The Hospital + Healthsystem Association of Pennsylvania

September 21, 2026

The Honorable Dr. Debra L. Bogen
Secretary of Health
Pennsylvania Department of Health
Health and Welfare Building
625 Forster Street, 8th Floor West
Harrisburg, PA 17129

Dear Secretary Bogen:

The Hospital and Healthsystem Association of Pennsylvania (HAP) appreciates the opportunity to comment on the Department of Health's (DOH) proposed changes to Chapter 27 of the state's health and safety regulations for responding to and reporting communicable and noncommunicable diseases.

HAP advocates for approximately 235 member hospitals across the commonwealth, as well as for the patients and communities they serve. HAP's member hospitals and health systems provide health services across the continuum of care and are collectively committed to improving the health of Pennsylvanians and ensuring access to high-quality, cost-effective care.

Our member hospitals support the intent to strengthen Pennsylvania's public health infrastructure and modernize disease reporting requirements but have significant concerns regarding the current reporting framework, operational impacts of additional reporting, compliance concerns from proposed tighter reporting timelines, and implementation schedule for the proposed changes.

Expanded disease reporting requirements should be scaled or phased over time.

DOH proposes to increase the number of reportable diseases, infections, and conditions from 52 to 125 and indicates that for many hospitals, this change would require one-time changes to workflows in the electronic medical records system. However, our member hospitals have indicated that the expansion will materially increase reporting volume and the associated follow-up work. The burden associated with disease reporting is not limited to submitting the initial report. It includes phone calls, supplemental requests, exposure information, corrections, and ongoing communication with DOH. That work can become substantial very quickly during active events.

The preamble indicates that for hospitals without electronic reporting capabilities, the impact of expanded disease reporting requirements would be more significant. However, there is no indication of the number of hospitals that fall into this category, nor is there an alternative pathway to help these hospitals meet the reporting requirements.

The expanded disease reporting requirements exceed those in neighboring states. While HAP is supportive of a robust state disease surveillance system, we recommend the Department of Health phase in the expanded disease reporting requirements over time. Considerations must

also be made for small and rural hospitals that lack the electronic reporting capabilities needed to streamline reporting.

The current reporting infrastructure and workflows cannot support the scale of the proposed expansion.

The regulated community is concerned that Pennsylvania's National Electronic Disease Surveillance System (PA-NEDSS) infrastructure is not ready to absorb the magnitude of reporting that will happen with the new requirements proposed in these regulations. Notifications submitted by most laboratories through PA-NEDSS are automated through Electronic Lab Reporting (ELR), but reporting corresponding clinical case information (progress notes, diagnosis windows, corresponding lab results, discharge summaries, etc.) remains largely manual. These reports could be automated with Electronic Case Reporting (ECR); however, local and state health departments currently lack the infrastructure to receive these reports from popular electronic medical record (EMR) systems—including EPIC. At this point, that means that even though pathways can be built in the EMR to generate the required reports, the reports still need to be manually exported and submitted to the Department of Health.

During flu season or disease outbreaks, the manual reporting process becomes extremely time-consuming for health care providers and for the Department of Health. Completing and submitting a single report, depending on disease and county, could take an infection preventionist or health care worker 20 minutes to complete. That time commitment easily climbs to multiple hours as cases increase. The infrastructure failures also burden the disease surveillance teams at DOH. When reports are submitted manually or health care providers use workarounds to meet reporting requirements, DOH must commit additional time and manpower to ensure the data is received and cataloged appropriately. Neither the health care providers nor DOH have the resources to spare to support these manual workflows long term.

The department is proposing to double the number of diseases, infections, and conditions tied to required reporting. The expansion to new diseases, infections, or conditions that are not currently supported within NEDSS will require a separate form and reporting process for each. Expanding mandatory reporting requirements before the reporting platform is capable of supporting them is setting both health systems and DOH up for failure. Our hospitals point to recent experiences with measles and *Candida auris* reporting requirements both of which have reportedly resulted in duplicative reporting through various mechanisms, removing hospital staff from impactful bedside prevention work, and keeping them at desks to take care of administrative tasks.

HAP recommends that the Department of Health develop an electronic reporting infrastructure that can receive Electronic Case Reporting from EMRs before moving forward with expanded reporting requirements.

Hospitals are concerned about "immediate" reporting requirements.

The timelines for several of the requirements shift to achieve earlier reporting, but the hospital community is requesting additional clarity on expectations for "immediate" reporting.

Specifically, at 27.4, the Department of Health writes that hospitals "shall report immediately, by telephone," any cases of the 29 diseases, infections, or conditions that require immediate reporting. There is no indication in the regulatory language of when the "clock" starts for reporting (for example, at the time a clinician suspects a disease, infection, or condition versus when it is confirmed). Similarly, the language fails to account for instances when a health care worker may be unable to reach someone at the Department of Health to make the report.

