Rules of
Department of Health and Senior Services
Division 20—Division of Community and Public Health
Chapter 20—Communicable Diseases

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 20—Communicable Diseases

19 CSR 20-20.010 Definitions Relating to Communicable, Environmental and Occupational Diseases

PURPOSE: This rule defines terminology used throughout this chapter and defines terms related to infectious waste.

(1) Administrator is the person in charge of an institution, such as the chief executive officer, chairperson of the board, administrator, clinician in charge, or any equivalent position.

(2) Adult respiratory distress syndrome (ARDS) is a syndrome with the following simultaneous characteristics:

(A) Hypoxemia due to intrapulmonary shunting of blood;

(B) Increased lung stiffness; and

(C) Chest x ray evidencing diffuse infiltration.

(3) Board is the State Board of Health.

(4) Carrier is a person who harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source or reservoir of infection for man.

(5) Case, as distinct from a carrier, is a person in whose tissues the etiologic agent of a communicable disease is present and which usually produces signs or symptoms of disease. Evidence of the presence of a communicable disease also may be revealed by routine laboratory findings.

(6) Cluster is a group of individuals who manifest the same or similar signs and symptoms of disease.

(7) Communicable disease is an illness due to an infectious agent or its toxic products and transmitted, directly or indirectly, to a susceptible host from an infected person, animal or arthropod, or through the agency of an intermediate host or a vector, or through the inanimate environment.

(8) Contact is a person or animal that has been in association with an infected person or animal and through that association has had the opportunity to acquire the infection.

(9) Designated representative is any person or group of persons appointed by the director of the Department of Health and Senior Services to act on behalf of the director or the State Board of Health.

(10) Director is the state Department of Health and Senior Services director.

(11) Disinfection is the killing of pathogenic agents outside the body by chemical or physical means, directly applied.

(A) Concurrent disinfection is disinfection immediately after the discharge of infectious material from the body of an infected person or after the soiling of articles with the infectious discharges.

(B) Terminal disinfection is the process of rendering the personal clothing and immediate physical environment of a patient free from the possibility of conveying the infection to others after the patient has left the premises or after the patient has ceased to be a source of infection or after isolation practices have been discontinued.

(12) Environmental and occupational diseases are illnesses or adverse human health effects resulting from exposure to a chemical, radiological or physical agent.

(13) Exposure is defined as contact with, absorption, ingestion or inhalation of chemical, biologic, radiologic, or other physical agents by a human that results in biochemical, physiological or histological changes.

(14) Food is any raw, cooked or processed edible substance, ice, beverage or ingredient used or intended for use in whole or in part for human consumption.

(15) Heat exhaustion means a reaction to excessive heat marked by prostration, weakness and collapse resulting from dehydration.

(16) Heat stroke means a severe illness caused by exposure to excessively high temperatures and characterized by severe headache; high fever with a dry, hot skin; tachycardia; and in serious cases, collapse, coma or death.

(17) Hyperthermia means a physician-diagnosed case of heat exhaustion or heat stroke.

(18) Hypothermia means a physician-diagnosed case of cold injury associated with a fall of body temperature to less than ninety-four and one-tenth degrees Fahrenheit (94.1°F) and resulting from exposure to a cold environment.

(19) Immediately reportable diseases are those diseases or findings listed in 19 CSR 20-20.020(1)(A)–(C) and shall be reported at once, without delay and with a sense of urgency by means of rapid communication to the Missouri Department of Health and Senior Services or to the local public health agency, regardless of the day or hour.

(20) Immunization is a treatment which renders an individual less susceptible to the pathologic effects of a disease or provides a measure of protection against the disease.

(21) Infectious waste is waste capable of producing an infectious disease. For a waste to be infectious, it must contain pathogens with sufficient virulence and quantity so that exposure to the waste by a susceptible host could result in an infectious disease. Infectious waste generated by small quantity generators shall include the following categories:

(A) Sharps—all discarded sharps including hypodermic needles, syringes and scalpel blades. Broken glass or other sharp items that have come in contact with material defined as infectious are included;

(B) Cultures and stocks of infectious agents and associated biologicals—included in this category are all cultures and stocks of infectious organisms as well as culture dishes and devices used to transfer, inoculate and mix cultures; and

(C) Other wastes—those wastes designated by the medical authority responsible (physician, podiatrist, dentist, veterinarian) for the care of the patient which may be capable of producing an infectious disease.

(22) Institution is any public or private hospital, nursing home, clinic, mental health facility, home health agency, or medical or professional corporation composed of health care workers.

(23) Invasive disease is caused by a pathogen that invades the bloodstream and/or normally sterile bodily fluids and has the potential to cause severe morbidity and/or mortality. Culturing organisms from blood, cerebrospinal fluid, joint fluid, or pleural fluid identifies invasive diseases. Examples of conditions caused by invasive organisms include:

(A) *Haemophilus influenzae*—meningitis, occult febrile bacteremia, epiglottitis, septic arthritis, pericarditis, abscesses, empyema, and osteomyelitis;

(B) *Streptococcus pneumoniae*—bacteremia, and meningitis;

(C) *Neisseria meningitidis*—meningitis with or without meningococcemia, septicemia (purpura fulminans), bacteremia, pericarditis, myocarditis, arthritis, and epididymitis;

(D) *Streptococcus pyogenes* (group A)—bacteremia associated with cutaneous infection, deep soft tissue infection (necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis, neonatal sepsis, and non-focal bacteremia.

(24) Isolation is the separation for the period of communicability of infected individuals and animals from other individuals and animals, in places and under conditions as will prevent the direct or indirect transmission of the infectious agent from infected individuals or animals to other individuals or animals who are susceptible or who may spread the agent to others.

(25) Laboratory means a facility for the biological, microbiological, serological, chemical, immuno-hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of a human. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories. Laboratory includes hand-held testing equipment. All testing laboratories must be certified under the Clinical Laboratories Improvement Amendment of 1988 (CLIA—42 CFR part 493).

(26) Local health authority is the city or county health officer, director of an organized health department or of a local board of health within a given jurisdiction. In those counties where a local health authority does not exist, the health officer or administrator of the Department of Health and Senior Services district in which the county is located shall serve as a local health authority.

(27) Local public health agency is a legally constituted body provided by a city, county or group of counties to protect the public health of the city, county or group of counties.

(28) Methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and nosocomial infection are:

(A) MRSA shall be defined as S. aureus strains that are resistant to oxacillin, nafcillin and methicillin; historically termed MRSA. These organisms are resistant to all β-lactam agents, including cephalosporins and carbapenems. (NOTE: MRSA isolates are often resistant to other multiple, commonly used classes of antimicrobial agents, including erythromycin, clindamycin, and tetracycline.)

(B) VRE shall be defined as enterococci that possess intrinsic or acquired resistance to vancomycin. Several genes, including *van*A, *van*B, *van*C, *van*D, and *van*E, contribute to resistance to vancomycin in enterococci.

(C) Nosocomial infection shall be defined by the national Centers for Disease Control and Prevention and applied to infections within hospitals, ambulatory surgical centers, and other facilities.

(29) Outbreak or epidemic is the occurrence in a community or region of an illness(es) similar in nature, clearly in excess of normal expectancy and derived from a common or a propagated source.

(30) Period of communicability is the period of time during which an etiologic agent may be transferred, directly or indirectly, from an infected person to another person or from an infected animal to a person.

(31) Person is any individual, partnership, corporation, association, institution, city, county, other political subdivision authority, state agency or institution or federal agency or institution.

