If 2 or more symptoms present, contact a medical provider for further direction.	☐ Fever ☐ Chills ☐ Muscle pain/aches ☐ Headache ☐ Loss of smell or taste ☐ Sore throat ☐ Fatigue ☐ Diarrhea ☐ Nausea ☐ Vomiting
	Obtain Vital signs to include: 02 sat, Temp, BP, P, and Lung Sounds.	
	Intake COVID-19 test performed?	○ Yes ○ No

Immediately notify a medical provider to alert them of any abnormal assessment findings.

**Reviewed/Revised 10-22-2020

CPS Clinical Guideline for COVID-19/CORONAVIRUS

Incubation period of COVID-19/CORONAVIRUS is 2-14 days after exposure. All staff evaluating patients of concern are to wear full personal protective equipment (PPE).

1. COVID-19/CORONAVIRUS symptoms or combination of symptoms can include any of the following:

Cough
Shortness of breath/difficulty breathing
Fever
Chills
Repeated shaking with chills
Muscle pain/aches
Headache
Loss of smell or taste
Sore throat
Tiredness
Diarrhea
Nausea
Vomiting
Discoloration on toes or feet

Emergency warning signs include:

Trouble breathing
Persistent chest pain or pressure
New confusion or inability to arouse
Cyanosis of lips or face

Mask patients immediately upon symptom detection and place in single cell isolation.

The CDC/DPH considers an exposure to be within 6 feet of space for over 15 minutes.

*****Newest guideline (CDC 10-21-2020) includes Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.***

2. If patient presents with concerning symptoms then:

Test for COVID-19/CORONAVIRUS

3. If COVID-19/CORONAVIRUS test is positive, initiate the following:

a. Monitor vital signs, especially temp and oxygen saturation BID
b. Offer Acetaminophen 650mg BID/PRN for CORONAVIRUS symptoms x7 days.
c. Monitor patients' respiratory status to include 02 saturation, trouble breathing, persistent chest pain or pressure, new onset of confusion or inability to arouse and any signs of cyanosis. Nurses **must** notify on-call provider immediately if any signs or symptoms are present and discuss possible transport to the local Hospital Emergency Dept..
d. Restrict movement, unless emergent, for anyone in isolation. Any movement occurs while in isolation staff must wear a mask with shield, gloves and gown.

4. Current (5/3/2020) the CDC recommended Guidelines are as follows:

Medical Isolation of Confirmed or Suspected COVID-19 Cases

√ As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.
√ Keep the individual's movement outside the medical isolation space to an absolute minimum.
- o Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
- o Serve meals to cases inside the medical isolation space.
- o Exclude the individual from all group activities.
- o Assign the isolated individual a dedicated bathroom when possible.

√ Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters. Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.
√ Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom when possible.
If individual medical isolation is not possible due to lack of space availability, only COVID-19 confirmed cases can remain as a cohort.
√ If an individual who is part of a quarantined cohort, due to close contact with a confirmed COVID-19 case, becomes symptomatic the individual should be moved to medical Isolation:

o If the individual is tested for COVID-19 and tests positive, the individual should remain in medical isolation. The 14 day quarantine clock for the remainder of the cohort must be reset to 0.

o If the individual is tested for COVID-19 and tests negative: the **14-day** quarantine clock for this individual does not need to be reset.

This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.

o If the individual is not tested for COVID-19 remains in medical isolation: the **14-day** quarantine clock for the remainder of the cohort must be reset to 0.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

√ If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.

√ Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing.

√ Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated. Refer to CDC guidelines for information on evaluation and testing.

√ If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.

o **If the COVID-19 test is positive, continue medical isolation x 14 days since onset of symptoms or from the positive test result.**

o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

**Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.

If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, **contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.