

Chapter DHS 145

CONTROL OF COMMUNICABLE DISEASES

Subchapter I — General Provisions

- DHS 145.01 Statutory authority.
 DHS 145.02 Purpose and scope.
 DHS 145.03 Definitions.
 DHS 145.04 Reports of communicable diseases.
 DHS 145.05 Investigation and control of communicable diseases.
 DHS 145.06 General statement of powers for control of communicable disease.
 DHS 145.07 Special disease control measures.

Subchapter II — Tuberculosis

- DHS 145.08 Definitions.
 DHS 145.09 Laboratory procedures.
 DHS 145.10 Restriction and management of patients and contacts.
 DHS 145.11 Discharge from isolation or confinement.

- DHS 145.12 Certification of public health dispensaries.
 DHS 145.13 Dispensary reimbursement.

Subchapter III — Sexually Transmitted Disease

- DHS 145.14 Definitions.
 DHS 145.15 Case reporting.
 DHS 145.16 Reporting of cases delinquent in treatment.
 DHS 145.17 Determination of sources and contacts.
 DHS 145.18 Criteria for determination of suspects.
 DHS 145.19 Examination of suspects.
 DHS 145.20 Commitment of suspects.
 DHS 145.21 Treatment of minors.
 DHS 145.22 Treatment guidelines.

Note: Chapter HSS 145 was renumbered chapter HFS 145 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., [Register, June, 1997, No. 498](#). Chapter HFS 145 was renumbered chapter DHS 145 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., [Register, January 2009 No. 637](#).

Subchapter I — General Provisions

DHS 145.01 Statutory authority. This chapter is promulgated under the authority of ss. [252.02 \(4\)](#), [252.06 \(1\)](#), [252.07 \(1p\)](#) and [\(11\)](#), [252.10 \(1\)](#), [252.10 \(6\) \(a\)](#) and [\(b\)](#), [252.11 \(1\)](#) and [\(1m\)](#), [254.51 \(3\)](#) and [990.01 \(5g\)](#), Stats.

History: Cr. [Register, April, 1984, No. 340](#), eff. 5-1-84; corrections made under s. 13.93 (2m) (b) 7., Stats., [Register, August, 1995, No. 476](#); am. [Register, March, 2000, No. 531](#), eff. 4-1-00; correction made under s. 13.93 (2m) (b) 7., Stats., [Register, March, 2002 No. 555](#); CR 01-105; am. [Register March 2002 No. 555](#), eff. 4-1-02.

DHS 145.02 Purpose and scope. This chapter establishes a surveillance system for the purpose of controlling the incidence and spread of communicable diseases. This surveillance system consists of timely and effective communicable disease reporting, means of intervention to prevent transmission of communicable diseases, and investigation, prevention and control of outbreaks by local health officers and the department, and in addition provides information otherwise pertinent to understanding the burden of communicable disease on the general population.

History: Cr. [Register, April, 1984, No. 340](#), eff. 5-1-84; am. [Register, March, 2000, No. 531](#), eff. 4-1-00.

DHS 145.03 Definitions. In this chapter:

(1) “Advanced practice nurse prescriber” means an advanced practice nurse, as defined in s. [N 8.02 \(1\)](#), who under s. [441.16 \(2\)](#), Stats., has been granted a certificate to issue prescription orders.

(2) “Case” means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both.

(3) “Chief medical officer” means the person appointed by the state health officer under s. [250.02 \(2\)](#), Stats., to provide public health consultation and leadership in the program area of acute and communicable disease and who serves also as state epidemiologist for that program area.

(4) “Communicable disease” means a disease or condition listed in Appendix A of this chapter.

(5) “Control” means to take actions designed to prevent the spread of communicable diseases.

(6) “Conveyance” means any publicly or privately owned vehicle used for providing transportation services.

(7) “Date of onset” means the day on which the case or suspected case experienced the first sign or symptom of the communicable disease.

(8) “Day care center” has the meaning prescribed in s. [48.65](#), Stats., and includes nursery schools that fit that definition.

(9) “Department” means the department of health services.

(10) “Food handler” means a person who handles food utensils or who prepares, processes or serves food or beverages for people other than members of his or her immediate household.

(11) “Health care facility” has the meaning prescribed in s. [155.01 \(6\)](#), Stats., and includes providers of ambulatory health care.

(12) “HIV” means human immunodeficiency virus.

(13) “Individual case report form” means the form provided by the department for the purpose of reporting communicable diseases.

(14) “Investigation” means a systematic inquiry designed to identify factors which contribute to the occurrence and spread of communicable diseases.

(15) “Laboratory” means any facility certified under [42 USC 263a](#).

(16) “Local health department” means an agency of local government that takes any of the forms specified in s. [250.01 \(4\)](#), Stats.

(17) “Local health officer” has the meaning prescribed in s. [250.01 \(5\)](#), Stats., and applies to the person who is designated as the local health officer for the place of residence of a case or suspected case of communicable disease.

(18) “Organized program of infection control” means written and implemented policies and procedures for the purpose of surveillance, investigation, control and prevention of infections in a health care facility.

(19) “Other disease or condition having the potential to affect the health of other persons” means a disease that can be transmitted from one person to another but that is not listed in Appendix A of this chapter and therefore is not reportable under this chapter, although it is listed in the official report of the American Public Health Association, unless specified otherwise by the state epidemiologist.

Note: The official report of the American Public Health Association entitled *Control of Communicable Diseases Manual*, 20th edition (2015), edited by David L.