(32) Pesticide poisoning means human disturbance of function, damage to structure or illness which results from the inhalation, absorption or ingestion of any pesticide.

(33) Poisoning means injury, illness or death caused by chemical means.

(34) Quarantine is a restriction of movement of persons or animals that have been exposed to a communicable disease, but have not yet developed disease. The period of quarantine will not be longer than the entire incubation period of the disease. The purpose of quarantine is to prevent effective contact with the general population.

(A) Complete quarantine is a limitation of freedom of movement of persons or animals exposed to a reportable disease, for a period of time not longer than the entire incubation period of the disease, in order to prevent effective contact with the general population.

(B) Modified quarantine is a selective, partial limitation of freedom of movement of persons or animals determined on the basis of differences in susceptibility or danger of disease transmission. Modified quarantine is designed to meet particular situations and includes, but is not limited to, the exclusion of children from school, the closure of schools and places of public or private assembly and the prohibition or restriction of those exposed to a communicable disease from engaging in a particular occupation.

(35) Reportable disease is any disease or condition for which an official report is required. Any unusual expression of illness in a group of individuals which may be of public health concern is reportable and shall be reported to the local health department, local health authority or the Department of Health and Senior Services by the quickest means.

(36) Small quantity generator of infectious waste is any person generating one hundred kilograms (100 kg) or less of infectious waste per month and as regulated in 10 CSR 80.

(37) Statewide pandemic is an outbreak of a particularly dangerous disease affecting a high proportion of the population, appearing in three (3) or more counties, as declared by the director of the Department of Health and Senior Services.

(38) Terrorist event is the unlawful use of force or violence committed by a group or individual against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives. Terrorist attacks are classified as chemical, biological, or radiological.

(A) Chemical means any weapon that is designed or intended to cause widespread death or serious bodily injury through the release, dissemination, or impact of toxic or poisonous chemicals or precursors of toxic or poisonous chemicals.

(B) Biological means any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product.

(C) Radiological means any weapon that is designed to release radiation or radioactivity at a level dangerous to human life.

(39) Toxic substance is any substance, including any raw materials, intermediate products, catalysts, final products or by-products of any manufacturing operation conducted in a commercial establishment that has the capacity

through its physical, chemical or biological properties to pose a substantial risk of death or impairment, either immediately or later, to the normal functions of humans, aquatic organisms or any other animal.

(40) Unusual diseases—Examples include, but are not limited to, the following:

(A) Diseases uncommon to a geographic area, age group, or anatomic site;

(B) Cases of violent illness resulting in respiratory failure;

(C) Absence of a competent natural vector for a disease; or

(D) Occurrence of hemorrhagic illness.

(41) Unusual manifestation of illness—Examples include, but are not limited to, the following:

(A) Multiple persons presenting with a similar clinical syndrome at a steady or increasing rate;

(B) Large numbers of rapidly fatal cases, with or without recognizable signs and symptoms;

(C) Two (2) or more persons, without a previous medical history, presenting with convulsions;

(D) Persons presenting with grayish colored tissue damage; or

(E) Adults under the age of fifty (50) years, without previous medical history, presenting with adult respiratory distress syndrome (ARDS).

(42) Varicella (Chickenpox) severity of illness shall include the following categories:

(A) Mild—less than fifty (50) lesions (able to count lesions within thirty (30) seconds);

(B) Moderate—fifty to five hundred (50–500) lesions (anything in between mild and severe); and

(C) Severe—more than five hundred (500) lesions (difficult to see the skin) or lesions with complications.

AUTHORITY: sections 192.006 and 260.203, RSMo 2000 and 192.020, RSMo Supp. 2006. This rule was previously filed as 13 CSR 50-101.010. Original rule filed July 15, 1948, effective Sept. 13, 1948. Rescinded and readopted: Filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Amended: Filed Oct. 1, 2004, effective April 30, 2005. Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006. Emergency amendment filed June 15, 2007, effective July 6, 2007, expired Jan. 1, 2008. Amended: Filed June 15, 2007, effective Jan. 30, 2008.*

**Original authority: 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004; and 260.203, RSMo 1986, amended 1988, 1992, 1993.*

19 CSR 20-20.020 Reporting Infectious, Contagious, Communicable, or Dangerous Diseases

PURPOSE: This rule designates the diseases which are infectious, contagious, communicable, or dangerous and must be reported to the local health authority or the Department of Health and Senior Services. It also establishes when they must be reported.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The diseases within the immediately reportable disease category pose a risk to national security because they: can be easily disseminated or transmitted from person to person; result in high mortality rates and have the potential for major public health impact; might cause public panic and social disruption; and require special action for public health preparedness. Immediately reportable diseases or findings shall be reported to the local health authority or to the Department of Health and Senior Services immediately upon knowledge or suspicion by telephone (1 (800) 392-0272), facsimile, or other rapid communication. Immediately reportable diseases or findings are—

(A) Selected high priority diseases, findings or agents that occur naturally, from accidental exposure, or as the result of a bioterrorism event:

Anthrax
Botulism
Coronavirus Disease 2019 (COVID-19)
Paralytic poliomyelitis
Plague
Rabies (Human)
Ricin toxin
Severe Acute Respiratory syndromeassociated Coronavirus (SARS-CoV) Disease
Smallpox
Tularemia (suspected intentional release)

Viral hemorrhagic fevers, suspected intentional (e.g., Viral hemorrhagic fever diseases: Ebola, Marburg, Lassa, Lujo, new world Arenavirus (Guanarito, Machupo, Junin, and Sabia viruses), or Crimean-Congo);

(B) Instances, clusters, or outbreaks of unusual diseases or manifestations of illness and clusters or instances of unexplained deaths which appear to be a result of a terrorist act or the intentional or deliberate release of biological, chemical, radiological, or physical agents, including exposures through food, water, or air;

(C) Instances, clusters, or outbreaks of unusual, novel, and/or emerging diseases or findings not otherwise named in this rule, appearing to be naturally occurring, but posing a substantial risk to public health and/or social and economic stability due to their ease of dissemination or transmittal, associated mortality rates, or the need for special public health actions to control.

(2) Reportable within one (1) day, diseases or findings shall be reported to the local health authority or to the Department of Health and Senior Services within one (1) calendar day of first knowledge or suspicion by telephone, facsimile, or other rapid communication. Reportable within one (1) day, diseases or findings are—

(A) Diseases, findings, or agents that occur naturally, or from accidental exposure, or as a result of an undetected bioterrorism event:

Animal (mammal) bite, wound, humans
Brucellosis
Chikungunya
Cholera
Dengue virus infection
Diphtheria
Glanders (Burkholderia mallei)
Haemophilus influenzae, invasive disease
Hantavirus pulmonary syndrome
Hemolytic uremic syndrome (HUS), postdiarrheal
Hepatitis A
Influenza-associated mortality
Influenza-associated public and/or private school closures
Lead (blood) level greater than or equal to forty-five micrograms per deciliter ($\geq$45 μg/dl) in any person
Legionellosis
Measles (rubeola)
Melioidosis (Burkholderia pseudomallei)
Meningococcal disease, invasive
Novel Influenza A virus infections, human
Outbreaks (including nosocomial) or epidemics of any illness, disease, or condition that may be of public health concern, including any illness in a food handler that is

potentially transmissible through food
Pertussis
Poliovirus infection, nonparalytic
Q fever (acute and chronic)
Rabies (animal)
Rubella, including congenital syndrome
Shiga toxin-producing Escherichia coli (STEC)
Shiga toxin positive, unknown organism
Shigellosis
Staphylococcal enterotoxin B
Syphilis, including congenital syphilis
T-2 mycotoxin
Tetanus
Tuberculosis disease
Tularemia (all cases other than suspected intentional release)
Typhoid fever (Salmonella typhi)
Vancomycin-intermediate Staphylococcus aureus (VISA), and Vancomycin-resistant Staphylococcus aureus (VRSA)
Venezuelan equine encephalitis virus neuroinvasive disease
Venezuelan equine encephalitis virus nonneuroinvasive disease
Viral hemorrhagic fevers other than suspected intentional (e.g., Viral hemorrhagic fever diseases: Ebola, Marburg, Lassa, Lujo, new world Arenavirus (Guanarito, Machupo, Junin, and Sabia viruses), or Crimean-Congo)
Yellow fever
Zika;

