Recommendations for Providers during the Current Hepatitis A Outbreak

On November 28, 2017 the Kentucky Department for Public Health declared an outbreak of acute Hepatitis A (HAV) with cases in multiple counties in Kentucky. The overwhelming majority of the cases have been in Louisville. Cases have shown a genetic match to Hepatitis A outbreaks in California. General information on Hepatitis A for providers can be found at https://www.cdc.gov/hepatitis/hav/havfaq.htm

Recommendations for Providers:

1. Consider HAV infection in individuals, especially the homeless, those who use illicit drugs and MSMs (Men who have Sex with Men) with discrete onset of symptoms (e.g., nausea, vomiting, diarrhea, anorexia, fever, malaise, dark urine, light-colored stool, or abdominal pain), and jaundice or elevated liver function tests.

2. Complete the HAV Risk Questionnaire on all suspect cases and report all confirmed cases with 24 hours. Please complete the HAV Risk Questionnaire found on page 2 on all suspected cases and fax it to the Louisville Metro Department of Public Health and Wellness at 502-574-5865**.**

Providers should also report all lab confirmed HAV cases within 24 hours to the Louisville Metro Department of Public Health and Wellness by fax at 502-574-5865 or by phone at 502-574-6675. Please use the EPID200 form found on page 3 & 4. This is required reporting and is not a violation of HIPAA.

3. Provide post-exposure prophylaxis (PEP) for close contacts of confirmed HAV cases. Susceptible people exposed to hepatitis A virus (HAV) should receive a dose of single-antigen HAV vaccine or intramuscular (IM) immune globulin (IG) (0.1 mL/kg), or both, as soon as possible within 2 weeks of last exposure. The efficacy of combined HAV/Hepatitis B virus (HBV) vaccine for PEP has not been evaluated, so it is not recommended for PEP. Providers who do not have available vaccine may direct patients to the Louisville Metro Department of Public Health and Wellness at 400 E. Gray St.

4. Provide HAV vaccine to the homeless, illicit drug users and MSMs (Men who have Sex with Men) who are not already immunized. The combined HAV/HBV vaccine may be used in this group if the individual is not already immune to HBV.

5. Provide HAV vaccine to unimmunized school age children. Effective July 1, 2018 all Kentucky students in kindergarten through twelfth grade must show proof of having received two doses of Hepatitis A vaccine to attend school. Providers should begin providing these immunizations to their patients.

If acute viral Hepatitis is suspected as a diagnosis for a patient, please complete the following questions to the best ability possible and fax to 502-574-5865. Please call the Communicable Disease office at 502-574-6677 if you have any questions. Additionally if lab results are positive for Hepatitis please report this to the fax number above.

Patient Information		
Name:		Patient ID:
In the last 7 weeks: Number of Male sexual partners: _____		Number of Female sexual partners:_____
Patient Interviewed? Yes / No	Date of Interview: / /	Previous Hepatitis B vaccination? Yes / No
Reporting Provider:	Facility:	Provider Phone Number:

	Question (Within the last 7 weeks…)		Yes	No	Unk	Comments	
Housing (if homeless)	1. Did you spend the night at any of the following places? (Select all that apply)	A. Friend's/family member's home				• Any contacts in home? • Last stay?	
		B. Shelter				• Shelter name and location: • Date of last stay:	
		C. Street				• Cross-streets, detailed location:	
		D. Jail/prison				• Location and date of release:	
		E. Other:				• How long did you stay?	
Activity	2. Did you work for, or volunteer at a place that serves homeless persons?					• Names and locations: • Food worker? Yes / No o Dates you worked there?	
	3. Did you or anyone you have close contact with travel outside of the United States?					• If yes, specify where travelled and travel dates:	
Food Sources	4. Did you get your food from:	A. Restaurants				• Name and location:	
		B. Shelter, soup kitchen, food lines, churches				• Shelter/Kitchen/Agency/Church name and location:	
		C. Other				• Specify:	
Contacts	5. Do you know anyone else with similar symptoms in the past few months? The health department may want to contact others who may have become ill like you. May we contact the people you've mentioned? **Y / N**					Name: Phone Number:	Name: Phone Number:
Drug use (if applicable)	6. Did you use any recreational drugs?					• Method of drug use (Please circle all that apply): Injected smoked snorted ingested other (_____)	