Heymann, is on file in the Department's Division of Public Health and the Legislative Reference Bureau, and is available for purchase from the American Public Health Association, Publications Sales, PO Box 933019, Atlanta, GA 31193-3019.

(20) "Outbreak" means an unusual aggregation of health events that are grouped together in a short time period and limited geographic area.

(21) "Personal care" means the service provided by one person to another person who is not a member of his or her immediate household for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding and other services involving direct physical contact.

(22) "Physician" means an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the medical examining board, and holding a license granted by the board under s. 448.01 (5), Stats.

(23) "Public building" means any privately or publicly owned building which is open to the public.

(24) "Public health intervention" means an action designed to promote and protect the health of the public.

(25) "State epidemiologist" means the person appointed by the state health officer under s. 250.02 (1), Stats., to be the person in charge of communicable disease control for the state who serves also as chief medical officer for the acute and communicable disease program area.

(26) "Surveillance" means the systematic collection of data pertaining to the occurrence of specific diseases, the analysis and interpretation of these data and the dissemination of consolidated and processed information to those who need to know.

(27) "Suspected case" means a person thought to have a particular communicable disease on the basis of clinical or laboratory criteria or both.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; am. (2) and (11), Register, February, 1989, No. 398, eff. 3-1-89; correction in (8) and (9) made under s. 13.93 (2m) (b) 7, Stats., Register, August, 1995, No. 476; r. and recr. Register, March, 2000, No. 531, eff. 4-1-00; CR 07-090: am. (19) and (20) Register February 2008 No. 626, eff. 3-1-08; correction in (9) made under s. 13.92 (4) (b) 6., Stats., Register January 2009 No. 637; CR 17-014: am. (19), Register June 2018 No. 750 eff. 7-1-18; correction in (19) made under s. 35.17, Stats., Register June 2018 No. 750.

DHS 145.04 Reports of communicable diseases.

(1) RESPONSIBILITY FOR REPORTING. (a) Any person licensed under ch. 441 or 448, Stats., knowing of or in attendance on a case or suspected case shall notify the local health officer or, if required under Appendix A of this chapter, the state epidemiologist, in the manner prescribed in this section.

(b) Each laboratory shall report the identification or suspected identification of a disease-causing organism or laboratory findings indicating the presence of a communicable disease to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist.

(bg) Each laboratory shall forward a specimen to the state laboratory of hygiene, or another laboratory designated by the state epidemiologist, for confirmatory or investigation purposes if requested by the state epidemiologist.

(br) Each laboratory shall report a negative test result to the local health officer to justify release from isolation or quarantine if requested by the state epidemiologist or the local health officer.

(c) Each health care facility shall ensure that reports are made to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist, in the manner specified in sub. (3). When a case is identified or suspected in a health care facility having an organized program of infection control, the person in charge of the infection control program shall ensure that the case or suspected case is reported to the local health officer

or, if required under Appendix A of this chapter, to the state epidemiologist, minimizing unnecessary duplication.

(cm) Each health care facility shall report a negative test result to the local health officer to justify release from isolation or quarantine if requested by the state epidemiologist or the local health officer.

(d) Any teacher, principal or nurse serving a school or day care center knowing of a case or suspected case in the school or center shall notify the local health officer or, if required under Appendix A of this chapter, the state epidemiologist, in the manner prescribed in this section.

(e) Any person who knows or suspects that a person has a communicable disease shall report the facts to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist.

(g) Nothing in this subsection lessens the requirement for confidentiality of HIV test results under s. 252.15, Stats.

(2) CONTENT OF REPORT. (a) Each report under sub. (1) (a) to (d) of a case or suspected case of a communicable disease to the local health officer or the state epidemiologist shall include the name and address of the person reporting and of the attending physician, if any, the diagnosed or suspected disease, the name of the ill or affected individual, that individual's address and telephone number, age or date of birth, race and ethnicity, sex, county of residence, date of onset of the disease, name of parent or guardian if a minor, and other facts the department or local health officer requires for the purposes of surveillance, control and prevention of communicable disease.

(b) Reports may be written, verbal, or by electronic transmission. Written reports shall be on the individual case report form provided by the department and distributed by the local health officer or on a form containing the information required under par. (a). Reports shall be submitted to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist.

(c) Reports by laboratories of the identification or suspected identification of a disease-causing organism or laboratory findings indicating the presence of a communicable disease shall be made to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist. These reports shall include the name of the individual affected or ill, the individual's address, telephone number, county of residence, age or date of birth, the name of the attending physician and the identity or suspected identity of the organism or the laboratory findings.

(d) All information provided under this subsection shall remain confidential except as may be needed for the purposes of investigation, control and prevention of communicable diseases.

(3) URGENCY OF REPORTS. (a) A person, laboratory or health care facility required to report under sub. (1) shall report communicable diseases of urgent public health importance as listed in category I of Appendix A of this chapter to the local health officer immediately upon identification of a case or suspected case. If the local health officer is unavailable, the report shall be made immediately to the state epidemiologist.

(b) A person, laboratory or health care facility required to report under sub. (1) shall report communicable diseases of less urgent public health importance as listed in categories II and III of Appendix A of this chapter to the local health officer or, if required under Appendix A, to the state epidemiologist, by individual case report form or by telephone within 72 hours of the identification of a case or suspected case.

(4) HANDLING OF REPORTS BY THE LOCAL HEALTH OFFICER. (a) The local health officer shall notify the state epidemiologist

immediately of any cases or suspected cases reported under sub. (3) (a).