(B) Diseases, findings or adverse reactions that occur as a result of inoculation to prevent smallpox, including, but not limited to, the following:
Accidental administration
Contact transmission (i.e., vaccinia virus infection in a contact of a smallpox vaccinee)
Eczema vaccinatum
Erythema multiforme (roseola vaccinia, toxic urticaria)
Fetal vaccinia (congenital vaccinia)
Generalized vaccinia
Inadvertent autoinoculation (accidental implantation)
Myocarditits, pericarditis, or myopericarditis
Ocular vaccinia (can include keratitis, conjunctivitis, or blepharitis)
Post-vaccinial encephalitis or encephalamyelitis
Progressive vaccinia (vaccinia necrosum, vaccinia gangrenosa, disseminated vaccinia)
Pyogenic infection of the vaccination site
Stevens-Johnson Syndrome.

(3) Reportable within three (3) days diseases or findings shall be reported to the local health authority or the Department of Health and Senior Services within three (3) calendar days of first knowledge or suspicion. These diseases or findings are—
Acquired immunodeficiency syndrome (AIDS)/Human immunodeficiency virus (HIV) infection, Stage 3
Babesiosis
California serogroup virus neuroinvasive disease
California serogroup virus non-neuroinvasive disease
Campylobacteriosis
Carbon monoxide exposure
CD4+ T cell count and percent
Chancroid
Chemical poisoning, acute, as defined in the most current ATSDR CERCLA Priority List of Hazardous Substances; if terrorism is suspected, refer to subsection (1)(B)
Chlamydia trachomatis, infections
Coccidioidomycosis
Creutzfeldt-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Eastern equine encephalitis virus neuroinvasive disease
Eastern equine encephalitis virus non-neuroinvasive disease
Ehrlichiosis/Anaplasmosis (*Ehrlichia chaffeensis* infection, *Ehrlichia ewingii* infection, *Anaplasma phagocytophilum* infection, and Ehrlichiosis/Anaplasmosis, human, undetermined)
Giardiasis
Gonorrhea
Hansen's disease (Leprosy)
Heavy metal poisoning including, but not limited to, arsenic, cadmium, and mercury
Hepatitis B, acute
Hepatitis B, chronic
Hepatitis B surface antigen (prenatal HBsAg) in pregnant women
Hepatitis B Virus Infection, perinatal (HBsAg positivity in any infant aged equal to or less than twenty-four ($\leq$24) months who was born to an HBsAg-positive mother)
Hepatitis C, acute
Hepatitis C, chronic
Human immunodeficiency virus (HIV) infection, exposed newborn infant (i.e., newborn infant whose mother is infected with HIV)
Human immunodeficiency virus (HIV) infection, including any test or series of tests used for the diagnosis or periodic monitoring of HIV infection. For series of tests which indicate HIV infection, all test results in the series (both positive and negative) must be reported.
Human immunodeficiency virus (HIV) infection, including any negative, undetectable, or indeterminate test or series of tests used for the diagnosis or periodic monitoring of HIV infection conducted within one hundred eighty (180) days prior to the test result used for diagnosis of HIV infection
Human immunodeficiency virus (HIV) infection, pregnancy in newly identified or pre-existing HIV positive women
Human immunodeficiency virus (HIV) infection, test results (including both positive and negative results) for children less than two (2) years of age whose mothers are infected with HIV
Human immunodeficiency virus (HIV) infection, viral load measurement (including undetectable results)
Hyperthermia
Hypothermia
Lead (blood) level less than forty-five micrograms per deciliter ($<$45 μg/dl) in any person
Leptospirosis
Listeriosis
Lyme disease
Malaria
Methemoglobinemia, environmentally induced
Mumps
Non-tuberculosis mycobacteria (NTM)
Occupational lung diseases including silicosis, asbestosis, byssinosis, farmer's lung, and toxic organic dust syndrome
Pesticide poisoning
Powassan virus neuroinvasive disease
Powassan virus non-neuroinvasive disease
Psittacosis
Rabies Post-Exposure Prophylaxis (Initiated)
Respiratory diseases triggered by environmental contaminants including environmentally or occupationally induced asthma and bronchitis
Rickettsiosis, Spotted Fever
Saint Louis encephalitis/virus neuroinvasive disease
Saint Louis encephalitis virus non-neuroinvasive disease
Salmonellosis
Streptococcus pneumoniae, Invasive disease (IPD-Invasive Pneumococcal Disease)
Streptococcal toxic shock syndrome (STSS)
Toxic shock syndrome, non-streptococcal
Trichinellosis
Tuberculosis infection
Varicella (Chickenpox)
Varicella deaths
Vibriosis (non-cholera Vibrio species infections)
West Nile virus neuroinvasive disease
West Nile virus non-neuroinvasive disease

Western equine encephalitis virus neuroinvasive disease

Western equine encephalitis virus non-neuroinvasive disease

Yersiniosis.

(4) Reportable weekly diseases or findings shall be reported directly to the Department of Health and Senior Services weekly. These diseases or findings are:

Influenza, laboratory-confirmed.

(5) Reportable quarterly diseases or findings shall be reported directly to the Department of Health and Senior Services quarterly. These diseases or findings are—

Carbapenem-resistant enterobacteriaceae (CRE), nosocomial

Methicillin-resistant *Staphylococcus aureus* (MRSA), nosocomial

Vancomycin-resistant enterococci (VRE), nosocomial.

(6) A physician, physician's assistant, nurse, hospital, clinic, or other private or public institution providing diagnostic testing, screening or care to any person with any disease, condition, or finding listed in sections (1)–(4) of this rule or who is suspected of having any of these diseases, conditions, or findings, shall make a case report to the local health authority or the Department of Health and Senior Services, or cause a case report to be made by their designee, within the specified time.

(A) A physician, physician's assistant, or nurse providing care in an institution to any patient with any disease, condition, or finding listed in sections (1)–(4) of this rule may authorize, in writing, the administrator or designee of the institution to submit case reports on patients attended by the physician, physician's assistant, or nurse at the institution. But under no other circumstances shall the physician, physician's assistant, or nurse be relieved of this reporting responsibility.

(B) Duplicate reporting of the same case by health care providers in the same institution is not required.

(7) Except for influenza, laboratory-confirmed and Varicella (Chickenpox); a case report as required in section (6) of this rule shall include the patient's name, home address with zip code, date of birth, age, sex, race, home phone number, name of disease, condition or finding diagnosed or suspected, the date of onset of the illness, name and address of the treating facility (if any) and the attending physician, any appropriate laboratory results, name and address of the reporter, treatment information for sexually transmitted diseases, and the date of report.