Similarly, hospitals must report within 30 minutes any unusual cases of disease, infections, conditions, or suspicion of a public health emergency. It would be helpful if the Department of Health could be clearer about the criteria. The term "unusual cases of disease, infections, or conditions" seems to be a catchall. Absent a matrix or decision-making tool, it would be easy for a health care worker to be unaware that they should have reported a patient's condition as "unusual." Similarly, the proposed regulations are lacking substantial criteria for identifying a "suspected public health emergency." It seems rare that one health care worker would see enough cases of a disease, infection, or condition to suspect a public health emergency, and even if they did, it would be unclear when the 30-minute timeline would begin.

The shorter reporting timelines will ultimately come with increased compliance risks, particularly for hospitals with very limited resources. Staff leading infection prevention or infectious disease response efforts can't always step away from immediate, urgent prevention and response activities to make the report over the phone. This is particularly true for organizations that have one infection preventionist (IP) for an entire health system and smaller hospitals where the IP serves in multiple roles.

The hospital community requests that reasonable flexibility be given for review and confirmation of a patient's diagnosis or condition and that the Department of Health provides more clarity around its expectations for unusual cases or public health emergency reporting. We would also advocate that the Department of Health consider good-faith reporting efforts when enforcing compliance with the tighter timelines.

Requirements for emergency department visit data must account for data requirements tied to other DOH initiatives

In the proposed regulations, the Department of Health would require emergency departments to report visit data for the purposes of syndromic surveillance. The DOH indicates that hospitals are already voluntarily reporting these data elements. On its face, the proposed change seems reasonable, but it does not account for other DOH initiatives currently underway that require reporting on emergency department capacity. Hospitals should not be expected to submit overlapping information through multiple channels. The expectation should be a single, automated, interoperable data feed whenever possible. This transition would also seemingly come at the same time as expanded disease reporting requirements, further adding to the weight of the proposed changes.

HAP encourages the Department of Health to coordinate any emergency department data requirements with other initiatives currently under way. The shift from voluntary reporting to mandatory reporting should only occur if reporting can be streamlined and if the hospital

community is given time to implement and test reporting pathways.

Vaccine reporting should only be required when DOH systems are interoperable.

Required vaccine reporting is also reasonable in principle, but the operational impact depends entirely on interoperability. If vaccine administration can flow automatically from the electronic health record system (EHR) to the state immunization information system, the burden is manageable for those hospitals and providers that have the ability to electronically report. If manual entry, reconciliation, or duplicate documentation is expected, the volume will be significant and unnecessary. The department must also account for hospitals or providers that don't use EHRs or don't have electronic reporting capabilities.

HAP is advocating that the Department of Health ensure the infrastructure needed to receive automated electronic reporting for vaccine administration is in place prior to requiring reporting and to imposing any penalties on providers for non-reporting.

Pennsylvania should have an electronic birth defect registry, but the reporting expectations need to be clearly defined and electronically supported.

In the preamble, the Department of Health indicates that Pennsylvania is one of the only states without a birth defect registry. The hospital community is supportive of an electronic birth registry and applauds the DOH for devoting the time and scarce resources to build one. HAP also appreciates that the DOH will not require new reporting until the birth defect registry is built and ready to accept reporting from hospitals. The success of the new registry will depend on its capabilities. A registry that depends on manual identification and reporting will create another parallel workflow and increase the likelihood of inconsistent reporting across the state.

HAP implores the Department of Health to use the opportunity and funds allocated to build an electronic birth defect registry that accepts electronic reporting and is interoperable with hospital electronic medical record systems.

The Department of Health should collaborate with poison centers for reporting on environmental toxicants.

Efficient public health infrastructure strives to limit redundancy. Hospitals must already report environmental toxicant cases to state-designated poison centers. This reporting should meet the requirements outlined in the proposed regulations as poison centers will report these data to the state health department on a daily basis. The Department of Health can provide special protection to poison centers for disclosing patient identifying information on these reportable conditions.

Overall, HAP believes that a robust surveillance system can support earlier detection and prevention of communicable and noncommunicable diseases, infections, and conditions, but remains concerned that the DOH could create a more expansive reporting mandate on paper without first building the operational infrastructure needed to make it work in practice. On behalf of our member hospitals, HAP is advocating for phased implementation, clear reporting

definitions, electronic interoperability, standardized reporting pathways, elimination of duplicate reporting, and demonstrated DOH system capacity before enforcement begins. The state should not expand mandatory reporting requirements faster than its infrastructure can support them.

Thank you for your consideration.

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