(b) At the close of each week, the local health officer shall notify the state epidemiologist in writing on a form provided by the department of all cases of reported diseases listed in Appendix A.

(c) Local health departments serving jurisdictions within the same county may, in conjunction with the department, establish a combined reporting system to expedite the reporting process.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; am. (1), (2) (a) to (c), (3) (a) and (b), cr. (1m), Register, February, 1989, No. 398, eff. 3-1-89; correction in (1m) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1995, No. 476; renum. and am. (1m) to be (1) (g), am. (3) (a), (4) (a) and cr. (4) (c), Register, March, 2000, No. 531, eff. 4-1-00; CR 07-090: cr. (1) (bg), (br) and (cm), am. (2) (b), r. (3) (c) Register February 2008 No. 626, eff. 3-1-08.

DHS 145.05 Investigation and control of communicable diseases. (1) The local health officer shall use all reasonable means to confirm in a timely manner any case or suspected case of a communicable disease and shall ascertain so far as possible all sources of infection and exposures to the infection. Follow-up and investigative information shall be completed by the local health officer and reported to the state epidemiologist on forms provided by the department.

(2) Local health officers shall follow the methods of control set out in official reports of the American Public Health Association and the American Academy of Pediatrics, unless specified otherwise by the state epidemiologist. Specific medical treatment shall be prescribed by a physician or an advanced practice nurse prescriber.

(3) Any person licensed under ch. 441 or 448, Stats., attending a person with a communicable disease shall instruct the person in the applicable methods of control contained in official reports of the American Public Health Association and the American Academy of Pediatrics, unless specified otherwise by the state epidemiologist, and shall cooperate with the local health officer and the department in their investigation and control procedures.

(4) The department in cooperation with the local health officer shall institute special disease surveillances, follow-up reports and control measures consistent with contemporary epidemiologic practice in order to study and control any apparent outbreak or unusual occurrence of communicable diseases.

Note: The official report of the American Public Health Association entitled *Control of Communicable Diseases Manual*, 20th edition (2015), edited by David L. Heymann, is available for purchase from the American Public Health Association, Publications Sales, PO Box 933019, Atlanta, GA 31193-3019. The official report of the American Academy of Pediatrics entitled *Red Book: 2015 Report of the Committee on Infectious Diseases*, 30th edition (2015), edited by David W. Kimberlin is available for purchase from the American Academy of Pediatrics, 141 Northwest Point Blvd, Elk Grove Village, IL 60007-1019. These reports are on file in the Department's Division of Public Health and the Legislative Reference Bureau.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; am. (2) and (3), Register, February, 1989, No. 398, eff. 3-1-89; am. (2) and (3), Register, March, 2000, No. 531, eff. 4-1-00; CR 03-033: am. (2) and (3) Register December 2003 No. 576, eff. 1-1-04; CR 07-090: am. (2) and (3) Register February 2008 No. 626, eff. 3-1-08; CR 17-014: am. (2), (3), Register June 2018 No. 750 eff. 7-1-18.

DHS 145.06 General statement of powers for control of communicable disease. (1) **APPLICABILITY.** The general powers under this section apply to all communicable diseases listed in Appendix A of this chapter and any other infectious disease which the chief medical officer deems poses a threat to the citizens of the state.

(2) **PERSONS WHOSE SUBSTANTIATED CONDITION POSES A THREAT TO OTHERS.** A person may be considered to have a contagious medical condition which poses a threat to others if that person has been medically diagnosed as having any communicable disease and exhibits any of the following:

(a) A behavior which has been demonstrated epidemiologically to transmit the disease to others or which evidences a careless disregard for the transmission of the disease to others.

(b) Past behavior that evidences a substantial likelihood that the person will transmit the disease to others or statements of the person that are credible indicators of the person's intent to transmit the disease to others.

(c) Refusal to complete a medically directed regimen of examination and treatment necessary to render the disease noncontagious.

(d) A demonstrated inability to complete a medically directed regimen of examination and treatment necessary to render the disease noncontagious, as evidenced by any of the following:

1. A diminished capacity by reason of use of mood-altering chemicals, including alcohol.

2. A diagnosis as having significantly below average intellectual functioning.

3. An organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation or memory.

4. Being a minor, or having a guardian appointed under ch. 54, Stats., following documentation by a court that the person is incompetent.

(e) Misrepresentation by the person of substantial facts regarding the person's medical history or behavior, which can be demonstrated epidemiologically to increase the threat of transmission of disease.

(f) Any other willful act or pattern of acts or omission or course of conduct by the person which can be demonstrated epidemiologically to increase the threat of transmission of disease to others.

(3) **PERSONS WHOSE SUSPECTED CONDITION POSES A THREAT TO OTHERS.** A person may be suspected of harboring a contagious medical condition which poses a threat to others if that person exhibits any of the factors noted in sub. (2) and, in addition, demonstrates any of the following without medical evidence which refutes it:

(a) Has been linked epidemiologically to exposure to a known case of communicable disease.

(b) Has clinical laboratory findings indicative of a communicable disease.

(c) Exhibits symptoms that are medically consistent with the presence of a communicable disease.

(4) **AUTHORITY TO CONTROL COMMUNICABLE DISEASES.** When it comes to the attention of an official empowered under s. 250.02 (1), 250.04 (1) or 252.02 (4) and (6), Stats., or under s. 252.03 (1) and (2), Stats., that a person is known to have or is suspected of having a contagious medical condition which poses a threat to others, the official may direct that person to comply with any of the following, singly or in combination, as appropriate:

(a) Participate in a designated program of education or counseling.