(A) A report of an outbreak or epidemic as required in subsections (1)(B) and (1)(C) of this rule shall include the diagnosis or principal symptoms, the approximate number of cases, the local health authority jurisdiction within which the cases occurred, the identity of any cases known to the reporter, and the name and address of the reporter.

(B) Influenza, laboratory-confirmed reporting as required in section (4) of this rule shall include the patient's age group (i.e., 0–4, 5–24, 25–64, and 65+ years) and serology/serotype (i.e., A, B, and unknown), the local health authority jurisdiction within which the cases occurred, and the date of report. Aggregate patient data shall be reported weekly.

(C) Varicella (Chickenpox) reporting as required in section (3) of this rule shall include the patient's name, date of birth, vaccination history, and severity of illness; the local health authority jurisdiction within which the cases occurred, and the date of report.

(8) Any person in charge of a public or private school, summer camp, or child or adult care facility shall report to the local health authority or the Department of Health and Senior Services the presence or suspected presence of any diseases or findings listed in sections (1)–(4) of this rule according to the specified time frames.

(9) All local health authorities shall forward to the Department of Health and Senior Services reports of all diseases or findings listed in sections (1)–(4) of this rule. All reports shall be forwarded according to procedures established by the Department of Health and Senior Services director as listed in sections (1)–(4). Reports will be forwarded immediately if a terrorist event is suspected or confirmed. The local health authority shall retain from the original report any information necessary to carry out the required duties in 19 CSR 20-20.040(2) and (3).

(10) Information from patient medical records received by local public health agencies or the Department of Health and Senior Services in compliance with this rule is to be considered confidential records and not public records.

(11) Reporters specified in section (6) of this rule will not be held liable for reports made in good faith in compliance with this rule.

(12) The following material is incorporated into this rule by reference:

(A) 2005 Agency for Toxic Substances and Disease Registry (ATSDR) 1825 Century Blvd., Atlanta, GA 30345, Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) Priority List of Hazardous Substances, available at: http://www.atsdr.cdc.gov/cercla. This rule does not incorporate any subsequent amendments or additions.

(13) Each hospital and ambulatory surgical center shall report on a quarterly basis antibiogram data for infection, not colonization, from all body sites monitored by that health care facility. Antibiogram data to be reported shall include nosocomial methicillin sensitive *Staphylococcus aureus (S. aureus)*, nosocomial *S. aureus*, nosocomial vancomycin sensitive enterococci, and nosocomial enterococci isolates. Data shall be reported directly to the Department of Health and Senior Services. Reporting shall include only a patient's first diagnostic nosocomial isolate per admission of *Staphylococcus aureus (S. aureus)* and enterococci and the isolates corresponding methicillin or vancomycin sensitivity; irrespective of location or of other anti-microbial sensitivity(ies). Intermediate methicillin or vancomycin sensitivity shall be reported as resistant (i.e., methicillin-resistant *Staphylococcus aureus* (MRSA) or vancomycin-resistant enterococci (VRE), respectively).

(A) Isolates from cultures performed for routine surveillance purposes are excluded from the requirement to report. Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) nosocomial infections to be reported to the Department of Health and Senior Services are limited to those body sites monitored by the individual hospital or ambulatory surgical center.

(B) Aggregate antibiogram data for patients' non-duplicative isolates, per admission, of nosocomial MRSA and VRE infections shall reflect susceptibility patterns and shall be reported as the:

1. Number of nosocomial isolates of *S. aureus* sensitive to methicillin (oxacillin, etc.);

2. Number of nosocomial isolates *S. aureus*;

3. Number of nosocomial isolates of enterococci sensitive to vancomycin; and

4. Number of nosocomial isolates enterococci.

(C) Aggregate data shall be reported for the quarters January–March, April–June, July–September, and October–December within ten (10) days of the end of the quarter. Each quarter's aggregate report shall include only those data that are available within a ten-(10-) day reporting period from the end of that quarter.

AUTHORITY: sections 192.006, 192.020, 210.040, and 210.050, RSMo 2016. This rule*

*was previously filed as 13 CSR 50-101.020. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Sept. 1, 1981, effective Dec. 11, 1981. Rescinded and readopted: Filed Nov. 23, 1982, effective March 11, 1983. Emergency amendment filed June 10, 1983, effective June 20, 1983, expired Sept. 10, 1983. Amended: Filed June 10, 1983, effective Sept. 11, 1983. Amended: Filed Nov. 4, 1985, effective March 24, 1986. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed June 3, 1987, effective Oct. 25, 1987. Emergency amendment filed June 16, 1989, effective June 26, 1989, expired Oct. 23, 1989. Amended: Filed July 18, 1989, effective Sept. 28, 1989. Amended: Filed Nov. 2, 1990, effective March 14, 1991. Emergency amendment filed Oct. 2, 1991, effective Oct. 12, 1991, expired Feb. 8, 1992. Amended: Filed Oct. 2, 1991, effective Feb. 6, 1992. Amended: Filed Jan. 31, 1992, effective June 25, 1992. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1994, effective March 30, 1995. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Emergency amendment filed Dec. 16, 2002, effective Dec. 26, 2002, expired June 23, 2003. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Oct. 1, 2004, effective April 30, 2005. Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006. Amended: Filed Nov. 15, 2007, effective May 30, 2008. Amended: Filed Nov. 10, 2015, effective April 30, 2016. Emergency amendment filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Amended: Filed Aug. 29, 2016, effective Feb. 28, 2017. Emergency amendment filed June 28, 2019, effective July 8, 2019, terminated Jan. 30, 2020. Amended: Filed June 28, 2019, effective Jan. 30, 2020. ** Emergency amendment filed Jan. 27, 2020, effective Feb. 10, 2020, expired Aug. 7, 2020. Amended: Filed Jan. 27, 2020, effective July 30, 2020.*

**Original authority: 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004, 2016; 210.040, RSMo 1941, amended 1993; and 210.050, RSMo 1941, amended 1993.*

***Pursuant to Executive Order 21-07, 19 CSR 20-20.020, sections (1), (6), and (8) was suspended from March 23, 2020 through August 31, 2021; section (10) and section 192.067, RSMo was suspended from March 26, 2020 through August 31, 2021; section (6) was suspended from April 2, 2020 through August 31, 2021; 19 CSR 20-20.020 and sections 192.067 and 192.667, RSMo was suspended from April 3, 2020 through August 31, 2021; and 19 CSR 20-20.020 and sections 192.067 and 192.667, RSMo was suspended from April 8, 2020 through August 31, 2021.*

19 CSR 20-20.030 Exclusion From School and Readmission

PURPOSE: This rule requires the exclusion of persons from school who have a reportable disease or who are liable to transmit a reportable disease. The methods of readmission to school are also established.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Persons suffering from a reportable disease or who are liable to transmit a reportable disease listed in 19 CSR 20-20.020(1)–(3) shall be barred from attending school.

