Title 15: Mississippi State Department of Health

Part 2: Epidemiology

Subpart 11: Office of Communicable Diseases

Chapter 1 MISSISSIPPI STATE DEPARTMENT OF HEALTH RULES AND REGULATIONS GOVERNING REPORTABLE DISEASES AND CONDITIONS.

Subchapter 1 DUTY TO REPORT

Rule 1.1.1 Each clinician including each physician, pathologist, nurse practitioner, medical examiner; and coroner, laboratory director and veterinarian, in epizootic diseases, shall report to the Department of Health any diagnosed case or suspected case of a reportable disease or condition, including those hereinafter listed, which he or she is attending, has examined, or of which he or she has knowledge. Reports on patients originating from institutions (including but not limited to hospitals and nursing homes) may be coordinated through a designated person, such as an infection control practitioner, provided there is prior arrangement with the Mississippi State Department of Health, Epidemiology Program. Such report shall include, unless otherwise specified, the patient's name, address, age and/or date of birth, race, sex, the disease or suspected disease or condition, the date of onset of the disease, method of diagnosis, and name of attending clinician.

1. All reports so made are confidential. Reports shall be made as required for each class. Case Report Cards for written reports are supplied through the local health department. When a report to the local health department is made by telephone or in person, the local health officer or his or her designee shall be responsible for preparing the Case Report Card, and forwarding it to the Epidemiology Program.

2. The designated diseases and conditions listed in Appendix A to the Rules and Regulations Governing Reportable Diseases and Conditions shall be reported using the following classifications. The list designating the reportable diseases and conditions shall be published annually in the Mississippi Morbidity Report and is also available upon request to the Epidemiology Program.

Source: Miss. Code Ann. §41-91-7

Rule 1.1.2 Definitions.

1. Class 1A: Diseases of major public health importance which shall be reported directly to the Department of Health by telephone within 24 hours of first knowledge or suspicion. Class 1A diseases and conditions

are dictated by requiring an immediate public health response. Laboratory directors have an obligation to report laboratory findings for selected diseases (Refer to Appendix B in the Rules and Regulations Governing Reportable Diseases and Conditions).

2. Class 1B: Diseases of major public health importance which shall be reported directly to the Department of Health by telephone on the next business day after first knowledge or suspicion. Class 1B diseases and conditions require individual case investigation, but not an immediate public health response. Laboratory directors have an obligation to report laboratory findings for selected diseases (Refer to Appendix B in the Rules and Regulations Governing Reportable Diseases and Conditions).

3. Class 2: Diseases or conditions of public health importance of which individual cases shall be reported by mail, telephone or electronically, within 1 week of diagnosis. In outbreaks or other unusual circumstances they shall be reported the same as Class 1. Class 2 diseases and conditions are those for which an immediate public health response is not needed for individual cases. Laboratory directors have an obligation to report laboratory findings for selected diseases (Refer to Appendix B to the Rules and Regulations Governing Reportable Diseases and Conditions).

4. Class 3: Laboratory based surveillance. Reported by laboratory only. Diseases or conditions of public health importance of which individual laboratory findings shall be reported by mail, telephone, or electronically within one week of completion of laboratory test (refer to Appendix B of the Rules and Regulations Governing Reportable Diseases and Conditions.). Types of results deemed reportable may be updated due to changes in technology by the State Epidemiologist upon advice of the Director of the Public Health Laboratory.

5. Class 4: Diseases of public health importance for which immediate reporting is not necessary for surveillance or control efforts. Diseases and conditions in this category shall be reported to the Mississippi Cancer Registry within 6 months of the date of first contact for the reportable condition.

i. **<u>All Class 4 reports should be submitted to:</u>**

Mississippi Cancer Registry
Cancer Research and Registries
University of Mississippi Medical Center
2500 North State Street
Jackson, MS39216

Phone: 601-815-5482
Fax: 601-815-5483

Source: Miss.Code Ann. §41-91-7

Rule 1.1.3 State Epidemiologist; with the concurrence of the State Health Officer, when the Board is not in session, may declare a disease or condition reportable for a specific length of time, not to exceed 12 months. The Board shall be informed of any action taken under this provision at its next regular meeting. The intent and purpose of this authority is to allow rapid investigation of and response to new or emerging threats to the health of the public.

Source: Miss. Code Ann. §41-3-17

Subchapter 2 CASE DEFINITIONS

Rule 1.2.1 For surveillance and reporting purposes, the criteria for diagnosis of reportable conditions shall be those specified by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention. Current criteria can be found at http://wwwn.cdc.gov/nndss/case-definitions.html for infectious diseases.

Source: Miss.Code Ann. §41-3-17

Subchapter 3 DUTY OF LABORATORY DIRECTORS TO REPORT

Rule 1.3.1 It shall be the duty of the director or other person in charge of any clinical laboratory in the State of Mississippi or serving Mississippi clinicians or institutions to notify the Mississippi State Department of Health of any laboratory finding as provided for in Appendix A of the Rules and Regulations Governing Reportable Diseases and Conditions for all classes of diseases or conditions. The report shall in all cases include the name and location of the physician or other health care provider ordering the test in addition to the patient identifying information specified in Subchapter 1. Tests considered reportable shall be those listed in Appendix B to the Rules and Regulations Governing Reportable Diseases and Conditions.

Source: Miss.Code Ann. §41-3-17

Subchapter 4 DUTIES OF LOCAL HEALTH OFFICER

Rule 1.4.1 The director of the local health department, as the local health officer, shall be responsible for the control of communicable diseases and other conditions within his or her jurisdiction considered prejudicial to the public health. It shall be his or her duty to collect and make reports as required to the Mississippi State Department of Health, to provide consultation services to physicians regarding communicable diseases, to advise and consult with all others in matters relating to

public health, and to investigate reports of known or suspected communicable diseases or of conditions which might be prejudicial to the public health. It shall be his or her duty to determine in individual cases or groups of cases whether to impose restrictions on the activities of patients or contacts of persons with a communicable disease and to fix the period of isolation for such diseases. For all the diseases listed in Appendix A, Class 1A and Class 1B, the local health officer shall, on first knowledge or suspicion, conduct an investigation into all the circumstances and prescribe such reasonable methods of control as may be calculated to minimize the danger of further dissemination of the disease process. The measures proposed in the most current edition of the Control of Communicable Diseases Manual, published by the American Public Health Association shall be considered as supplementary. In all matters where there is disagreement as to diagnosis, isolation or in any other situation where the responsibility rests with the health officer, the opinion of the health officer shall prevail. In the discharge of his or her duties, the health officer or designee shall not be denied the right of entry to any premises nor shall he or she be denied pertinent patient health information and patient identifiers.

Source: Miss.Code Ann. §41-3-17

Subchapter 5 REPORTING OF PATIENTS WHO ABANDON TREATMENT

Rule 1.5.1 If any patient suffering from any of the diseases or conditions listed in Appendix A to the Rules and Regulations Governing Reportable Diseases and Conditions leaves the care of his/her physician or leaves any hospital, and the condition of the patient is considered harmful to the public health, it shall be the duty of the attending physician or superintendent or other person in charge of the hospital to report the circumstances to the Department of Health, whether the case has been previously reported or not.

Source: Miss.Code Ann. §41-3-17

Subchapter 6 SUSPECTS OR CONTACTS OF COMMUNICABLE DISEASES REQUIRED TO SUBMIT TO EXAMINATION

Rule 1.6.1 The local health officer is authorized to examine, treat, and/or isolate at his or her discretion or under the direction of the State Health Officer any person who, on credible information, is suspected of suffering from any communicable disease, or who is a contact with a known case of such disease or may be a carrier or have the disease in the incubation or prodromal phase. Said suspect or contact shall be notified in writing to report to a reasonable place at a reasonable time for such examination. Should the suspect or contact refuse to submit to examination satisfactory to the health officer, said suspect or contact shall be prosecuted at law to compel compliance and/or be isolated in a manner prescribed by the health officer until the danger of transmitting the disease in question has passed. In the event that the aforementioned suspect or contact is a minor, the parent or guardian shall be apprised of the facts and requested to deliver said minor for examination.

In the event of refusal, the health officer shall maintain action at law to compel compliance of the parent or guardian and/or impose isolation as necessary.

Source: Miss.Code Ann. §41-3-17

Subchapter 7 PERSONS IN CHARGE OF CERTAIN BUSINESSES AND INSTITUTIONS REQUIRED TO EXCLUDE CERTAIN PERSONS

Rule 1.7.1 When any superintendent or other person in charge of any school or other institution, whether public or private, or the person in charge of any establishment or business dealing with perishable foods or foodstuffs for public consumption knows or suspects that any person attending or employed in said school, institution, or business is afflicted with any disease transmissible under the conditions prevailing in that institution or establishment, said person in charge shall exclude the affected person from attending or working in said school, institution or business until he/she shall have been declared by the health officer, or by medical certification acceptable to the health officer, not to be a significant threat to the health of others as a result of the above mentioned disease.