(b) Participate in a defined program of treatment for the known or suspected condition.

(c) Undergo examination and tests necessary to identify a disease, monitor its status or evaluate the effects of treatment on it.

(d) Notify or appear before designated health officials for verification of status, testing or direct observation of treatment.

(e) Cease and desist in conduct or employment which constitutes a threat to others.

(f) Reside part-time or full-time in an isolated or segregated setting which decreases the danger of transmission of the communicable disease.

(g) Be placed in an appropriate institutional treatment facility until the person has become noninfectious.

(5) **FAILURE TO COMPLY WITH DIRECTIVE.** When a person fails to comply with a directive under sub. (4), the official who issued the directive may petition a court of record to order the person to comply. In petitioning a court under this subsection, the petitioner shall ensure all of the following:

(a) That the petition is supported by clear and convincing evidence of the allegation.

(b) That the respondent has been given the directive in writing, including the evidence that supports the allegation, and has been afforded the opportunity to seek counsel.

(c) That the remedy proposed is the least restrictive on the respondent which would serve to correct the situation and to protect the public's health.

(6) **HAZARDS TO HEALTH.** Officials empowered under ss. 250.02 (1), 250.04 (1) and 252.02 (4) and (6), Stats., or under s. 252.03 (1) and (2), Stats., may direct persons who own or supervise real or physical property or animals and their environs, which present a threat of transmission of any communicable disease under sub. (1), to do what is reasonable and necessary to abate the threat of transmission. Persons failing or refusing to comply with a directive shall come under the provisions of sub. (5) and this subsection.

History: Cr. Register, March, 2000, No. 531, eff. 4-1-00; correction in (2) (d) 4, made under s. 13.92 (4) (b) 7., Stats., Register February 2008 No. 626.

DHS 145.07 Special disease control measures. (1) SCHOOLS AND DAY CARE CENTERS. Any teacher, principal, director or nurse serving a school or day care center may send home, for the purpose of diagnosis and treatment, any pupil suspected of having a communicable disease or of having any other disease or condition having the potential to affect the health of other students and staff including but not limited to pediculosis and scabies. The teacher, principal, director or nurse authorizing the action shall ensure that the parent, guardian or other person legally responsible for the child or other adult with whom the child resides and the nurse serving the child's school or day care center are immediately informed of the action. A teacher who sends a pupil home shall also notify the principal or director of the action.

(2) **PERSONAL CARE.** Home health agency personnel providing personal care in the home and persons providing personal care in health care facilities, day care centers and other comparable facilities shall refrain from providing care while they are able to transmit a communicable disease through the provision of that care, in accord with the methods of communicable disease control contained in official guidance of the Centers for Disease Control and Prevention, unless specified otherwise by the state epidemiologist.

Note: The official guidance of the Centers for Disease Control and Prevention entitled, "Guideline for Infection Control in Health Care Personnel, 1998," is on file in the Department's Division of Public Health and the Legislative Reference Bureau, and may be found in the *American Journal of Infection Control*, vol. 26, 1998, pp. 289-354.

(3) **FOOD HANDLERS.** Food handlers shall refrain from handling food while they have a disease in a form that is communicable by food handling, in accord with the methods of communicable disease control contained in the official report of the American Public Health Association, unless specified otherwise by the state epidemiologist.

Note: The official report of the American Public Health Association entitled *Control of Communicable Disease Manual*, 20th edition (2015), edited by David L. Heymann, is on file in the Department's Division of Public Health and the Legislative Reference Bureau, and is available for purchase from the American Public Health Association, Publication Sales, PO Box 933019, Atlanta, GA 31193-3019.

(4) **PREVENTION OF OPHTHALMIA NEONATORUM.** The attending physician or midwife shall ensure placement of 2 drops of a one percent solution of silver nitrate, or a 1-2 centimeter ribbon of an ophthalmic ointment containing 0.5% erythromycin or one percent tetracycline, in each eye of a newborn child as soon as possible after delivery but not later than one hour after delivery. No more than one newborn child may be treated from an individual container.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; r. and recr. (4), Register, November, 1984, No. 347, eff. 12-1-84; am. (1) to (3), Register, February, 1989, No. 398, eff. 3-1-89; renum. from HFS 145.06 and am., Register, March, 2000, No. 531, eff. 4-1-00; CR 17-014: am. (2), (3), Register June 2018 No. 750 eff. 7-1-18; correction in (3) made under s. 35.17, Stats., Register June 2018 No. 750.

Subchapter II — Tuberculosis

DHS 145.08 Definitions. In this subchapter:

(1) "Case management" means the creation and implementation of an individualized treatment plan for a person with tuberculosis infection or disease that ensures that the person receives appropriate treatment and support services in a timely, effective, and coordinated manner.

(2) "Confinement" means the restriction of a person with tuberculosis to a specified place in order to prevent the transmission of the disease to others, to prevent the development of drug-resistant organisms or to ensure that the person receives a complete course of treatment.

(3) "Contact" means a person who shares air with a person who has infectious tuberculosis.

(4) "Contact investigation" means the process of identifying, examining, evaluating and treating a person at risk of infection with *Mycobacterium tuberculosis* due to recent exposure to infectious tuberculosis or suspected tuberculosis.

(5) "Directly observed therapy" means the ingestion of prescribed anti-tuberculosis medication that is observed by a health care worker or other responsible person acting under the authority of the local health department.