(2) Any person excluded from school under section (1) of this rule may be readmitted to school by one (1) of the following methods:

(A) Certification in writing by an attending physician attesting to the person's noninfectiousness;

(B) After a period of time equal to the longest period of communicability of the disease as established in the 1990 fifteenth edition of the *Control of Communicable Diseases in Man* published by the American Public Health Association; the 1991 twenty-second edition of the *Report of the Committee on Infectious Diseases* published by the American Academy of Pediatrics; or the following recommendations of the Immunization Practices Advisory Committee published by the Centers for Disease Control in the *Morbidity and Mortality Weekly Report: General Recommendations on Immunization*, April 7, 1989; *Update on Adult Immunization*, November 15, 1991; *New Recommended Schedule for Active Immunization of Normal Infants and Children*, September 19, 1986; *Pertussis Vaccination: Acellular Pertussis Vaccine for Reinforcing and Booster Use—Supplementary ACIP Statement*, February 7, 1992; *Diphtheria, Tetanus and Pertussis: Recommendations for Vaccine Use and Other Preventive Measures*, August 8, 1991; *Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenza Type b Disease Among Infants and Children Two Months of Age and Older*, January 11, 1991; *Immunization of Children Infected With Human Immunodeficiency Virus—Supplementary ACIP Statement*, April 1, 1988; *Immunization of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, September 26, 1986; *Prevention and Control of Influenza*, May 15, 1992; *Measles Prevention: Recommendations of the Immunization Practices Advisory Committee (ACIP)*, December 29, 1989; *Meningococcal Vaccines*, May 10, 1985; *Mumps Prevention*, June 9, 1989; *Pneumococcal Polysaccharide Vaccine*, February 10, 1989; *Poliomyelitis Prevention: Enhanced-Potency Inactivated Poliomyelitis Vaccine Supplementary— Statement*, December 11, 1987; *Poliomyelitis Prevention*, January 29, 1982; *Rabies Prevention*, March 22, 1991; *Rubella Prevention*, November 23, 1990; *Varicella-Zoster Immune Globulin for the Prevention of Chickenpox*, February 24, 1984; *Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination*, November 22, 1991; *Plague Vaccine,* June 11, 1982*; Typhoid Immunization*, July 13, 1990; *Typhus Vaccine*, June 2, 1978; and *Yellow Fever Vaccine*, May 4, 1990; or

(C) When the local health authority declares that the designated health emergency is ended, after consultation and concurrence of the director of the Department of Health or his/her designated representative.

AUTHORITY: sections 192.005.2. and 192.020, RSMo 1994. This rule was previously filed as 13 CSR 50-101.041. Original rule filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Sept. 16, 1982, effective Jan. 14, 1983. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed April 4, 1988, effective June 27, 1988. Emergency amendment filed Jan. 13, 1989, effective Jan. 23, 1989, expired May 22, 1989. Amended: Filed Jan. 13, 1989, effective May 11, 1989. Amended: Filed Oct. 3, 1989, effective Feb. 25, 1990. Amended: Filed Nov. 2, 1990, effective March 14, 1991. Amended: Filed July 12, 1991, effective Oct. 31, 1991. Amended: Filed Aug. 14, 1992, effective Feb. 26, 1993.*

**Original authority: 192.005.2., RSMo 1985, amended 1993 and 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.040 Measures to Determine the Prevalence and Prevent the Spread of Diseases which are Infectious, Contagious, Communicable, or Dangerous in their Nature

PURPOSE: This rule defines investigative and control measures for reportable diseases and establishes who is responsible for them.

(1) The director shall use the legal means necessary to control, investigate, or both, any disease or condition listed in 19 CSR 20-20.020 which is a threat to the public health.

(2) It shall be the duty of the local health authority, the director of the department, or the director's designated representative on receiving a report of a disease which is infectious, contagious, communicable, or dangerous in its nature as included in 19 CSR 20-20.020 to—

(A) Inspect any premises that they have reasonable grounds to believe are in a condition conducive to the spread of the disease;

(B) Confer with the physician, laboratory or person making the report;

(C) Collect for laboratory analysis any samples or specimens that may be necessary to confirm the diagnosis or presence of the disease or biological, chemical, or physical agents and to determine the source of the infection, epidemic, or exposure. Health program representatives and other personnel employed by the department, after training and certification to perform venipuncture, and after specific authorization from a physician, are authorized to perform venipuncture utilizing procedures within the scope of the training they have been given. The content and scope of this training shall be established by the department. Training shall be provided by a physician or his/her designee and the certificate shall be signed by the physician. Nothing in this rule shall limit the authority of local public health departments to establish their own training policies, with or without certification, or to limit their voluntary participation in the certification program developed by the department, nor shall it apply to venipuncture for other purposes;

(D) Make a complete epidemiological, environmental or occupational industrial hygiene investigation and record of the findings on a communicable disease or exposure report form;

(E) Establish and maintain quarantine, isolation or other measures as required;

(F) Provide the opportunity to be immunized to all contacts of persons suffering from those diseases for which there is a reliable and approved means of immunization;

(G) Establish appropriate control measures which may include isolation, quarantine, disinfection, immunization, closure of establishment, notification to potentially exposed individuals to make them aware of the risk or potential risk of the disease and such information required to avoid or appropriately respond to the exposure, notification to the public of the risk or potential risk of the disease and such information required to avoid or appropriately respond to the exposure, the creation and enforcement of adequate orders to prevent the spread of the disease and other measures considered by the department and/or local health authority as appropriate disease control measures based upon the disease, the patient's circumstances, the type of facility available, and any other available information related to the patient and the disease or infection;

(H) Establish, as the local health authority, whenever a case of unrecognized illness is reported or otherwise brought to the attention of the local health authority or the department and investigation presents symptoms of a communicable disease, but sufficient time has not elapsed to render a positive diagnosis, after consultation with the director or his/her designated representative, the control measures applicable in actual cases of the suspected communicable disease, until a positive diagnosis can be established. If a disease proves to be noncommunicable, the temporary control measures shall be terminated at once;

(I) Assume direct responsibility as director of health to make necessary investigation and immediately institute appropriate control measures necessary for the protection of the public health in occurrence of outbreaks or unusual clusters of illness involving more than one (1) county or a general regional area; and

(J) Investigate, as the local health authority, the disease within the local jurisdiction with assistance from the director of the department or his/her designated representative when any outbreak or unusual occurrence of a reportable disease is identified through reports required by 19 CSR 20-20.020. If, in the judgment of the director, the disease outbreak or unusual occurrence constitutes a medical emergency, the director may assume direct responsibility for the investigation.

(3) It shall be the duty of the local health authority, upon identification of a case of a reportable disease or upon receipt of a report of that disease, to take actions and measures as may be necessary according to any policies which have been or may be established by the director of the department, within the provisions of section (2) and subsections (2)(A)–(J) of this rule.

(A) When the local health authority is notified of a reportable disease or has reason to suspect the existence of a reportable disease within the local jurisdiction, the local health authority, either in person or through a designated representative, shall make an investigation as is necessary and immediately institute appropriate control measures as set forth in section (2) and subsections (2)(A)–(J) of this rule.

(B) The local health authority shall use every reasonable means to determine the presence of a communicable disease or the source of any disease listed in 19 CSR 20-20.020 or of any epidemic disease of unknown cause. In the performance of this duty, the local health authority shall examine or cause to be examined any person reasonably suspected of being infected or of being a source or contact of infection and any person who refuses examination shall be quarantined or isolated.

(C) Control measures implemented by the local health authority shall be at least as stringent as those established by the director of the department and shall be subject to review and alteration by the director. If the local health authority fails to carry out appropriate control measures, the director or his/her designated representative shall take steps necessary to protect the public health.

(4) It shall be the duty of the attending physician, immediately upon diagnosing a case of a reportable communicable disease, to give detailed instructions to the patient, members of the household and attendants regarding proper control measures. When a person dies while infected with a communicable disease, it shall be the duty of the attending physician to learn immediately who is to prepare the body for burial or cremation and then notify the funeral director, embalmer or other responsible person regarding the communicable disease the deceased had at the time of death. A tag shall also be affixed to the body providing the name of the communicable disease likely to have been present at the time of death.