Source: Miss.Code Ann. §41-3-17

Subchapter 8 FOOD HANDLING ESTABLISHMENTS

Rule 1.8.1 The production, processing, storage, handling, distribution and sale of food for human consumption shall conform to the specifications of the current Mississippi Food Code. Local authorities may impose additional, specific requirements. It shall be the duty of the local health officer to investigate any potential or actual disease occurrence in connection with food handling and to impose any measures he/she deems necessary for its control.

Source: Miss.Code Ann. §41-3-17

Subchapter 9 NOTIFICATION OF OTHER HEALTH CARE PROVIDERS

Rule 1.9.1 Any provider of health care services, including but not limited to physician, hospital, and emergency clinic who refers or transfers a patient to another provider of health care services and who has knowledge that the patient has one of the conditions listed in Subchapter 13 or carries the infectious agent thereof or any other disease or agent transmissible under the circumstances of the care to be provided, shall advise the health care service provider to whom the patient is referred or transferred of the presence of the condition together with pertinent details as indicated by accepted standards of medical practice.

Source: Miss.Code Ann. §41-3-17

Subchapter 10 NOTIFICATION OF THIRD PARTY INDIVIDUALS

Rule 1.10.1 In certain circumstances where such notification has significant potential for interrupting the transmission of disease, the Department of Health, through its official representatives, may notify a third party of the presence of a reportable disease in another person. Such notification shall be subject to the prior approval of the State Health Officer or of the State Epidemiologist, and shall take place only under the following conditions:

1. Significant, medically recognized, and biologically plausible potential for the transmission of the disease involved must exist under the circumstances;

2. The party to be notified:

   a. Must be at significant risk of acquiring the disease in question or of aggravation of the disease by additional exposure if such notification does not occur, and be potentially able to avoid such transmission by realistic means as a result of the notification; or,

   b. Must stand in loco parentis or otherwise be responsible for the activities of other persons whose activities could realistically be expected to produce the potential for transmission of the disease to other individuals, and such notification would enable that person to take action which could realistically result in prevention of transmission; or,

   c. Could, with such notification, aid in preventing further transmission of the disease by offering testimony in a judicial proceeding concerning the infected individual's violation of an order of the Mississippi State Department of Health.

Source: Miss.Code Ann. §41-3-17

Rule 1.10.2 Such notification shall always be dependent on the presence of a disease that can be transmitted under the circumstances involved, and where there either is no other practical means of limiting transmission or where notification provides such a significant advantage over other means of attempting to reduce transmission that in the opinion of the State Health Officer or the State Epidemiologist, notification is warranted.

Source: Miss.Code Ann. §41-3-17

Subchapter 11 NOTIFICATION OF EMERGENCY MEDICAL SERVICE PROVIDERS -POSTEXPOSURE

Rule 1.11.1 When in the course of providing emergency services to an individual, an emergency medical technician, firefighter, peace officer, or other provider of emergency services comes into direct bare-skin contact with the patient's blood or

other internal body fluids, and the patient is transported to a medical care facility, the emergency medical services provider shall notify the medical facility of the blood exposure. Notification shall be in writing and shall include the date and time of the exposure, a description of the nature of the exposure, and the circumstances under which it occurred. If the medical facility to whom the victim is delivered learns during that admission or episode of treatment that the patient has one of the conditions listed in Subchapter 13 or carries the causative agent thereof, the medical facility shall then advise the emergency medical service worker who was exposed as to the condition which was present, and the need for any protective measures to be taken. The hospital shall retain in the patient's medical record a copy of the written notification by the emergency medical services provider of the exposure. The emergency service provider and/or the agency to which he or she is employed shall not disclose any patient identifying information provided under this section to any other person or agency.

Source: Miss.Code Ann. §41-3-17

Subchapter 12 PREVENTION OF BLOODBORNE PATHOGENS DURING EXPOSURE-PRONE PROCEDURES

Rule 1.12.1 The Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients during Exposure-Prone Invasive Procedures published in the MMWR by the Centers for Disease Control and Prevention shall be the guidelines followed in all applicable circumstances in the State of Mississippi. (Copies of these guidelines may be obtained by contacting the Epidemiology Program at 601-576-7725.) This document may also be accessed at www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm.

Source: Miss.Code Ann. §41-3-17

Subchapter 13 BLOODBORNE AGENTS

Rule 1.13.1 The State Board of Health declares the diseases listed in the following table and/or infectious agents, transmissible by blood or body fluids, to require the use of appropriate blood and body fluid precautions, including notification of other health care personnel, emergency medical personnel, and providers of post-mortem services as indicated by accepted standard of medical practice or required by law.

Transmissible by Blood or Body Fluids	
Creutzfeldt-Jakob Disease (CJD)	Human Immunodeficiency Virus (HIV) infection
Hepatitis B	Syphilis
Hepatitis C	Viral Hemorrhagic Fever

Source: Miss. Code Ann. §41-3-17

Subchapter 14 TESTING FOR HUMAN IMMUNODEFICIENCY VIRUS INFECTION

Rule 1.14.1 Testing for infection with human immunodeficiency virus (HIV) shall be performed only under the following conditions:

1. No individual or agency shall perform screening tests or collect specimens for the performance of such tests without either the ability to perform appropriate confirmatory tests, such as fluorescent antibody, Western blot, or other tests accepted as confirmatory by the State Department of Health, or arrangements to have such confirmatory tests performed.

2. Individuals tested for HIV infection shall be notified of the results of the testing only upon completion of appropriate confirmatory or second level test such as fluorescent antibody, Western blot, or other tests accepted as confirmatory by the State Department of Health.

3. No testing shall be performed without appropriate post-test counseling of individuals tested.

4. All conditions stated above pertain to any brand of rapid HIV test. Exceptions: 1) “negative” rapid HIV test results may be provided directly to the patient. 2) provision of “preliminary positive” rapid HIV test results to the patient pending receipt of required confirmatory test results is permitted. Providers offering rapid HIV testing should receive specific pre- and post-test counseling training. It is preferred that the confirmatory test specimen collection occur immediately, but if that is not possible, every effort should be made to assure that the patient reports for confirmatory testing as soon as possible.

5. For all diagnosed cases of HIV infection, subsequent HIV-related serology results as defined shall be reported to the health department. Laboratories shall report each test result for the following required HIV-related serology:
    a. HIV viral load results, both detectable and undetectable

b. CD4+ (T4) lymphocyte results of any value

Source: Miss.Code Ann. §41-3-17

Subchapter 15 IMPORTATION OF WILD ANIMALS

Rule 1.15.1 Any wild animal (including but not limited to raccoons, skunks, foxes, prairie dogs and ferrets) known to be capable of harboring and transmitting any disease which may affect humans (such as rabies), or of harboring the vector which transmits the illness (such as plague), from an area or farm enzootic for that illness, shall not be imported into the state

Source: Miss.Code Ann. §41-3-17

Subchapter 16 STORAGE OF BIOLOGICALS

Rule 1.16.1 All local health offices, pharmacies, drug stores, apothecary shops, wholesale drug houses and other entities or institutions located within the State of Mississippi and selling or offering to sell or furnish to the public certain biologicals to be used for the purpose of preventing or curing disease shall maintain refrigeration systems in which said biologicals shall be stored at all times. The temperature of the refrigeration system shall not be above 46º F at any time. In the compartment of the refrigeration system where biologicals are stored, a standard thermometer shall be so placed in a fixed position as to indicate the average temperature of the storage compartment. Except for oral polio vaccine, varicella vaccine and other biologicals which must remain frozen until time of use, products should not be placed against ice or stored and maintained at temperatures below 35º F

Source: Miss.Code Ann. §41-3-17

Subchapter 17 SPECIFIC DISEASE CONTROL MEASURES

Rule 1.17.1 The following measures shall be used to control or prevent the included diseases of public health importance. The measures proposed in the most current edition of the Control of Communicable Diseases Manual, published by the American Public Health Association shall be considered as supplementary.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.2 Anthrax

1. Class 1A case report required.

2. Human infections: Any person infected with anthrax shall be isolated until all lesions are healed or the diagnosis disproved to the satisfaction of the

health officer. All lesion discharges shall be subjected to concurrent disinfection in a manner acceptable to the health officer.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.3 Brucellosis (Undulant Fever)

1. Class1A case report required.

2. Whenever the local health officer shall have reason to suspect that any dairy herd may be infected with brucellosis he/she shall prohibit the movement, sale or giving of milk from the herd until the herd is proven free of brucellosis by veterinary certification acceptable to him/her. Milk shall be from dairy herds under a brucellosis eradication program complying with requirements set forth in the current Mississippi State Board of Health Regulations, and the Mississippi State Department of Health's Regulations Governing the Production and Sale of Milk and Milk Products.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.4 Cancer

1. Class 4 case report required.

2. Diseases and conditions in this category shall be reported within six months of the first date of contact for the reportable condition to the Mississippi Cancer Registry. The National Program of Cancer Registries at the Centers for Disease Control and Prevention requires the reporting of certain diseases and conditions. A comprehensive reportable list including ICD9CM/ICD10CM codes is available on the Mississippi Cancer Registry website, https://www.umc.edu/Administration/Outreach_Services/Mississippi_Cancer_Registry/Reportable_Diseases.aspx

3. Each record shall provide a minimum set of data items which meets the uniform standards required by the National Program of Cancer Registries and documented in the *North American Association of Central Cancer Registries (NAACCR) Data Standards and Data Dictionary, Volume II*. [Refer to Section 41-91-7(2) (b), Mississippi Code 1972 as amended. See Preface.]