Kentucky Reportable Disease Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001

EPID 200 – 6/2016

Disease Name _____

Fax or Mail the Completed Form to the Local Health Department

DEMOGRAPHIC DATA

Patient's Last Name	First	M.I.	Date of Birth / /	Age	Gender ☐M ☐F ☐Unk.
Address	City	State	ZIP Code		County of Residence
Phone Number	Patient ID Number	Ethnic Origin ☐Hisp. ☐Non-Hisp.	Race ☐W ☐B ☐A/PI ☐Am. Ind. ☐Other		

DISEASE INFORMATION

Disease/Organism	Date of Onset / /	Date of Diagnosis / /
List Symptoms/Comments	Highest Temperature	
	Days of Diarrhea	

Hospitalized? ☐Yes ☐ No	Admission Date / /	Discharge Date / /	Died? ☐Yes ☐No ☐Unk.	Date of Death / /
Hospital Name:		Is Patient Pregnant? ☐Yes ☐No If yes, Due Date (EDC): / /		
School/Daycare Associated? ☐Yes ☐No Name of School/Daycare:			Outbreak Associated? ☐Yes ☐No Food Handler? ☐Yes ☐No	

Person or Agency Completing form: Name: Agency:	Attending Physician: Name:
Address:	Address:
Phone: Date of Report: / /	Phone:

LABORATORY INFORMATION

Date	Name or Type of Test	Name of Laboratory	Specimen Source	Results

ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY

Disease:	Stage		Disease:	Site: (Check all that apply)		Resistance:
☐Syphilis	☐Primary (lesion)	☐Secondary (symptoms)	☐Gonorrhea	☐Genital, uncomplicated	☐Ophthalmic	☐Penicillin
	☐Early Latent	☐Late Latent	☐Chlamydia	☐Pharyngeal	☐PID/Acute	☐Tetracycline
	☐Congenital	☐Other	☐Chancroid	☐Anorectal	Salpingitis	☐Other _____
				☐Other_____		

Date of Spec. Collection	Laboratory Name	Type of Test	Results	Treatment Date	Medication	Dose

If syphilis, was previous treatment given for this infection? ☐Yes ☐No

If yes, give approximate date and place_____

Please use the following information and fax numbers (when relevant) for reporting:

HIV/AIDS Cases:

Forms other than the EPID 200 are required for reporting HIV/AIDS cases in children and adults. Obtain those forms by calling 866-510-0008, or those forms can be downloaded from the DPH Website, http://chfs.ky.gov/dph/epi/HIVAIDS/surveillance.htm. Contact information for telephoning case reports and addresses for mailing case reports are on that Website.
Reports for HIV/AIDS cases should not be faxed.

Pediatric Confidential Case Form (PDF, 451k)
(for patients younger than 13 at time of diagnosis)

Adult Confidential Form (PDF, 441k)
(for patients 13 or older at time of diagnosis)

Sexually Transmitted Disease Cases:

Confidential reports for STD cases can be submitted on the EPID 200 form.

Fax a completed form for STD Cases, only, to 502-564-5715. Or, mail to:

Kentucky Department for Public Health
STD Prevention and Control Program
275 E Main St, MS: HS2CC
Frankfort, KY 40621

Animal Bite Reports:

Healthcare providers and healthcare facilities should fax reports about animal bites directly to the **Local Health Department (LHD) serving the county in which the patient resides**. Please do not fax reports about animal bites to the Kentucky Department for Public Health.

Reporting All Other Diseases and Conditions Listed in 902 KAR 2:020 (Reportable Disease Surveillance) or in any Public Health Advisory (PHA) Issued per that KAR that Requires Using the EPID 200 Form for Reporting:

Reports, depending upon the notification classification described in 902 KAR 2:020 or in a PHA, shall be submitted by phone, by electronic submission, or by fax or mail submission on an EPID 200 form to the **Local Health Department (LHD) serving the county in which the patient resides**.

If submitted by telephone, an electronic or fax submission shall be made within one business day to the LHD serving the county in which the patient resides.

Kentucky Department for Public Health in Frankfort
Telephone 502-564-3418 or 888-9REPORT (888-973-7678)
SECURE FAX 502-696-3803