(5) Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the director of the department or the director's designated representative to examine and review any medical records which are in the practitioner's or person's possession or to which the practitioner or person has access, upon request of the director or the director's designated representative in the course of investigation of reportable diseases in 19 CSR 20-20.020.

(6) In order to determine the prevalence of infectious diseases, contagious diseases, communicable diseases, or diseases dangerous in their nature within Missouri, the department may inspect, investigate, make findings, and make and enforce adequate orders to prevent the spread of such diseases included in 19 CSR 20-20.020.

(7) In order to prevent the spread of infectious diseases, contagious diseases, communicable diseases, or diseases that are dangerous in their nature within Missouri, it shall

be the duty of the local health authority, the director of the department or the director's designated representative to do the following:

(A) Notify or ensure adequate notice is given to potentially exposed individuals when such official determines that a case or outbreak of any such disease subjects such individuals to serious illness or death, if acquired; and

(B) Notify or ensure adequate notice is given to the public when such official determines that a case or outbreak of any such disease subjects the public to serious illness or death, if acquired, and the identity of potentially exposed individuals is not known at such time or cannot be known.

Such notice shall provide necessary information for the recipient to avoid or appropriately respond to the exposure.

AUTHORITY: sections 192.006 and 192.020, RSMo 2016. This rule was previously filed as 13 CSR 50-101.050. Original rule filed July 15, 1948, effective Sept. 13, 1948. Rescinded and readopted: Filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Sept. 16, 1982, effective Jan. 14, 1983. Amended: Filed March 21, 1984, effective July 15, 1984. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Nov. 15, 1989, effective Feb. 11, 1990. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 13, 2002, effective July 1, 2002, expires Dec. 27, 2002. Amended: Filed June 13, 2002, effective Nov. 30, 2002. Emergency amendment filed June 28, 2019, effective July 8, 2019, expired Feb. 27, 2020. Amended: Filed June 28, 2019, effective Jan. 30, 2020.* **

**Original authority: 192.006, RSMo 1993, amended 1995 and 192.020, RSMo 1939, amended 1945, 1951.*

***Pursuant to Executive Order 21-07, 19 CSR 20-20.040 was suspended from March 24, 2020 through May 1, 2021.*

19 CSR 20-20.050 Quarantine or Isolation Practices and Closing of Schools and Places of Public and Private Assembly

PURPOSE: This rule provides for the isolation or quarantine of persons and animals with a communicable disease and their contacts; it also authorizes the closing of schools and places of public and private assembly.

(1) The local health authority, the director of the Department of Health and Senior Services or the director's designated representative shall require isolation of a patient or animal with a communicable disease, quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures necessary for the protection of the public health. The isolation of a patient, animal or contact shall be carried out according to the methods of control in 19 CSR 20-20.040(1).

(2) No person or animal infected with or suspected of having a communicable disease listed in 19 CSR 20-20.020(1)–(3) or any contact of a disease subject to quarantine or isolation shall move or be moved from one (1) health jurisdiction to another, unless necessary for medical care, without notice to and consent from the local health authority, the director of the Department of Health and Senior Services or the director's designated representative. If a person is moved for the reason of medical care, the health authority who ordered the isolation or quarantine shall be notified within seventy-two (72) hours.

(3) The local health authority, the director of the Department of Health and Senior Services or the director's designated representative is empowered to close any public or private school or other place of public or private assembly when, in the opinion of the local health authority, the director of the Department of Health and Senior Services or the director's designated representative, the closing is necessary to protect the public health. However, in a statewide pandemic, only the director of the Department of Health and Senior Services or the director's designated representative shall have the authority to close a public or private school or other place of public or private assembly. The director or designated representative shall consult with the local health authorities prior to any such closing. Any school or other place of public or private assembly that is ordered closed shall not reopen until permitted by whomever ordered the closure.

AUTHORITY: section 192.020, RSMo Supp. 2006. This rule was previously filed as 13 CSR 50-101.061. Original rule filed Dec. 11, 1981, effective May 13, 1982. Emergency amendment filed June 15, 2007, effective July 6, 2007, expired Jan. 1, 2008. Amended: Filed June 15, 2007, effective Jan. 30, 2008.* **

**Original authority: 192.020, RSMo 1939, amended 1945, 1951, 2004.*

***Pursuant to Executive Order 21-07, 19 CSR 20-20.050 was suspended from March 24, 2020 through May 1, 2021.*

19 CSR 20-20.060 Control Measures for Food Handlers

PURPOSE: This rule establishes control measures for persons working with food products who are suspected of having a communicable disease.

(1) For the purpose of this rule, a communicable disease is defined as a disease transmitted through handling food.

(2) No person infected with a communicable disease, whether actively infected or a chronic carrier, and no person with any one (1) of the signs and symptoms listed in this section, shall engage in the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food. The following signs and symptoms indicate infection with a foodborne pathogen: diarrhea, vomiting, open skin sores, boils, fever, dark urine or jaundice, unless determined not to be caused by a pathogen able to be transmitted by food. The local health authority, the director of the Department of Health or the director's designated representative may order examinations necessary to determine the presence of a foodborne infection.

(3) Notice shall be sent immediately to the local health authority, to the director of the Department of Health or to the director's designated representative by any person responsible for the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food if any infection or disease known to be transmissible through food occurs on the premises or among the employees.

(4) When the possibility of transmission of infection is suspected in any person engaged in the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food; the local health authority, the director of the Department of Health or the director's designated representative is authorized to require any of the following measures:

(A) The immediate exclusion of that person from the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food;

(B) The immediate exclusion of the food supply concerned from distribution and use; and

(C) Adequate medical examination of that person and his/her associates, including necessary laboratory testing of blood, feces, sputum, throat cultures and other bodily secretions or excreta.

AUTHORITY: sections 192.005.2., 192.020, 196.045 and 196.225, RSMo 1994. This rule was previously filed as 13 CSR 50-101.071. Original rule filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Nov. 4, 1992, effective May 6, 1993.*

**Original authority: 192.005.2., RSMo 1985, amended 1993; 192.020, RSMo 1939, amended 1945, 1951; 196.045, RSMo 1943, amended 1993; and 196.225, RSMo 1939, amended 1977.*

19 CSR 20-20.070 Duties of Local Health Departments

PURPOSE: This rule establishes procedures for reporting communicable diseases to the Missouri Department of Health by local health departments.

(1) All local health authorities shall forward reports of all diseases and conditions mentioned in 19 CSR 20-20.020 to the Missouri Department of Health. These reports shall be forwarded within twenty-four (24) hours after they are received, according to procedures established by the Department of Health director. Local health authorities shall transcribe from the original reports information necessary to the conduct of their duties in 19 CSR 20-20.040(2), (2)(A)–(J), (3) and (3)(A)–(C) before forwarding the reports. All reports received by either the local health authority or the Department of Health are to be considered confidential records and not public records.

AUTHORITY: section 192.020, RSMo 1994. This rule was previously filed as 13 CSR 50-101.080. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Dec. 11, 1981, effective May 13, 1982.*

**Original authority: 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.075 Confidentiality of Information Obtained for Reporting of Communicable, Environmental and Occupational Diseases and Conditions

PURPOSE: This rule requires local public health agencies to establish confidentiality policies and procedures which are as stringent as Missouri Department of Health (MDOH) policies and procedures for information obtained for reporting of communicable, environmental and occupational diseases. It also requires establishment of security policies and procedures for access to MDOH information systems.