Source: Miss.Code Ann. §41-91-7

Rule 1.17.5 Diphtheria

1. Class 1A case report required.

a. Every case or suspected case of diphtheria shall be isolated until 2 cultures from the throat and 2 from the nose taken not less than 24 hours apart and not less than 24 hours after antibiotic therapy fail to show diphtheria bacilli. Where culturing is impractical, isolation may be ended after 14 days of appropriate antibiotic treatment. In suspected cases, isolation may be terminated if laboratory and clinical findings fail to confirm the diagnosis.

b. All articles in contact with a patient and all articles soiled by discharges of a patient shall be disinfected or disposed of in a manner acceptable to the health officer.

c. At termination of isolation, the quarters shall undergo terminal disinfection.

d. All close contacts should have cultures taken and should be kept under surveillance for 7 days. Adult contacts whose occupation involves handling food or close association with children must be excluded from these occupations until shown by bacteriological examination not to be carriers.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.6 Foodborne Illness

1. Class 1A case report required for outbreaks. Some foodborne diseases require case reports for a single case see Appendix A to the Rules and Regulations Governing Reportable Diseases and Conditions.

a. Whenever the local health officer shall know of or suspect the existence of an outbreak of illness due to food infection or food poisoning, he/she shall conduct an immediate investigation of all the circumstances.

b. The local health officer shall prohibit infected or potentially infected persons from engaging in the preparation or handling of foods or foodstuffs until said health officer is satisfied that said persons are free of pathogenic microorganisms.

c. The local health officer shall, upon investigation, prohibit practices in preparation, processing, storing or handling of food or foodstuffs which are known or may be reasonably inferred to be conducive to food poisoning.

d. The local health officer shall require compliance of all persons or firms with at least the minimum sanitary requirements of the Mississippi State Board of Health in regard to the physical plant in

which or from which perishable foods or foodstuff are offered to the public.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.7 Hepatitis

1. Class 1A case report required for hepatitis A.

   a. Patients with hepatitis A should be questioned as to whether they work as a food-handler (including voluntary work) and whether they have children in the household who attend a daycare center. This information shall be a part of the case report.

   b. The local health officer shall prohibit persons infected or potentially infected with hepatitis A from engaging in the preparation or handling of foods or foodstuffs until said health officer is satisfied that said persons are free of hepatitis A virus.

2. Class 2 case report required for acute viral hepatitis other than hepatitis A.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.8 Hansen Disease (Leprosy)

1. Class 3 case report required.

2. Treatment should be in consultation with the Mississippi State Department of Health for local treatment.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.9 Influenza-Associated Pediatric Mortality: Class 1A case report required.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.10 Measles: Class 1A case report required. Effective outbreak control is dependent on immediate telephone report of individual cases.

Source: Miss. Code Ann. §41-3-17

Rule 1.17.11 Meningitis: Class 1A case report required for meningococcal and *Haemophilus influenzae* meningitis or other forms of invasive disease, since chemoprophylaxis for high risk contacts is provided by the Department of Health. (Usually presents as meningitis or septicemia, or less commonly as cellulites, epiglottitis, osteomyelitis, pericarditis, or septic arthritis.)

Source: Miss.Code Ann. §41-3-17

Rule 1.17.12 Ophthalmia Neonatorum (Neonatal Gonococcal Ophthalmia): All physicians and midwives attending births must install in the eyes of the newborn 1 drop of a 1 percent solution of silver nitrate within 1 hour after birth except that physicians may elect to use penicillin or other antibiotics in the manner and after the technique which may from time to time be generally accepted by the medical profession as being at least as effective as 1 percent silver nitrate.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.13 Poisoning

1. Class 2 case report required for individual cases.

2. For the purpose of reporting, poisoning includes, but is not limited to cases involving observable clinical symptomology or significant clinical laboratory changes as a result of over exposure to drugs, household products, pesticides, agricultural or industrial chemicals, plants, venomous animals or any other toxicant. Reports made to the Mississippi Poison Control Center at the University of Mississippi Medical Center in Jackson (1-800-222-1222) will satisfy this requirement

Source: Miss.Code Ann. §41-3-17

Rule 1.17.14 Rabies

1. Class 1A case report required.

2. Control in Animals: The Mississippi State Department of Health subscribes to the most current edition of the Compendium of Animal Rabies Prevention and Control, parts I, II, and III, by the National Association of State Public Health Veterinarians. The provisions of this compendium have been endorsed by the CDC, U. S. Public Health Service, Department of Health and Human Services; the American Veterinary Medical Association; the Council of State and Territorial Epidemiologists; and other public and private agencies. The compendium can be found at www.nasphv.org/documentsCompedia.html .The following are state specific modifications to the Compendium.

3. Vaccine Administration: All animal rabies vaccines are restricted to use by or under the supervision of a veterinarian or person specifically licensed or designated by the State Board of Health to administer rabies vaccine.

4. Vaccine Selection: The current Compendium lists vaccines licensed for use in the United States. Only licensed vaccines shall be used. Vaccines selected for immunizing dogs and cats shall be licensed as providing 3-year immunity.

5. Wildlife Vaccination: Vaccination of wildlife is not recommended since no vaccine is licensed for use in wild animals. Offspring of wild animals bred with domestic dogs or cats are considered wild animals.

6. Pre-Exposure Vaccination (Dogs and Cats): All dogs and cats shall be vaccinated against rabies at three months of age, revaccinated one year later and every three years thereafter, using a rabies vaccine approved as providing a 3 year immunity.

7. Post-Exposure Management

   a. Any animal bitten or scratched by a wild, carnivorous mammal or bat that is not available for testing should be regarded as having been exposed to rabies.

   b. Dogs, Cats, and Ferrets: Unvaccinated dogs, cats, and ferrets exposed to a rabid animal should be euthanized immediately. If the owner is unwilling to have this done, the animal should be placed in strict isolation for 6 months and vaccinated 1 month before being released. Animals with expired vaccinations need to be evaluated on a case-by-case basis. Dogs, cats, and ferrets that are currently vaccinated should be revaccinated immediately, kept under the owner's control, and observed for 45 days.

8. Management of Animals that Bite Humans

   a. A healthy dog, cat, or ferret that bites a person shall be confined and observed for 10 days in a manner acceptable to the local health officer or his or her designee. Rabies vaccine shall not be administered during the observation period. Such animals shall be evaluated by a veterinarian at the first sign of illness during confinement. Any illness in the animal shall be reported immediately to the local health department. If signs suggestive of rabies develop, the animal shall be euthanized, its head removed, and the head shipped under refrigeration to the Department of Health Laboratory for examination. Any stray or unwanted dog, cat, or ferret that bites a person may be euthanized immediately, in lieu of 10 days of observation, and the head submitted as described above for rabies examination.

   b. Animals other than dogs, cats, or ferrets that might have exposed a person to rabies should be reported immediately to the health department. This is not to include low risk animals such as small

rodents and lagomorphs (e.g., squirrels, rats, mice, gerbils, and rabbits). Prior vaccination of an animal does not preclude the necessity for euthanasia and testing if the period of virus shedding is unknown for that species. Management of animals other than dogs, cats, and ferrets depends on the species, the circumstances of the bite, the epidemiology of rabies in the area, and the biting animal's history, current health status, and potential for exposure to rabies. The need for euthanizing and testing the animal shall be decided upon consultation with the Epidemiology Program. Post-exposure management of persons should follow the recommendations of the ACIP.

Source: Miss.Code Ann. §41-3-17

Rule 1.17.15 Sexually Transmitted Diseases – General

1. Any person known or suspected of having syphilis, gonorrhea, Chlamydia, chancroid, human immunodeficiency virus (HIV) or other sexually transmissible disease (STD) or suspected of having been exposed to syphilis, gonorrhea, Chlamydia, chancroid, HIV or other STD shall submit to examination as provided in Section 105. Any person who, after due notification, fails or refuses to report for examination at the time and place designated by the health officer shall be subject to prosecution and the local health officer or the Mississippi State Department of Health or its representative may make an affidavit of such fact and cause the issuance of a warrant returnable before any court of competent jurisdiction. All records and reports herein required shall be kept in secret files and disclosed only as required before the court (Section 41-23-29, Mississippi Code of 1972 as amended.).

2. It shall be the duty of the local health officer or his or her representative to conduct effective epidemiological actions including initial and follow up interviews, rapid contact and suspect referral to medical examination, satisfactory determination of the source of patient infection and all subsequent infections, and appropriate administration of prophylactic treatment to all at risk critical period contacts.

3. Case reports of genital Chlamydia, gonorrhea, chancroid and syphilis shall include date, type of treatment and dose, or if no treatment has been initiated.