(6) "Infectious tuberculosis" means tuberculosis disease of the respiratory tract capable of producing infection or disease in others, as demonstrated by the presence of acid-fast bacilli in the sputum or bronchial secretions, or by radiographic and clinical findings.

(7) "Isolate" means a population of *Mycobacterium tuberculosis* bacteria that has been obtained in pure culture medium.

(8) "Isolation" means the separation of persons with infectious tuberculosis from other persons, in a place and under conditions that will prevent transmission of the infection.

(9) "Licensed prescriber" means an advanced practice nurse prescriber, a physician assistant, or other person licensed to prescribe medication under Wisconsin law.

(10) "Public health dispensary" means a program of a local health department or group of local health departments to prevent and control tuberculosis disease and infection by the identification, medical evaluation, treatment and management of persons at risk for tuberculosis infection or disease.

(11) "Repository" means a central location at the Wisconsin State Laboratory of Hygiene for receipt and storage of patient isolates of *Mycobacterium tuberculosis*.

(12) "Sputum conversion" means the conversion of serial sputum cultures for *Mycobacterium tuberculosis* from positive to negative, in response to effective treatment.

(13) "Suspected tuberculosis" means an illness marked by symptoms, signs, or laboratory tests that may be indicative of infectious tuberculosis such as prolonged cough, prolonged fever,

hemoptysis, compatible radiographic findings or other appropriate medical imaging findings.

(14) “Tuberculosis disease” means an illness determined by clinical or laboratory criteria or both to be caused by *Mycobacterium tuberculosis*.

(15) “Tuberculosis infection” means an infection with *Mycobacterium tuberculosis* in a person who has no symptoms of tuberculosis disease and is not infectious.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; r. and recr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: r. and recr. Register March 2002 No. 555, eff. 4-1-02.

DHS 145.09 Laboratory procedures. (1) Any laboratory that receives a specimen for tuberculosis testing shall report all positive results as specified in s. DHS 145.04, including those obtained by an out-of-state laboratory, to the local health officer and to the department. The laboratory shall also submit an isolate from a patient with a positive culture to the state repository.

Note: Isolates for the state repository should be sent to: Mycobacteriology Laboratory, Wisconsin State Laboratory of Hygiene, 2601 Agriculture Dr., Room 254, Madison, WI 53718.

(2) Any laboratory that performs primary culture for mycobacteria shall perform organism identification using an approved rapid testing procedure specified in the official statement of the Association of Public Health Laboratories, unless specified otherwise by the state epidemiologist. The laboratory shall ensure at least 80% of culture-positive specimens are reported as either *Mycobacterium tuberculosis* complex or not *Mycobacterium tuberculosis* complex within 21 calendar days of the laboratory’s receipt of the specimens.

Note: The official statement of the Association of Public Health Laboratory entitled “*Mycobacterium tuberculosis: assessing your laboratory*”, 2013 is on file in the Legislative Reference Bureau, and is available from the Department’s Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

(3) Any laboratory that identifies *Mycobacterium tuberculosis* shall ensure that antimicrobial drug susceptibility tests are performed on all initial isolates. The laboratory shall report the results of these tests to the local health officer or the department.

Note: Reports may be submitted to the Department’s Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; am. (1), Register, February, 1989, No. 398, eff. 3-1-89; r. and recr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: r. and recr. Register March 2002 No. 555, eff. 4-1-02.

DHS 145.10 Restriction and management of patients and contacts. (1) All persons with infectious tuberculosis or suspected tuberculosis, and their contacts, shall exercise all reasonable precautions to prevent the infection of others, using the applicable methods of control set out in the official report of the American Public Health Association, unless specified otherwise by the state epidemiologist.

Note: The official report of the American Public Health Association entitled *Control of Communicable Diseases Manual*, 20th edition (2015), edited by David L. Heymann, is on file in the Department’s Division of Public Health and the Legislative Reference Bureau, and is available for purchase from the American Public Health Association, Publications Sales, PO Box 933019, Atlanta, GA 31193-3019.

(2) All persons with infectious tuberculosis or suspected tuberculosis shall be excluded from work, school and other premises that cannot be maintained in a manner adequate to protect others from being exposed to tuberculosis, as determined by the local health officer.

(3) Official statements of the American Thoracic Society shall be considered in the treatment of tuberculosis, unless specified otherwise by the state epidemiologist. Specific medical treatment shall be prescribed by a physician or other licensed prescriber.

Note: The official statements of the American Thoracic Society may be found in the Centers for Disease Control and Prevention’s recommendations and report “Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection.” The report may be found in the *Morbidity and Mortality Weekly Report*, June 9, 2000, Vol. 49, No. RR-6. The official statements of the American Thoracic Society, entitled

Published under s. 35.93, Stats. Updated on the first day of each month. Entire code is always current. The Register date on each page is the date the chapter was last published.

“Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis” may be found in *Clinical Infectious Diseases*, vol. 63, 2016, pp. e147-e195. These reports are on file in the Legislative Reference Bureau, and are available from the Department’s Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

(4) (a) Any physician or licensed prescriber who treats a person with tuberculosis disease shall report all of the following to the local health officer:

1. The date of the person’s sputum conversion.
2. The date of the person’s completion of the tuberculosis treatment regimen.

(b) The physician or his or her designee shall immediately report to the local health officer when a person with tuberculosis disease does any of the following:

1. Terminates treatment against medical advice.
2. Fails to comply with the medical treatment plan.
3. Fails to comply with measures to prevent transmission.
4. Leaves the hospital against the advice of a physician.