(1) Local public health agencies shall adopt and abide by confidentiality policies and procedures which are as stringent as Missouri Department of Health (MDOH) policies and procedures for information obtained for the reporting of communicable, environmental and occupational diseases defined in 19 CSR 20-20.020.

(2) Such information may be used only for investigation to determine the source of exposure and/or potential for spread; follow-up screening to monitor disease, exposure status, or communicability; counseling and patient education regarding the disease or condition and its prevention; administration of immunizations and/or prophylactic medications to the case or contacts; isolation and/or restriction of the client's or contact's activities; environmental assessment and other activities undertaken to eliminate the source of exposure; or epidemiologic analysis to determine trends in incidence, prevalence, treatment, disease progression, and/or risk factors associated with diseases.

(3) Local public health agencies shall forward reports to MDOH in accordance with 19 CSR 20-20.020. Otherwise, such information shall be released only in a statistical aggregate form that precludes and prevents the identification of an individual, physician, or medical facility except when such release is specifically authorized by law.

(4) Local public health agencies that access MDOH information systems shall establish security policies and procedures which are as stringent as MDOH policies and procedures to protect information systems against unauthorized data disclosure, modification, or destruction and to protect the integrity of the information system. Local public health agencies and employees who use MDOH information systems to perform their duties shall abide by MDOH policies and procedures for access to and use of information systems.

(5) Local public health agencies shall provide comprehensive training to employees on confidentiality and security policies, laws, and the administrative, civil, and criminal penalties for violations. Local public health agencies shall monitor employees to assure compliance with confidentiality laws, rules, policies and procedures. Local public health agencies shall immediately report to MDOH any breaches of confidentiality and security as specified by MDOH policy.

(6) Contractors performing work for MDOH or local public health agencies that involves access to information obtained for the reporting of communicable, environmental and occupational diseases shall be required, through their contracts, to abide by sections (1)–(5) of this rule.

AUTHORITY: sections 191.656, 192.006, 701.328, RSMo Supp. 1998 and 167.183, 192.020, 192.067 and 192.802, RSMo 1994. Original rule filed Aug. 4, 1999, effective Jan. 30, 2000.*

**Original authority: 167.183, RSMo 1992; 191.656, RSMo 1988, amended 1992, 1993, 1996; 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951; 192.067, RSMo 1988; 192.802, RSMo 1992; and 701.328, RSMo 1993, amended 1998.*

19 CSR 20-20.080 Duties of Laboratories

PURPOSE: This rule establishes the responsibility of laboratories to report to the Missouri Department of Health and Senior Services specified results of tests and to submit isolates/specimens for certain diseases and conditions.

(1) The director, person in charge of any laboratory, or designee of the director or person in charge of any laboratory shall report to the local health authority or the Missouri Department of Health and Senior Services the result of any test that is positive for, or suggestive of, any disease or condition listed in 19 CSR 20-20.020. These reports shall be made according to the time and manner specified for each disease or condition following completion of the test and shall designate the test performed, all results of the test, including numeric results, if applicable, units of measure of the results, and reference ranges for normal and abnormal results, the name and address of the attending physician, the name of the disease or condition diagnosed or suspected, the date the test results were obtained, the name and home address (with zip code) of the patient and the patient's age, date of birth, sex, race, and ethnicity.

(2) In reporting findings for diseases or conditions listed in 19 CSR 20-20.020, laboratories shall report—

Arsenic—results of all biological specimens including time frame of urine specimen collection, if applicable;

Cadmium—results of all biological specimens including time frame of urine specimen collection, if applicable;

Carboxyhemoglobin proportion—all results;

Chemical/pesticide (blood or serum)—all results, including if none detected;

Lead level—results of all biological specimens;

Mercury—results of all biological specimens including time frame of urine specimen collection, if applicable; and

Methemoglobin proportion—all results.

(3) Isolates or specimens positive for the following reportable diseases or conditions must be submitted to the State Public Health Laboratory for epidemiological or confirmation purposes:

Anthrax (*Bacillus anthracis*)

Cholera (*Vibrio cholerae*)

Diphtheria (*Corynebacterium diphtheriae*)

Escherichia coli O157:H7

Glanders (Burkholderia mallei)

Haemophilus influenzae, invasive disease

Influenza Virus-associated mortality

Listeriosis

Malaria (*Plasmodium species*)

Measles (rubeola)

Melioidosis (Burkholderia pseudomallei)

Mycobacterium tuberculosis

Neisseria meningitidis, invasive disease

Orthopoxvirus (smallpox/cowpox-vaccinia/monkeypox)

Other Shiga Toxin positive organisms

Pertussis (*Bordetella pertussis*)

Plague (*Yersinia pestis*)

Salmonella species

Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease

Shigella species

Tularemia (Francisella tularensis)

Potential Vancomycin Resistant *Staphylococcus aureus* (VRSA), with MIC greater than or equal to eight ($\geq$ 8)

(4) Every laboratory performing culture and sensitivity testing on human specimens in Missouri for health care facilities shall annually report these results to the Missouri Department of Health and Senior Services (MDHSS) for each facility provided this service. The data submitted should be in the format of antibiograms as defined by the Clinical and Laboratory Standards Institute (CLSI), M39-A2, Analysis and Presentation of Cumulative Antimicrobial Susceptibility Test Data. Only data from the first unique isolate from each patient should be included. Duplicate cultures must be excluded when compiling these antibiograms. The antibiograms for the preceding year are to be sent to MDHSS by July 1 of the following year (ex: 2006 data, January 1, 2006–December 31, 2006, will be due on July 1, 2007).

AUTHORITY: section 192.006, RSMo 2000, and sections 192.020 and 192.131, RSMo Supp. 2013. This rule was previously filed as 13 CSR 50-101.090. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency rule filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Emergency rescission filed June 2, 2000, effective June 15, 2000, expired Dec. 11, 2000. Previous version of rule rescinded filed June 1, 2000, effective Jan. 30, 2001. Readopted: Filed June 1, 2000, effective Nov. 30, 2000. Amended: March 14, 2003, effective Sept. 30, 2003. Amended: Filed March 14, 2003, effective Sept. 30, 2003. Amended: Filed April 15, 2005, effective Oct. 30, 2005. Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006. Amended: Filed Nov. 15, 2007, effective May 30, 2008. Amended: Filed Nov. 10, 2015, effective April 30, 2016.*

**Original authority: 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004; and 192.131, RSMo 2004.*

19 CSR 20-20.090 Contact With Communicable Diseases by First Responders or Emergency Medical Person and Mortuary Personnel

PURPOSE: This rule defines the procedures for notification to a first responder or emergency medical person and mortuary personnel who are exposed to an individual who is human immunodeficiency virus seropositive, hepatitis B infected or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5).

(1) The following definitions shall be used in administering this rule:

(A) Authorized personnel—any individual who has the authority to hire or fire and demote or promote employees for a corporation, entity or organization;

(B) Emergency medical person—a licensed attendant who has been specially trained in emergency cardiac and noncardiac care, and who has successfully completed an emergency service training program certified by the Department of Health as meeting the requirements of sections 190.100–190.190, RSMo and any individual providing emergency medical services who is licensed under Chapters 334 and 335, RSMo;

(C) Employee—a wage earner or volunteer providing emergency care;

(D) Employer—one who provides gainful work for wage earners and volunteers in the emergency care area;

(E) Exposure—any contact with an individual who is human immunodeficiency virus (HIV) seropositive or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), when the contact is consistent with the known means of transmission and occurs within the period of communicability of the disease;

(F) Facility—a facility licensed under Chapter 197 or 198, RSMo.