4. Syphilis

   a. Class 1B case report required.

   b. General

i. Any reactive serologic test for syphilis (STS) shall be reported to the State Department of Health by the laboratory performing the test. Report shall include test result, patient's name, age, race, sex, and address, and name of physician ordering the test.

ii. RPR or VDRL ≥ 1:8 - Class 1B case report required.

iii. Any reactive STS in persons 10 years of age or younger - Class 1B case report required.

iv. RPR or VDRL ≤ 1:4 - Class 2 case report required. MSDH "Laboratory Log Sheet" or a form providing all the same information may be used.

Source: Miss. Code Ann. §41-3-17

Rule 1.17.16 Tuberculosis

1. Class 1A case report required.

2. Human Infections: The local health officer shall determine and prescribe for individual cases and contacts the isolation, quarantine restrictions and/or treatment necessary for their protection and that of other people. Should any patient fail to observe the isolation methods prescribed by the local health officer, said health officer shall quarantine the patient in writing and prescribe therein the procedures to be carried out by said patient. Should the patient break his/her quarantine restrictions, the local health officer may apply by letter outlining the circumstances to the Executive Secretary of the Mississippi State Board of Health and request approval of proceedings to commit the patient to a hospital. Upon approval by the Executive Secretary of the Mississippi State Board of Health, the local health officer may initiate proceedings as provided by law for the forcible commitment of the patient. (Sections 41-33-5, 41-33-7, Mississippi Code of 1972 as amended.)

3. Control in Animals: Bovine tuberculosis may be transmitted to man by infected cattle through close contact or the consumption of raw milk. Milk shall be from dairy herds that comply with tuberculosis requirements set forth in the current Mississippi State Board of Health Regulations, and the Mississippi State Department of Health Regulations Governing the Production and Sale of Milk and Milk Products.

4. Tuberculosis Management in Correctional Institution: The following regulations govern all Mississippi state correctional facilities, city and county facilities housing state prisoners, and privately operated correctional facilities in the state.

a. "Correctional Institutions" and/or "correctional facility" shall be construed to mean any of the state-operated penitentiaries, privately operated correctional facilities, community work centers, community pre-release centers, restitution centers, county or regional correctional facilities, and/or administrative offices as is applicable to each respective policy.

b. All inmates shall be medically screened for communicable diseases (including Mycobacterium tuberculosis [TB], syphilis, and Human Immunodeficiency Virus [HIV]) to prevent the spread of these diseases within the correctional institutions and to the public. Employees (i.e. full and part-time employees, contract staff and volunteers) shall be screened for tuberculosis infection and disease.

c. The correctional institution shall establish schedules, protocols, and responsibilities for the testing of inmates and employees to ensure compliance with all relevant Mississippi State Department of Health (MSDH) guidelines. The correctional institution shall appoint a liaison to ensure that all necessary screening is provided to each inmate and employee under its jurisdiction regardless of the individual's physical location.

d. The director of the correctional institution, in consultation with the correctional institution's medical director, shall issue procedures to ensure that inmates, prior to being transferred into the correctional institution from another correctional institution, a non-state facility, or out-of-state jurisdiction have been properly tested/screened for communicable disease within the previous thirty (30) days. If such testing and screening has not been accomplished, the director shall ensure that these procedures are completed prior to the transfer or upon the receipt of the inmate.

e. Screening shall include a Rapid Plasma Reagin (RPR) for syphilis, HIV serology, and TB testing, including, TB signs and symptoms assessment, exposure history, two-step Mantoux tuberculin skin test or blood assay for mycobacterium tuberculosis (BAMT) and chest x-ray if indicated. All HIV-Positive inmates and employees shall have an x-ray as part of the medical screening. No inmate shall be placed in the general population until the medical assessment is completed. Any symptomatic inmate shall remain in respiratory isolation until TB test results are known and active tuberculosis disease has been ruled out. Documentation of these screening tests shall be maintained for all inmates in a correctional institution. Test results shall be reported to the MSDH.

f. Screening, latent therapy, active treatment and treatment follow-up of inmates and employees for tuberculosis shall follow the policies

and procedures included in the latest revision of the Tuberculosis Manual of the MSDH. All latent and active TB treatment of the inmates shall be directly observed by a health care provider.

g. The correctional institution's medical director, in order to contain communicable disease and/or enforce screening schedules, with the approval of the correctional institutional superintendent and/or classification director shall have the authority to:

i. Place inmates in quarantine

ii. Suspend employees

iii. Move inmates between approved housing locations or to approved medical facilities

iv. Issue procedures for the care and treatment of inmates and employees with communicable diseases

h. Each correctional institution or correctional facility shall provide a complete, legible and accurate Tuberculin Testing Summary (MSDH Form 181) summarizing the correctional facility's tuberculin testing activity and containing a roster of all inmates and employees that were first identified as having a significant Mantoux tuberculin skin test reaction* or positive BAMT within the reporting period. This roster shall include comments and conclusions concerning the individual follow-up of each person listed. The Tuberculin Testing Summary, with appropriate notations, shall be logged in the Office of the State Tuberculosis Program on or before March 15th of each year for the twelve (12) months proceeding January 31st of that year.

5. Summary of TB screening and procedures:

a. All inmates shall have a two-step Mantoux tuberculin skin test or BAMT. Each Mantoux tuberculin skin test shall be administered using five tuberculin units (5 t.u.) of purified protein derivative (PPD) unless individually excluded by a licensed physician or nurse practitioner due to medical contraindications or exceptions noted herein. BAMT testing shall be collected and results interpreted by personnel trained and certified in the procedure BAMT results shall be given as EIA positive, Negative or Indeterminate. All Mantoux tuberculin skin test shall be administered and read by personnel trained and certified in the procedure and the results recorded in millimeters of induration. Exception to the tuberculin skin test requirements may be made if:

i. The individual is currently receiving or can provide documentation of having successfully completed a course of therapy for latent tuberculosis approved by the State Tuberculosis Program.

ii. The individual is currently receiving or can provide documentation of having successfully completed a course of multi-drug chemotherapy approved by the State Tuberculosis Program for active tuberculosis disease, or

iii. The individual has a documented previous significant tuberculin skin test reaction* or positive BAMT.

b. The tuberculin skin test status of all employees shall be documented in the individual's personnel record. The BAMT or the first step of a two-step Mantoux tuberculin skin test shall be performed (i.e. administered and read) on all new employees (and rehires) within thirty (30) days prior to the first day of employment. The Mantoux tuberculin skin test or BAMT shall be administered and read by personnel trained and certified in the procedure. The results of the tuberculin skin test shall be recorded in millimeters of induration. The results of the BAMT shall be recorded as EIA positive, negative or indeterminate. An employee shall not have contact with inmates or be allowed to work in areas of the correctional institution to which inmates have routine access prior to the reading of the first-step of a two-step Mantoux tuberculin skin test or having a BAMT and completing an exposure history and symptom assessment. The results of both steps of the two-step Mantoux tuberculin skin test or BAMT shall be documented in the individual's personnel record within fourteen (14) days of employment. Exception to the tuberculin skin test requirement may be if:

i. The individual is currently receiving or can provide documentation of having successfully completed a course of therapy for latent tuberculosis infection approved by the State Tuberculosis Program, or

ii. The individual is currently receiving or can provide documentation of having successfully completing a course of multi-drug chemotherapy approved by the State Tuberculosis Program for active tuberculosis disease, or

iii. The individual has a documented previous significant tuberculin skin test reaction* or positive BAMT

c. All inmates and employees with a previous significant Mantoux tuberculin skin test* or positive BAMT and/or symptoms suggesting TB (e.g. cough, sputum production, chest pain, anorexia, weight loss, fever, night sweats, especially if symptoms last three weeks or longer, regardless of the size of the skin test), shall receive a chest x-ray and be evaluated by a physician or nurse practitioner within 72 hours. Individuals found to have a significant Mantoux tuberculin skin test or positive BAMT, signs and symptoms of tuberculosis or a chest x-ray suggestive of active tuberculosis shall be placed in respiratory isolation according to MSDH policies, reported to MSDH and evaluated by physician or nurse practitioner for tuberculosis therapy.

d. Individuals found to have a significant Mantoux tuberculin skin test or positive BAMT or with a history of a previous significant Mantoux tuberculin skin test or positive BAMT and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner for latent tuberculosis therapy. Individuals with significant Mantoux tuberculin skin tests or positive BAMT and no evidence of active TB disease should be reminded periodically about the symptoms of tuberculosis and the need for prompt evaluation of any pulmonary symptoms of tuberculosis. A tuberculosis symptom assessment shall be documented as part of the annual health screening. No additional follow-up for these individuals is indicated unless symptoms suggestive of active tuberculosis develop; specifically, routine annual chest x-rays are not indicated.

e. Employees found to have a positive/significant reaction* to the skin test or a positive BAMT and no signs or symptoms of tuberculosis disease and a negative chest x-ray shall, as a condition of employment, have thirty (30) days to report to the MSDH office in their county of residence to confirm appropriate follow-up testing has been completed and receive treatment, if indicated. The employees shall provide the director or designee with a written statement from the MSDH verifying compliance with the directives set forth by the correctional institution's medical director and this regulation.