(5) Upon receiving a report under sub. (4) (b), the local health officer shall immediately investigate and transmit the report to the department.

(6) The local health officer or the department may do any of the following:

- (a) Order a medical evaluation of a person.
- (b) Require a person to receive directly observed therapy.
- (c) Require a person to be isolated under ss. 252.06 and 252.07 (5), Stats.

(d) Order the confinement of a person if the local health officer or the department decides that confinement is necessary and all of the following conditions are met:

1. The department or local health officer notifies a court in writing of the confinement.

2. The department or local health officer provides to the court a written statement from a physician that the person has infectious tuberculosis or suspected tuberculosis.

3. The department or local health officer provides to the court evidence that the person has refused to follow a prescribed treatment regimen or, in the case of a person with suspected tuberculosis, has refused to undergo a medical examination under par. (a) to confirm whether the person has infectious tuberculosis.

4. In the case of a person with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the person poses an imminent and substantial threat to himself or herself or to the public health. The department or the local health officer shall provide to the court a written statement of that determination.

(e) If the department or local health officer orders the confinement of a person under par. (d), a law enforcement officer, or other person authorized by the local public health officer, shall transport the person, if necessary, to a location that the department or local health officer determines will meet the person’s need for medical evaluation, isolation and treatment.

(f) No person may be confined under par. (d) for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (7) to determine whether the confinement should continue.

(7) (a) If the department or a local health officer wishes to confine a person for more than 72 hours, the department or a local health officer may petition any court for a hearing to determine whether a person with infectious or suspected tuberculosis should be confined for longer than 72 hours. The department or local health officer shall include in the petition documentation that demonstrates all the following:

1. The person named in the petition has infectious tuberculosis; the person has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the person has suspected tuberculosis.

2. The person has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under s. 252.07 (11), Stats.; or that the disease is resistant to the medication prescribed to the person.

3. All other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. The person poses an imminent and substantial threat to himself or herself or to the public health.

(b) If the department or a local health officer petitions the court for a hearing under par. (a), the department or local health officer shall provide the person who is the subject of the petition written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all the following information:

1. The date, time and place of the hearing.
2. The grounds, and underlying facts, upon which confinement of the person is being sought.
3. An explanation of the person's rights under sub. (8).
4. The proposed actions to be taken and the reasons for each action.

(8) A person who is the subject of a petition for a hearing under sub. (6) (a) has the right to appear at the hearing, the right to present evidence and cross-examine witnesses and the right to be represented by counsel. At the time of the filing of the petition, the court shall assure that the person who is the subject of the petition is represented by counsel. If the person claims or appears to be indigent, the court shall refer the person to the authority for indigency determinations under s. 977.07 (1), Stats. If the person is a child, the court shall refer that child to the state public defender who shall appoint counsel for the child without a determination of indigency, as provided in s. 48.23 (4), Stats. Unless good cause is shown, a hearing under this paragraph may be conducted by telephone or live audiovisual means, if available.

(9) An order issued by the court under sub. (6) (a) may be appealed as a matter of right. An appeal shall be heard within 30 days after the appeal is filed. An appeal does not stay the order.

(10) If the court orders confinement of a person under sub. (6) (a), the person shall remain confined until the department or local health officer, with the concurrence of a treating physician, determines that treatment is complete or that the person is no longer a substantial threat to himself or herself or to the public health. If the person is to be confined for more than 6 months, the court shall review the confinement every 6 months, beginning with the conclusion of the initial 6-month confinement period.

(11) (a) If the administrative officer of the facility where a person is isolated or confined has good cause to believe that the person may leave the facility, the officer shall use any legal means to restrain the person from leaving.

(b) The local health officer or a person designated by the local health officer shall monitor all persons under isolation or confinement as needed to ascertain that the isolation or confinement is being maintained.

(c) The local health officer or a person designated by the local health officer shall monitor all persons with tuberculosis disease until treatment is successfully completed.

(12) The local health officer or the department may order an examination of a contact to detect tuberculosis. Contacts shall be

reexamined at times and in a manner as the local health officer may require.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; r. and recr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: r. and recr. Register March 2002 No. 555, eff. 4-1-02; CR 07-090: am. (1) Register February 2008 No. 626, eff. 3-1-08; CR 17-014: am. (1), Register June 2018 No. 750 eff. 7-1-18.

DHS 145.11 Discharge from isolation or confinement. The local health officer or the department shall authorize the release of a person from isolation or confinement if all the following conditions are met:

(1) An adequate course of chemotherapy has been administered for a minimum of 2 weeks and there is clinical evidence of improvement, such as a decrease in symptom severity, radiographic findings indicating improvement, or other medical determination of improvement.

(2) Sputum or bronchial secretions are free of acid-fast bacilli.

(3) Specific arrangements have been made for post-isolation or post-confinement care.

(4) The person is considered by the local health officer or the department not to be a threat to the health of the general public and is likely to comply with the remainder of the treatment regimen.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; r. and recr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: r. and recr. Register March 2002 No. 555, eff. 4-1-02.

DHS 145.12 Certification of public health dispensaries. (1) A local health department or 2 or more local health departments jointly may be certified by the department as a public health dispensary under s. 252.10, Stats., if the public health dispensary provides or ensures provision of all of the following:

- (a) Tuberculin skin testing.
- (b) Medication for treatment of tuberculosis disease and infection.
- (c) Directly observed therapy.
- (d) Tuberculosis contact investigation.
- (e) Case management.
- (f) Sputum specimen collection and induction.
- (g) Medical evaluation by a physician or nurse.
- (h) Chest radiographs.
- (i) Collection of serologic specimens.