*Criteria for a significant tuberculin skin test
Reaction >5 mm (greater than or equal to 5mm)
High risk contact to an active tuberculosis case
HIV-positive persons
Fibrotic changes on chest radiograph consistent with prior TB Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of >15 mg. of prednisone for 1 mo or more-risk of TB in patients treated with corticosteroids increases with higher doses and longer duration)
Reaction >10 mm (greater than or equal to 10 mm) any other prisoner or employee of the prison

f. All inmates and employees who do not have a significant Mantoux tuberculin skin test or positive BAMT shall be retested annually within thirty (30) days of the anniversary of their last Mantoux tuberculin skin test. Inmates and employees exposed to an active infectious case of TB between annual tuberculin skin test shall be treated as contacts and be managed appropriately. All contacts to an active tuberculosis case shall have HIV testing as part of the exposure management.

Rule 1. 17.18 Typhoid Fever

1. Class 1B report required.

a. In case of typhoid fever, enteric precautions shall be maintained for not less than 4 weeks from date of onset, and urine and feces cultures for release from temporary carrier status shall not be taken earlier. A person diagnosed with typhoid fever or with growth of Salmonella typhi from feces, urine, blood, or other bodily source shall be considered a temporary typhoid carrier. Release from temporary carrier status and health department supervision shall be on the basis of not less than 3 consecutive negative cultures obtained from authenticated specimens of feces taken not less than 24 hours apart at least 48 hours after any antibiotic , and not earlier than one month after onset. If any one of this series is positive, the temporary carrier status shall be continued.

b. During the first 6 months of the temporary carrier status, the patient may again be tested for release by securing not less than 3 consecutive negative cultures obtained from authenticated specimens at intervals of 1 month. If the patient is positive at the 6th month or if no test is made, the case is classed as a permanent carrier. Final release from permanent carrier status must be with the advice and consent of the State Epidemiologist, and cannot be considered unless 3 consecutive monthly cultures obtained from authenticated specimens collected at least 48 hours after any antibiotic, have been negative on examination by the Department of Health Laboratory or other laboratories approved by the Department of Health.

c. Whenever the typhoid carrier status shall be declared by the local health officer and there is no patient history of typhoid during the preceding year, the patient shall be classed as a permanent carrier.

d. No person classed as a carrier shall engage in handling of foods or foodstuffs for public consumption, nor shall such carrier offer to perform such services for any family (other than his or her own) or for any other group or institution, either private or public. No such carrier shall engage in providing domestic services for hire or provide direct client care in a nursing home or child day care center without the advice and written consent of the health officer.

e. When any person is declared to be a carrier of typhoid, the local health officer shall collect pertinent information about the carrier. The necessity for imposing restrictions on the patient's activities shall be explained to the patient and the patient shall signify in writing his or her willingness to observe the carrier agreement and restrictions. A copy of the carrier information shall be forwarded

immediately to the Epidemiology Program, Mississippi State Department of Health, in Jackson.

f. When any known carrier of typhoid moves from the county, a copy of the carrier's history and agreements, together with the prospective future address of the carrier, shall be forwarded to the Mississippi State Department of Health by the local health officer of the county from which the carrier is moving. The original copy of the history and agreement shall remain as a part of the files of the county health department of the county from which the carrier has moved.

g. All family or other close contacts of a case of typhoid or other salmonella infection shall submit specimens of their feces as required by the health officer and submit to any reasonable examination as may aid in the search for unknown carriers and sub clinical cases.

h. All family or other close contacts of a carrier of typhoid or other salmonella infection shall be prohibited from handling foods or foodstuffs for public consumption until contact is broken and repeated negative laboratory examinations are reported. For salmonelloses, except typhoid, a series of 2 negative feces cultures taken not less than 24 hours apart at any time after contact is broken will satisfy this provision. For typhoid fever a series of 2 negative stools taken not less than 24 hours apart and not less than 14 days after contact is broken will satisfy this provision.

i. The owner or operator of a house, hotel, apartment or other institution in which a typhoid carrier resides shall provide a sanitary method of excreta disposal which will not subject other occupants of the house, apartment, hotel or other institution or the general public to typhoid or paratyphoid infection. If the owner or operator of the property on which a carrier resides fails for due cause to provide such sanitary methods of excreta disposal, the carrier shall provide such facilities as meet approval of the Mississippi State Department of Health.

j. Any typhoid carrier planning to change his/her place of residence or his/her occupation shall notify the local health officer in writing of such anticipated change.

k. Whenever a case or carrier of typhoid is diagnosed it shall be the duty and responsibility of the local health officer to conduct a search for the source of the infection and for the food, water or person from whom it was acquired. Strict measures for assuring the

safety of the water and milk supplies and of all foodstuffs should be instituted.

l. Mandatory report and surveillance required.

Source: Miss.Code Ann. §41-3-17

Subchapter 18 PENALTY FOR VIOLATION OF RULES AND REGULATIONS REGARDING REPORTABLE DISEASES

Rule 1.18.1 Any physician, dentist or other person who shall fail, neglect, or refuse to comply with, or shall falsify any report, or shall violate any of the Rules and Regulations of the Mississippi State Board of Health shall, upon conviction, be guilty of a misdemeanor and subject to the penalty provided by law.

Source: Miss.Code Ann. §41-3-17

Subchapter 19 MISSISSIPPI HEALTHCARE DATA REGISTRY SYSTEM

Rule 1.19.1 Reporting Requirements and Procedures

a. Authority-Mississippi Code Annotated § 41-63-4 requires certain licensed health care facilities operating in the state of Mississippi to report information on patient health care to the Mississippi State Department of Health. Further, Mississippi Code Annotated § 41-7-185 requires providers of institutional health services and home health services to make available statistical information or such other requested information by the Mississippi State Department of Health.

b. Purpose -The Mississippi State Department of Health (MSDH), acting as the state's public health authority, is required to design and establish a registry program concerning the condition and treatment of persons seeking medical care in the state of Mississippi. MSDH must collect, analyze and disseminate these health care data in order to improve the quality and efficiency of medical care.

c. Reporting Responsibility-Each of the following licensed health care facilities in the state of Mississippi shall be required to report the specified health care data described in these rules and regulations:

i. Hospital Facilities – See Rule 1.19.3;

ii. Ambulatory Surgical Facilities – See Rule 1.19.4 [Reserved];

iii. Outpatient Diagnostic Imaging Centers – See Rule 1.19.5 [Reserved];

iv. Other – See Rule 1.19.6 [Reserved];

d. Reporting Contact-In order to facilitate communication and problem solving, each reporting facility must designate a person as contact and advise the Department from time to time of any changes to such contact information. Contact information shall include the office name, telephone number, job title and name of the person assigned this responsibility to the MSDH.

e. Penalties for Not Reporting-

i. The MSDH is authorized to assess penalties as provided by statute pursuant to Mississippi Code Annotated § 41-63-4 Paragraph (12) which states, "A person or organization who fails to supply data required under this section is liable for a civil penalty of Five Cents (5¢) for each record for each day the submission is delinquent. A submission is delinquent if the department does not receive it within thirty (30) days after the date the submission was due. If the department receives the submission in incomplete form, the department shall notify the provider and allow fifteen (15) additional days to correct the error. The notice shall provide the provider an additional fifteen (15) days to submit the data before the imposition of any civil penalty. The maximum civil penalty for a delinquent submission is Ten Dollars ($10.00) for each record. The department shall issue an assessment of the civil penalty to the provider. The provider has a right to an informal conference with the department, if the provider requests the conference within thirty (30) days of receipt of the assessment. After the informal conference or, if no conference is requested, after the time for requesting the informal conference has expired, the department may proceed to collect the penalty. In its request for an informal conference, the provider may request the department to waive the penalty. The department may waive the penalty in cases of an act of God or other acts beyond the control of the provider. Waiver of the penalty is in the sole discretion of the department;" and

ii. Failure of any health care facility or other person or entity covered by the "Mississippi Health Care Certification of Need Law of 1979", Mississippi Code Annotated § 41-7-171 through § 41-7-209, to report any requested information, data or otherwise failure to report under these provisions, shall be in violation of the "Mississippi Health Care Certification of Need Law of 1979" and subject to violations provided in Mississippi Code Annotated § 41-7-209.

f. Confidentiality-Information maintained in the Mississippi Healthcare Registry Data System shall be confidential and shall not be distributed or released except with the permission of MSDH in accordance with its established policies and procedures. Violation of confidentiality requirements may be subject to severe civil and/or criminal penalties.

i. The release of identifiable patient health information may be made by MSDH only to the facility that initially reported the identifiable information, upon the written request of such facility. Any request by any other party for the release of identifiable information shall be reviewed by the MSDH Data Use Council (described below), and the Data Use Council may approve such request only for the purpose of public health assessment or research under such guidelines and stipulations as may be necessary to maintain confidentiality requirements.

ii. Prior to the dissemination or release of any data analysis or statistical reports concerning registry information, including any release to MSDH divisions or programs, the Data Use Council may review the methods and procedures deemed necessary to maintain the privacy and confidentiality of patient records, including the system security requirements.

iii. The MSDH shall be required to regularly monitor the physical security of the registry, to train personnel concerning the system's confidentiality standards, to limit access to the registry information solely to authorized personnel, and to implement password and encryption protections in the system.

g. Protected Health Information-The disclosure of protected health information by a reporting facility pursuant to these rules and regulations shall be recognized as a disclosure to a public health authority as required by law, pursuant to the Health Insurance Portability and Accountability Act and the Privacy Rules promulgated there under at 45 CFR Sections 164.512(a) and (b).

h. Data Use Council-The State Health Officer will create a Data Use Council consisting of not less than five individuals to recommend policies and procedures regarding the release of any registry data to MSDH divisions and programs, to the public, to researchers and to industry. Appointments to the Council shall be made at the sole discretion of the State Health Officer for such terms as may be established by the policies and procedures of the MSDH.MSDH divisions and programs may, with the consent of the Data Use Council, use patient abstract data to assist in fulfilling its public health mission. These data will not be re-released in

any form by the program without the prior authorization of the Data Use Council. Authorization for subsequent release shall be considered only if the proposed release does not identify a patient.

i. Temporary Waiver of Reporting Requirement-With respect to any licensed health care facility otherwise required to report data or other information to the MSDH pursuant to these rules and regulations, the MSDH shall be authorized to temporarily waive reporting requirements due to system requirements of MSDH or the reporting facility, or in the case of irregularities or errors involving data delivery. Any waiver of the reporting requirements must be made in writing by the MSDH and notice of the termination of any waiver shall be provided to the applicable reporting facility, at which time these Regulations shall become applicable to such facility.

j. Charges and Fees for Access to Data-Subject to the confidentiality requirements of these Regulations, the MSDH may develop reports and data analyses based upon registry data which may be released to the public. The reports may be published or disseminated for a reasonable charge, or without charge at the discretion of MSDH as outlined in Paragraph 11.At the time of the promulgation of these Regulations, the MSDH shall refrain from assessing any charges to reporting facilities for the collection of health care data. Nothing shall prohibit the State Board of Health from authorizing, at any future date in accordance with its statutory authority, the assessment of reasonable charges for the collection of such data, or the reporting of specified health care data to the MSDH for purposes of the registry.

k. Persons receiving encounter-level data must complete an application and submit the signed data use agreement to the MSDH-DUC with their order. Encounter level datasets available include: Inpatient, Outpatient, and Emergency Department. The following table provides the cost to purchase one or many datasets by calendar year. (Example: Dataset = Inpatient for Year = 2010 and Discharges = <50,000. The total cost = $1,200).

Discharges*	ONE DATASET	TWO DATASETS	THREE or MORE DATASETS
>1,000,000	$8,000	$14,000	$18,000
<1,000,000	$6,400	$10,560	$14,720

<500,000	$4,400	$7,260	$10,120
<250,000	$2,400	$3,960	$5,520
<100,000	$1,600	$2,640	$3,680
<50,000	$1,200	$1,980	$2,760

i. *Discharges = the number of discharges in the dataset. The dataset pricing above reflects pricing for a basic dataset based on either 1) all records, 2) discharges for a geographic area, or 3) discharges for a group of hospitals.

ii. The cost of additional datasets for individual calendar years (as shown above) includes 20% off the cost of the original dataset.

iii. Ad Hoc Data Request - Customized data requests are priced at $100 per hour and based on the average time required to analyze the request and write the query; and the time required to access, merge, validate and prepare the information for delivery.

iv. Annual Subscription - An annual subscription by dataset or original customized report is also available. The initial dataset(s)/Ad Hoc Report charge will apply and a $100 programming fee per month for each month data are requested. A minimum three month commitment for this reporting process is required.

v. Hospitals requesting data – The MSDH will not charge hospitals for data requests when the data they are requesting originated from their facility. We will follow the Ad Hoc Reports or dataset file request fee schedule for all other requests.

vi. Waiver Grants awarded to students – The MSDH will award grants to students actively involved in a school setting (High School, Undergraduate or Graduate). The grants will be in the form of a waiver for agreeing to allow the MSDH to publish their findings and methodology if the MSDH DUC deems the information appropriate. Should the student request more than three datasets, the Ad Hoc Data Request will apply.

Source: Miss.Code Ann. §41-3-17

Rule 1.19.2 Administrative Rules and Procedures

1. Assertion of Administrative Appeal Rights. In the case of the Department's enforcement of any of the measures described in these Regulations, if the matter is disputed by the affected party or parties and

the Department and the party have been unable to resolve the dispute, the affected party or parties shall petition the Department to appear at an administrative hearing before a hearing officer appointed by the State Health Officer.

2. Content and Form of Petition. The petition must be in writing and be submitted to the Department within 15 business days of the date upon which the petitioner received notice of the imposition of the enforcement measures. The petitioner must state in the petition the reasons for the appeal, and the petition must describe any facts which may be in dispute and must identify any grievances which are deemed by the petitioner to be genuine and substantial.

3. Opportunity to Remedy Grievances. If the Department is unable to resolve the disputed facts and remedy the petitioner's grievances within 5 business days of the Department's receipt of the petition, the unresolved matters shall be reviewable by the hearing officer at an administrative hearing conducted in accordance with these Regulations. No unresolved matters shall be reviewable in the event that the Department shall terminate its enforcement action prior to the commencement of the hearing.

a. General Principles for Administrative Reviews With respect to matters brought before the Department or the State Board of Health for administrative review, whether or not such review is initiated by the Department, a notice of the proceeding shall be prepared by the Department and the petitioner or the affected party or parties shall be afforded an opportunity to appear at such proceeding in accordance with the Regulations set forth in this Part Three. Any party who shall participate in the administrative proceeding shall be entitled to:

i. Timely scheduling of the hearing if appealed by the petitioner in accordance with Section 201, but in any event no more than 15 business days after the date of the Department's receipt of the petition;

ii. Representation by legal counsel, chosen in the discretion of such party and at such party's sole cost and expense;

iii. Submission of testimony and documentary evidence, and presentation of argument and rebuttal with respect to the issues;

iv. Conduct examination and cross-examination of witnesses to elicit a full and fair disclosure of the facts; and

v. Demand a timely completion of the proceedings.

b. Notice of Hearing. Notice of Hearing shall be served upon a petitioner or any other affected party in the same manner as authorized for the service of a Health Officer's Order or in such other manner as may be deemed reasonable and prudent by the hearing officer in order to properly notify the petitioner that a hearing has been scheduled.

c. Date of Hearing. Unless otherwise provided by law, the notice of hearing must be given at least ten (10) days prior to the hearing date unless this notice period is waived by the affected parties in the interest of expediting the administrative review. Unless otherwise provided by law, proof of receipt of notice shall not be a required condition for the conduct of the hearing.

d. Assignment of Hearing Officer. Within ten (10) days of the date on which the Department shall give Notice of Hearing, the State Health Officer or his authorized designee shall appoint the hearing officer assigned to hear the matter, and notice of such appointment shall be provided to all parties.

e. Conduct of Hearings. The hearing officer shall preside at the hearing, and shall rule on all questions of applicable procedure and submission of evidence in accordance with the policies and procedures approved by the hearing officer. The hearing officer may issue an order using particular provisions of the Mississippi Rules of Civil Procedure and related local rules for guidance; however, formal adherence to said Rules shall not be mandated. The hearing officer may waive the application of any of these rules to further administrative convenience, expedition, and economy if the waiver does not conflict with law, and the waiver does not cause undue prejudice to any party.

f. Rules of Evidence. The Mississippi Rules of Evidence shall be used as a general guide for the presentation of evidence. However, any evidence which reasonably appears to be relevant and probative to the issues may be allowed in the discretion of the hearing officer, notwithstanding its inadmissibility under said Rules, unless the evidence offered is clearly of a privileged nature.

g. Authority of Hearing Officer. The hearing officer shall have authority to do all things conformable to law that may be necessary to enable the officer effectively to discharge the duties of office, including, but not limited to, the authority to make final findings of fact and a written recommendation to the

Department as to which enforcement actions or other restrictions, if any, should apply to the party or parties.

h. Discovery. Discovery shall be limited to non-privileged documents. Depositions and requests for admissions may be directed, issued, and taken on order of the Department for good cause shown. These orders or authorizations may be challenged or enforced in the same manner as subpoenas. All requests for discovery must be timely and in writing. All disputes regarding the privileged nature of a document shall be resolved by the designated hearing officer prior to the commencement of the hearing.

i. Public Access. Unless otherwise provided by law, all hearings are open to the public.

j. Failure of Party to Appear for Hearing. If a party fails to appear at a hearing, the hearing officer may proceed with the presentation of the evidence of the appearing party, or vacate the hearing and return the matter to the Department for any further action.

k. Proof.

a. Standard of proof. Unless otherwise provided by law, the standard of proof is a preponderance of the evidence.

b. Burden of Proof. Unless otherwise provided by law:

i. The party asserting a claim, right, or entitlement has the burden of proof;

ii. A party asserting an affirmative defense has the burden of establishing the affirmative defense; and

iii. The proponent of a motion shall establish the grounds to support the motion.

l. Ex Parte Communications. A party shall not communicate, either directly or indirectly, with the hearing officer about any substantive issue in a pending matter unless:

m. All parties are present;

n. It is during a scheduled proceeding, where an absent party fails to appear after proper notice; or

o. It is by written motion with copies to all parties.