(2) A local health department that meets the requirements under sub. (1) and wishes to be certified as a public health dispensary shall submit a request for certification to the department. The request for certification shall include a list of the tuberculosis-related services provided or arranged for and a plan for tuberculosis prevention and control at the local level, including tuberculin skin testing of high-risk groups as defined by the Centers for Disease Control and Prevention.

Note: "High-risk groups" are defined in the Centers for Disease Control and Prevention report, entitled "Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection – United States, 2010." The report may be found in the *Morbidity and Mortality Weekly Report*, June 25, 2010, vol. 59, No. RR-5, and is on file in the Legislative Reference Bureau, and is available from the Department's Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

(3) Upon authority of s. 252.10, Stats., the department shall review the request for certification as a public health dispensary and the related local health department operations within 6 months of receiving the application. The department shall either issue a written certificate signed by the state health officer or deny the application and provide a written explanation of the recommendations for improvement needed before the department reconsiders the request for certification.

(4) (a) The department shall review the operations of the public health dispensary at least every 5 years.

(b) The department may withhold, suspend or revoke its certification if the local health department fails to comply with any of the following:

1. Applicable federal or state statutes, or federal regulations or administrative rules pertaining to medical assistance, occupational safety, public health, professional practice, medical records and confidentiality.

2. The official statement of the national tuberculosis controllers association.

Note: The official statement of the National Tuberculosis Controllers Association entitled *Tuberculosis Nursing: a Comprehensive Guide to Patient Care*, 2nd edition (2011) is on file in the Legislative Reference Bureau, and is available from the National Tuberculosis Controllers Association, 2452 Spring Rd, SE, Smyrna, GA 30080-3838.

3. The official statements of the American Thoracic Society.

Note: The official statements of the American Thoracic Society entitled “Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection” may be found in the *Morbidity and Mortality Weekly Report*, June 9, 2000, Vol. 49, No. RR-6. The official statements of the American Thoracic Society entitled “Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis” may be found in *Clinical Infectious Diseases*, vol. 63, 2016, pp. e147-e195. The official statements of the American Thoracic Society entitled “Diagnostic Standards and Classification of Tuberculosis in Adults and Children” may be found in *American Journal of Respiratory and Critical Care Medicine*, vol. 161, 2000, pp.1376-1395. These reports are on file in the Legislative Reference Bureau, and are available from the Department’s Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

4. The directives of the state health officer made under s. 252.02 (6), Stats.

(c) The department shall provide the local health department with at least 30 days notice of the department’s decision to withhold, suspend or revoke its certification.

(5) (a) A department action under sub. (3) or (4) is subject to administrative review under ch. 227, Stats. To request a hearing under ch. 227, Stats., the public health dispensary shall file, within 10 working days after the date of the department’s action, a written request for a hearing under s. 227.42, Stats. A request is considered filed on the date the division of hearings and appeals receives the request. A request by facsimile is complete upon transmission. If the request is filed by facsimile transmission between 5 P.M. and midnight, it shall be considered received on the following day.

Note: A hearing request should be addressed to the Department of Administration’s Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI. Hearing requests may be faxed to 608-264-9885.

(b) The division of hearings and appeals shall hold an administrative hearing under s. 227.44, Stats., within 30 calendar days after receipt of the request for the administrative hearing, unless the public health dispensary consents to an extension of that time period. The division of hearings and appeals shall issue a proposed decision to the department no later than 30 calendar days after holding the hearing, unless the department and the public health dispensary agree to a later date.

(6) Public health dispensaries or the department may contract with other agencies, institutions, hospitals, and persons for the necessary space, equipment, facilities and personnel to operate a public health dispensary or for provision of medical consultation.

(7) If a public health dispensary charges fees for its services, the dispensary shall do all the following:

(a) Establish a fee schedule that is based upon the reasonable costs the public health dispensary incurs.

(b) Forward a copy of the fee schedule and any subsequent changes to the department.

(8) (a) Public health dispensaries and branches thereof shall maintain records containing all the following:

1. The name of each person served.
2. The date of service for each person served.
3. The type of service provided to each person.
4. The amount the dispensary billed and received for providing service to each person.

(b) The department may audit the records of public health dispensary and branches specified under par. (a).

History: Cr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: r. and recr. Register March 2002 No. 555, eff. 4-1-02.

DHS 145.13 Dispensary reimbursement. (1) REIMBURSABLE SERVICES. Public health dispensary services reimbursable by the department shall include at least the following:

(a) Tuberculin skin testing of high-risk persons as defined by the Centers for Disease Control and Prevention. The administration and reading of a tuberculin skin test shall be considered one visit. Tuberculin skin tests administered to persons who are not defined as high-risk by the Centers for Disease Control and Prevention, such as school employees, are not reimbursable.

Note: “High-risk persons” are defined in the Centers for Disease Control and Prevention report entitled “Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection – United States, 2010.” The report may be found in the *Morbidity and Mortality Weekly Report*, June 25, 2010, vol. 59, No. RR-5, and is on file in the Legislative Reference Bureau, and is available from the Department’s Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659.

(b) One chest radiograph for a person with a newly identified significant skin test result, including interpretation and consultation services.

(c) One follow-up chest radiograph, including interpretation and consultation services, to document response to therapy.

(d) An initial medical evaluation and one interim medical evaluation, as needed.