4. Conflict Issues. All allegations of conflict or bias on the part of the appointed hearing officer must be filed at least three (3) business days prior to the hearing date. The State Health Officer who appointed the hearing officer shall then consider the assertion of conflict or bias, and shall issue a written opinion prior to the commencement of the hearing.

5. Hearing Record. A stenographic record of the hearing shall be made by a reporter chosen by the hearing officer. No transcript or other record of the proceeding shall be required to be maintained by the Department unless (i) required by statute or other rule, (ii) ordered by the hearing officer, or (iii) agreed in writing by all of the parties.

6. Remedies for Non-compliance with Rules. If a respondent shall fail to fully comply with the requirements of the hearing officer's policies and procedures or other rulings, the hearing officer shall be authorized to impose fines in an amount not to exceed $500 per occurrence and such other remedies as may be deemed appropriate by the hearing officer for the effective administration of those duties and responsibilities assigned to such officer.

7. Appeals. Any person adversely affected by a decision of the Department shall have a right to appeal the decision through an appropriate and timely court action against the Department and/or its agents, consistent with applicable laws and jurisdictional requirements. Unless applicable law provides a longer period of time in which to assert any appeal, no appeal of a decision of the Department shall be taken unless it is filed with a court having jurisdiction within thirty (30) days of the date of the Department's decision.

Source: Miss.Code Ann. §41-3-17

Rule 1.19.3 Hospital Reporting

1. Hospital Discharge Data

a. Purpose -A statewide Hospital Discharge Data System (HDDS) is one of the most important tools for addressing a broad range of health policy issues, including the improvement of the quality and efficiency of medical care. "Discharge data" is defined as the consolidation of complete billing, medical, and personal information describing a patient or resident, the services received, and charges billed for a single hospital stay. The requirements for

the collection and submission of data as described shall also apply to those non-federal acute care hospitals located in Alabama, Arkansas, Louisiana, and Tennessee. Data submitted by these non-Mississippi hospitals shall relate exclusively to those patients who are Mississippi residents.

b. Reporting Required-Each reporting facility will report discharge data to the MSDH on every inpatient and outpatient discharged, to include those seen in the Emergency Department. Hospitals may submit data to MSDH directly or through the Mississippi Hospital Association (MHA) for submission to the HDDS, as specified by law. The submission of similar collected data to the Mississippi Hospital Association (MHA) shall not relieve the reporting facility of its reporting requirements to the MSDH unless written approval for such reporting methodology is provided by the MSDH.

c. Data Elements -The Mississippi HDDS is based on the Health Care Finance Administration (HCFA) UB-04 or the most recent version and additional selected information routinely collected by health care facilities on each patient. Data elements are listed in the HDDS policy manual.

d. Quality Assurance-MSDH Data Use Council will develop guidelines for quality assurance and accuracy that each reporting hospital will be required to follow.

e. Time of Reporting and Methodology- Reporting facilities shall submit data for each calendar month based upon discharges occurring during such month. Collected data shall be submitted to the MSDH on or before the 15th day of the following month.

Questions concerning any reporting methodology or guidelines shall be reasonably addressed by the MSDH, and administrative remedies shall be available to any facility concerning any disputes.

2. Hospital Reporting of Healthcare Associated Infections and Healthcare Data via the National Healthcare Safety Network (NHSN)

a. Purpose – CMS currently requires that all acute care hospitals, long term acute care hospitals, inpatient rehabilitation facilities and outpatient dialysis centers participating in the Prospective Payment System (PPS) report specific measures related to HAI's and infection prevention to CDC via NHSN. CMS currently publishes selected measures on the Hospital Compare website for the

previous reporting year. As a mechanism of responding to specific HAI's exceeding acceptable thresholds, MSDH Department of Epidemiology will use these data to respond to specific outbreaks or aberrant events in collaboration with facilities involved. Facility-specific data obtained from NHSN by MSDH will be used for epidemiological purposes related to prevention and surveillance and will not be disclosed to third parties by MSDH. MSDH will also assist facilities to improve reporting where deficiencies are identified.

b. Reporting Required – Any facility, including acute care hospitals, long term acute care hospitals, inpatient rehabilitation facilities and outpatient dialysis centers, required to report to NHSN by CMS shall confer NHSN viewing rights to MSDH. MSDH will not require reporting of additional measures, beyond those required by CMS.

c. Time of Reporting – Timeliness of reporting shall be as directed by existing CMS / NHSN reporting requirements.

Source: Miss.Code Ann. §41-3-17

Appendices to the Rules and Regulations

Governing Reportable Diseases and Conditions

Appendix A

List of Reportable Diseases and Conditions

Appendix A. List of officially reportable diseases and conditions

The following diseases or conditions are hereby declared to be reportable.

Class 1A: Diseases of major public health importance which shall be reported directly to the Department of Health by telephone within 24 hours of first knowledge or suspicion. Class 1A diseases and conditions are dictated by requiring an immediate public health response. Laboratory directors have an obligation to report laboratory findings for selected diseases (Refer to Appendix B).

Any Suspected Outbreak (including foodborne and waterborne outbreaks)
(Possible biological weapon agents appear in ***bold italics***)

Anthrax
Botulism *(includes foodborne, infant or wound)*
Brucellosis
Diphtheria
Escherichia coli O157:H7 and any shiga toxin-producing *E. coli* (STEC)
Glanders
Haemophilus influenzae Invasive Disease*
Hemolytic Uremic Syndrome-post-diarrheal (HUS)
Hepatitis A
Influenza-Associated Pediatric Mortality (<18 years of age)
Measles
Neisseria meningitidis Invasive Disease*
Pertussis
Plague
Poliomyelitis
Psittacosis
Q Fever
Rabies (human or animal)
Ricin intoxication (castor beans)
Smallpox
Tuberculosis
Tularemia
Typhoid Fever
Typhus Fever
Viral hemorrhagic fevers *(filoviruses [e.g. Ebola, Marburg] and arena viruses [e.g., Lassa, Machupo])*

Any unusual disease or manifestation of illness, including but not limited to the appearance of a novel or previously controlled or eradicated infectious agent, or biological or chemical toxin.

*usually presents as meningitis or septicemia, or less commonly as cellulitis, epiglottitis, osteomyelitis, pericarditis or septic arthritis.

Class 1B: Diseases of major public health importance which shall be reported directly to the Department of Health by telephone on the next business day after first knowledge or suspicion. Class 1B diseases and conditions require individual case investigation, but not an immediate public health response. Laboratory directors have an obligation to report laboratory findings for selected diseases (Refer to Appendix B in the Rules and Regulations Governing Reportable Diseases and Conditions).

Arboviral infection including but not limited to
- California group,
- Chikungunya virus,
- Dengue,
- Eastern Equine Encephalitis virus,
- LaCrosse virus,
- Western Equine Encephalitis virus,
- St. Louis encephalitis virus,
- West Nile virus

Chancroid
Cholera
Encephalitis (human)
HIV infection-including AIDS
Legionellosis

Non-cholera *Vibrio* disease
Staphylococcus aureus,
vancomycin resistant (VRSA) or vancomycin intermediate (VISA)
Syphilis (including congenital)
Typhoid Fever
Varicella infection, Primary,
in patients >15 years of age
Yellow Fever

Class 2: Diseases or conditions of public health importance of which individual cases shall be reported by mail, telephone or electronically, within 1 week of diagnosis. In outbreaks or other unusual circumstances they shall be reported the same as Class 1A. Class 2 diseases and conditions are those for which an immediate public health response is not needed for individual cases.

Chlamydia trachomatis,
genital infection
Creutzfeldt-Jakob Disease,
including new variant
Ehrlichiosis
Enterococcus, invasive infection***,
vancomycin resistant
Gonorrhea
Hepatitis (acute, viral only)
Note-Hepatitis A requires Class 1A Report
Hepatitis B infection in pregnancy
HIV Infection in pregnancy
Listeriosis
Lyme disease
Malaria
Meningitis **other** than
Meningococcal or *Haemophilus influenzae*
Mumps
M. *tuberculosis* Infection (positive TST or positive IGRA****)
Poisonings*(including elevated blood lead levels**)
Rocky Mountain spotted fever
Rubella (including congenital)
Spinal Cord Injuries
Streptococcus pneumoniae, invasive infection***
Tetanus
Trichinosis
Viral Encephalitis in horses and ratities

*Reports for poisonings shall be made to Mississippi Poison Control Center, UMMC 1-800-222-1222

**Elevated Blood Levels should be reported to the MSDH Lead Program at 601-576-7447.
Blood lead levels (venous) ≥5µg/dL in patients ≤6 years of age

***Specimen obtained from a normally sterile site.

****TST-tuberculin skin test; IGRA-Interferon-Gamma Release Assay (to include size of TST in millimeters and numerical results of IGRA testing).

Except for rabies, and equine encephalitis, diseases occurring in animals are not required to be reported to the MSD

Class 3: Laboratory based surveillance. To be reported by laboratory only. Diseases or conditions of public health importance of which individual laboratory findings

shall be reported by mail, telephone, or electronically within one week of completion of laboratory test (refer to Appendix B).

All blood lead test results in patients ≤6 years of age
CD4 count and HIV Viral Load*
Campylobacteriosis
Carbapenem-resistant *Enterobacteriaceae*, (CRE)
Chagas Disease (*American trypanosomiasis*)
Hansen Disease (Leprosy)
Hepatitis C infection
Nontuberculous Mycobacterial Disease
Salmonellosis
Shigellosis

* HIV associated CD4 (T4) lymphocyte results of any value and HIV viral load results, both detectable and undetectable

Class 4: Diseases of public health importance for which immediate reporting is not necessary for surveillance or control efforts. Diseases and conditions in this category shall be reported to the Mississippi Cancer Registry within six months of the date of first contact for the reportable condition.

The National Program of Cancer Registries at the Centers for Disease Control and Prevention requires the collection of certain diseases and conditions. A comprehensive reportable list including ICD9CM/ICD10CM codes is available on the Mississippi Cancer Registry website,

https://www.umc.edu/Administration/Outreach_Services/Mississippi_Cancer_Registry/Reportable_Diseases.aspx.

Each record shall provide a minimum set of data items which meets the uniform standards required by the National Program of Cancer Registries and documented in the North American Association of Central Cancer Registries (NAACCR)

Appendix B
Laboratory Results That Must be Reported to the Mississippi State Department of Health

Laboratory Results That Must be Reported to the Mississippi State Department of Health

Laboratories shall report these findings to the Mississippi State Department of Health at least WEEKLY. Diseases in bold type shall be reported immediately by telephone. Isolates of organisms marked with a dagger (†) shall be sent to the Mississippi State Department of Health Public Health Laboratory. All referring laboratories should call the Public Health Laboratory prior to shipping any isolate (601-576-7582).

Positive Bacterial Cultures or Direct Examinations

Result	**Reportable Disease**
Any bacterial agent in CSF	Bacterial meningitis
Bacillus anthracis†	**Anthrax**
Bordetella pertussis	**Pertussis**
Borrelia burgdorferi†	Lyme disease
Brucella species†	**Brucellosis**
Burkholderia mallei†	**Glanders**
Burkholderia pseudomallei†	**Melioidosis**
Campylobacter species	Campylobacteriosis
Carbapenem-resistant Enterobacteriaceae	Carbapenem-resistant *Enterobacteriaceae* (CRE)
Chlamydia psittaci	Psittacosis
Chlamydia trachomatis	Chlamydia trachomatis genital infection
*Clostridium botulinum†***	**Botulism**
Clostridium tetani	Tetanus
Corynebacterium diphtheriae†	**Diphtheria**
Coxiella burnetii†	**Q fever**
Enterococcus species, vancomycin resistant*	*Enterococcus* infection, invasive vancomycin resistant
Escherichia coli O157:H7 and any shiga toxin-producing *E. coli (*STEC*)†*	**Escherichia coli O157:H7 and any shiga toxin-producing E. coli (STEC)**
Francisella tularensis†	**Tularemia**
Grimontia hollisae†	Noncholera *Vibrio* disease
Haemophilus ducreyi	**Chancroid**
Haemophilus influenza †(*not from throat, sputum*)*	**H. *influenzae* infection, invasive**
Legionella species	Legionellosis
Listeria monosytogenes†	Listeriosis
Mycobacterium species	Nontuberculous mycobacterial disease
Mycobacterium tuberculosis†	**Tuberculosis**
Neisseria gonorrhea	Gonorrhea
*Neisseria meningitidis †**	**Meningococcal infection, invasive**
Photobacterium damselae†	Noncholera *Vibrio* disease
Rickettsia prowazekii	**Typhus fever**
Rickettsia rickettsii	Rocky Mountain spotted fever
Salmonella species, not S. typhi†	Salmonellosis
Salmonella typhi †	**Typhoid fever**
Shigella species†	Shigellosis
Staphylococcus aureus- vancomycin resistant or vancomycin intermediate resistant	***Staphylococcus aureus* vancomycin resistant (VRSA) or vancomycin intermediate (VISA)**
*Streptococcus pneumoniae**	*Streptococcus pneumoniae*, invasive infection
Vibrio cholerae 01†	**Cholera**
Vibrio species†	Noncholera *Vibrio* disease
Yersinia pestis†	**Plague**

* Specimen obtained from a normally sterile site (usually blood or cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid). Do not report throat or sputum isolates.

† Isolates of organism should be sent to the Mississippi State Department of Health Public Health Laboratory. All referring laboratories should call the Public Health Laboratory at (601)-576-7582 prior to shipping any isolate.

**Contact the Mississippi State Department of Health, Epidemiology Program at 601-576-7725 or the Public Health Laboratory (601)576-7582 for appropriate tests when considering a diagnosis of botulism.

Laboratory Results That Must be Reported to the Mississippi State Department of Health

Laboratories shall report these findings to the Mississippi State Department of Health at least **WEEKLY**. Diseases in bold type shall be reported immediately by telephone. Confirmatory tests for some of these may be obtained by special arrangement through the Epidemiology Program at 601-576-7725.

Positive Serologic Tests

Arboviral agents including but not limited to:

- **California encephalitis**
- **Chikungunya virus**
- **Dengue**
- **Eastern equine encephalitis**
- **LaCrosse encephalitis**
- **St. Louis encephalitis**
- **Western equine encephalitis**
- **West Nile encephalitis**

Brucellosis
Chagas Disease (*American trypanosomiasis*)
Cholera
Chlamydia trachomatis genital infection
Ehrlichiosis
Hepatitis A (anti-HAV IgM)
Hepatitis B (anti-HBcIgM)
Hepatitis B (HBsAg) in pregnancy
Hepatitis C
HIV infection
Legionellosis[1]
Lyme disease
Malaria
Measles
Mumps
M. tuberculosis infection
Plague
Poliomyelitis
Psittacosis
Rocky Mountain Spotted Fever
Rubella
Syphilis
Smallpox
Trichinosis
Varicella infection, primary in patients > 15 years of age
Yellow fever

[1] Serologic confirmation of an acute case of Legionellosis cannot be based on a single titer. There must be a four-fold rise in titer to >1:128 between acute and convalescent specimens.

Laboratory Results That Must be Reported to the Mississippi State Department of Health

Laboratories shall report these findings to the Mississippi State Department of Health at least **WEEKLY. Diseases in bold type shall be reported immediately by telephone**. The dagger † indicates the positive specimens may be submitted to the Mississippi Public Health Laboratory for confirmation.

Positive Parasitic Cultures or Direct Examinations	
Result	**Reportable Disease Condition**
Any parasite in CSF†	Parasitic meningitis
Cryptosporidium parvum	Cryptosporidiosis
Trypanosoma cruzi	Chagas disease (*American trypanosomiasis*)
Plasmodium species†	Malaria
Positive Fungal Cultures or Direct Examinations	
Result	**Reportable Disease Condition**
Any fungus in CSF	Fungal meningitis
Positive Viral Cultures or Direct Examinations	
Result	**Reportable Disease Condition**
Any virus in CSF	Viral meningitis
Arboviral agents including but not limited to:	
California encephalitis virus	**California encephalitis**
Chikungunya virus	**Chikungunya virus disease**
Eastern equine encephalomyelitis virus	**Eastern equine encephalitis (EEE)**
LaCrosse encephalitis virus	**LaCrosse encephalitis**
St. Louis encephalitis virus	**St. Louis encephalitis (SLE)**
Western equine encephalomyelitis virus	**Western equine encephalitis (WEE)**
West Nile virus	**West Nile encephalitis (WNV)**
Arena viruses	**Viral hemorrhagic fevers**
Dengue virus, serotype 1, 2, 3, or 4	Dengue
Poliovirus, type 1, 2, or 3	**Poliomyelitis**
Filoviruses	**Viral hemorrhagic fevers**
Varicella virus	**Varicella in patients > 15 years of age**
Variola virus	**Smallpox**
Yellow fever virus	**Yellow fever**
Positive Blood Chemistries	
Blood lead levels (venous) of ≥ 5µg/dL	
Positive Toxin Identification	
Ricin toxin from *Ricinus communis* (castor beans)	
Surgical Pathology Results	
Creutzfeldt-Jakob Disease, including new variant	
Hansen disease (*Mycobacterium leprae*)	
Human rabies	
Malignant Neoplasms	
Mycobacterial disease including Tuberculosis	
Trichinosis	