(e) Blood specimen collection for one baseline and up to 3 follow-up liver function tests.

(f) Visits to collect initial diagnostic sputum specimens, either freely coughed or induced, and follow-up specimens to monitor successful treatment, up to a total of 3 initial and 6 follow-up specimens.

(g) Sputum induction for collection of up to 3 specimens for initial diagnosis and 3 for documentation of sputum conversion.

(h) Case management visits and visits to provide directly observed therapy to persons with tuberculosis disease up to a maximum of 66 visits.

(2) REIMBURSEMENT RATE. (a) The department shall reimburse public health dispensaries on a quarterly basis for services provided under sub. (1) to clients who are not recipients of medical assistance until the biennial appropriation under s. 20.435 (1) (e), Stats., is totally expended. Reimbursement shall be at least at the medical assistance program rate in effect at the time of the delivery of the service.

(b) Public health dispensaries may claim reimbursement from the medical assistance program under ss. 49.43 to 49.497, Stats., and chs. DHS 101 to 108 for services under sub. (1) provided to persons eligible for medical assistance under s. 49.46 (1) (a) 15., Stats.

History: Cr. Register, March, 2000, No. 531, eff. 4-1-00; CR 01-105: Cr. Register March 2002 No. 555, eff. 4-1-02; correction in (2) (b) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637; correction in (2) (a) made under s. 13.92 (4) (b) 7., Stats., Register July 2011 No. 667.

Subchapter III — Sexually Transmitted Disease

DHS 145.14 Definitions. In this subchapter:

(1) “Commitment” means the process by which a court of record orders the confinement of a person to a place providing treatment.

(2) “Contact” means a person who had physical contact with a case that involved the genitalia of one of them during a period of time which covers both the maximum incubation period for the disease and the time during which the case showed symptoms of the disease, or could have either infected the case or been infected by the case.

(3) “Minor” means a person under the age of 18.

(4) “Sexually transmitted diseases” means syphilis, gonorrhea, chancroid, genital herpes infection, chlamydia trachomatis, and sexually transmitted pelvic inflammatory disease.

(5) “Source” means the person epidemiologic evidence indicates is the origin of an infection.

(6) “Suspect” means a person who meets the criteria in s. DHS 145.18.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. and am. from HFS 145.12, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.15 Case reporting. Any administrator of a health care facility, state correctional institution or local facility subject to ch. DOC 350, who has knowledge of a case of a sexually transmitted disease shall report the case by name and address to the local health officer. If the services of an attending physician are available in an institution or health care facility, the physician or a designee shall report as described in s. DHS 145.04 (1) (a). The administrator shall ensure that this reporting requirement is fulfilled.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; correction made under s. 13.93 (2m) (b) 7., Stats., Register, October, 1991, No. 430; renum. and am. from HFS 145.13, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.16 Reporting of cases delinquent in treatment. Whenever any person with a sexually transmitted disease fails to return within the time directed to the physician or advanced practice nurse prescriber who has treated that person, the physician or advanced practice nurse prescriber or a designee shall report the person, by name and address, to the local health officer and the department as delinquent in treatment.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. and am. from HFS 145.14, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.17 Determination of sources and contacts. Physicians accepting cases for treatment shall determine the probable source of infection and any other contacts, and shall attempt to diagnose and treat those persons, or shall request that the local health officer or the department do so.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. from HFS 145.15, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.18 Criteria for determination of suspects. Any person falling into one or more of the following categories is designated as a suspect:

(1) Persons identified as sexual contacts of a sexually transmitted disease case;

(2) Persons having positive laboratory or clinical findings of sexually transmitted disease; and

(3) Persons in whom epidemiologic evidence indicates a sexually transmitted disease may exist.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. from HFS 145.16, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.19 Examination of suspects. Local health officers shall require the examination of suspects. The examination shall include a physical examination and appropriate laboratory and clinical tests.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. from HFS 145.17, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.20 Commitment of suspects. If, following the order of a local health officer or the department, a suspect refuses or neglects examination or treatment, a local health officer or the department shall file a petition with a court to have the person committed to a health care facility for examination, treatment or observation.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. from HFS 145.18, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.21 Treatment of minors. A physician or advanced practice nurse prescriber may treat a minor with a sexually transmitted disease or examine and diagnose a minor for the presence of the disease without obtaining the consent of the minor’s parents or guardian. The physician or advanced practice nurse prescriber shall incur no civil liability solely by reason of the lack of consent of the minor’s parents or guardian, as stated in s. 252.11 (1m), Stats.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. and am. from HFS 145.19, Register, March, 2000, No. 531, eff. 4-1-00.

DHS 145.22 Treatment guidelines. The official statements of the Centers for Disease Control and Prevention shall be considered in the treatment of sexually transmitted diseases unless otherwise specified by the state epidemiologist. Specific medical treatment shall be prescribed by a physician or advanced practice nurse prescriber.

Note: The official statements of the Centers for Disease Control and Prevention entitled “Sexually Transmitted Diseases Treatment Guidelines, 2015,” is on file in the Department’s Division of Public Health and the Legislative Reference Bureau, and may be found in the *Morbidity and Mortality Weekly Report*, June 5, 2015, vol. 64, RR-3.

History: Cr. Register, April, 1984, No. 340, eff. 5-1-84; renum. and am. from HFS 145.20, Register, March, 2000, No. 531, eff. 4-1-00; CR 07-090: am. Register February 2008 No. 626, eff. 3-1-08; CR 17-014: am., Register June 2018 No. 750 eff. 7-1-18.