(G) First responder—an individual with training in first aid or emergency medical care, who is associated with a police department, sheriff's department, fire service or ambulance service and who is routinely dispatched to the scene of an accident or unforeseen emergency medical incident prior to or with the arrival of a licensed, staffed and equipped ambulance;

(H) Mortuary personnel—those persons having direct contact with a corpse prior to completion of embalming, cremating or enclosing the corpse in a sealed casket; and

(I) To notify—within forty-eight (48) hours after confirming potential exposure, the facility shall report the potential exposure by phone or in person to the employer(s)/funeral director of the potentially exposed employee(s)/mortuary personnel.

(2) If a facility admits a patient who was in an emergency rescue operation, received medical treatment or was transported to the facility by a first responder or an emergency medical person and is subsequently diagnosed as HIV seropositive or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), the facility, after confirming the presence of the disease, shall notify the employer(s) of the potentially exposed employee(s). The employer(s) shall be provided with the ambulance run number, police incident report or sufficient information to enable identification of the potentially exposed employee without reference to the patient's name. Notifications shall remain confidential and shall be released to authorized personnel only.

(3) If mortuary personnel remove a corpse from a facility or provide care to the corpse and the facility subsequently determines the presence at the time of death of HIV seropositivity or infection with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), the facility shall notify the funeral director of the mortuary personnel's contact.

(4) The employer/funeral director shall investigate the potential exposure of the employee/mortuary personnel to determine if it was consistent with the known means of transmission and occurred within the period of communicability of the disease in question.

(A) If the exposure was consistent with the known means of transmission and occurred within the period of communicability, the employer/funeral director shall notify the employee/mortuary personnel within forty-eight (48) hours.

(B) The employer/funeral director shall instruct the employee/mortuary personnel to contact the facility for medical direction.

AUTHORITY: sections 190.100–190.190 and 191.653, RSMo 1994. Original rule filed July 18, 1989, effective Nov. 11, 1989. ***

**Original authority: 190.100, RSMo 1973, amended 1987, 1989; 190.105–190.115, RSMo 1973; 190.120, RSMo 1973, amended 1980; 190.125–190.135, RSMo 1973; 190.140, RSMo 1973, amended 1987; 190.141, RSMo 1989; 190.145, RSMo 1973, amended 1975; 190.150–190.160, RSMo 1973; 190.165, RSMo 1973, amended 1978; 190.171, RSMo 1978; 190.175–190.180, RSMo 1973; 190.185, RSMo 1973, amended 1989, 1993; 190.190, RSMo 1973; and 191.653, RSMo 1988.*

***Pursuant to Executive Order 21-07, 19 CSR 20-20.090, section (2) was suspended from April 14, 2020 through August 31, 2021.*

19 CSR 20-20.091 Testing for Contagious or Infectious Disease

PURPOSE: This rule determines the contagious or infectious diseases for which testing is reasonable and appropriate and which may be administered pursuant to section 191.631, RSMo.

(1) Tests for the following contagious or infectious diseases may be administered pursuant to sections 191.630 to 191.631, RSMo:

(A) Hepatitis B;

(B) Hepatitis C;

(C) Syphilis; and/or

(D) Human T-Cell Lymphotropic Virus (HTLV) I/II.

AUTHORITY: section 191.631, RSMo Supp. 2002. Original rule filed March 14, 2003, effective Sept. 30, 2003.*

**Original authority: 191.631, RSMo 2002.*

19 CSR 20-20.092 Blood-Borne Pathogen Standard Required for Occupational Exposure of Public Employees to Blood and Other Infectious Materials

PURPOSE: This rule establishes standards for protection of public employees from occupational exposure to blood-borne pathogens in the workplace.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) The blood-borne pathogen standard governing public employers in the state of Missouri having employees with occupational exposure to blood or other potentially infectious materials shall be the standard of the Occupational Safety and Health Administration as codified in 29 CFR 1910.1030. The Occupational Safety and Health Administration standard as codified in 29 CFR 1910.1030 is incorporated herein by reference.

(2) As part of the Occupational Safety and Health Administration blood-borne pathogen standard codified in 29 CFR 1910.1030, each public employer having employees with occupational exposure is required to establish a written Exposure Control Plan. Such plan shall include a requirement that the most effective available needleless systems and sharps with engineered sharps injury protection be included as engineering and work practice controls. However, such engineering controls shall not be required if:

(A) None are available in the marketplace; or

(B) An evaluation committee, as described in section 191.640.5, RSMo determines by means of objective product evaluation criteria that use of such devices will jeopardize patient or employee safety with regard to a specific medical procedure.

AUTHORITY: sections 191.640, RSMo Supp. 2002 and 192.006, RSMo 2000. Original rule filed March 14, 2003, effective Sept. 30, 2003.*

**Original authority: 191.640, RSMo 2001; 192.006, RSMo 1993, amended 1995.*

19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities and State Correctional Centers

PURPOSE: This rule establishes tuberculosis testing requirements for residents and workers in long-term care facilities and state correctional centers.

(1) General Requirements. Long-term care facilities and state correctional centers shall screen their residents and staff for tuberculosis using the Mantoux method purified protein derivative (PPD) five tuberculin unit (5 TU) test. Each facility shall be responsible for ensuring that all test results are completed and that documentation is maintained for all residents, employees, and volunteers.

(A) In interpreting this rule, long-term care facilities shall include employees, volunteers, and residents of residential care facilities I, residential care facilities II, intermediate care facilities and skilled nursing facilities as defined in section 198.006, RSMo.

(B) In interpreting this rule, state correctional centers shall include all employees and volunteers of the Missouri Department of Corrections and the residents of all correctional institutions operated by the Missouri Department of Corrections.

(C) Whenever tuberculosis is suspected or confirmed, or tuberculosis infection is diagnosed among residents, employees or volunteers, the Department of Health or local health authority shall be notified as required in 19 CSR 20-20.020(2).

(2) Long-Term Care Residents. Within one (1) month prior to or one (1) week after admission, all residents new to long-term care are required to have the initial test of a Mantoux PPD two (2)-step tuberculin test. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test, which can be given after admission, should be given one to three (1–3) weeks later. Documentation of chest X ray evidence ruling out tuberculosis disease within one (1) month prior to admission, along with an evaluation to rule out signs and symptoms compatible with infectious tuberculosis, may be accepted by the facility on an interim basis until the Mantoux PPD two (2)-step test is completed.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) Bacillus of Calmette and Guerin (BCG) vaccination shall not prevent residents from receiving a tuberculin test.

(C) A reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis* for an individual with a history of BCG vaccination.

(D) Evidence of tuberculosis infection is considered to be a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X-ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Residents with a negative, zero to nine millimeters (0–9 mm), Mantoux PPD two (2)-step test need not be routinely retested unless exposed to infectious tuberculosis or they develop signs and symptoms which are compatible with tuberculosis disease.

(F) Residents with a documented history of tuberculosis infection or an adequate course of preventive treatment shall not be required to be retested. Residents with a documented history of tuberculosis disease and adequate chemotherapy shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All skin test results of five millimeters (5 mm) or more for contacts to infectious tuberculosis or for an individual who is immunocompromised, or ten millimeters (10 mm) or more for all others, shall require a chest X ray within one (1) week, or a review of the results of a chest X ray taken within the month prior to admission along with an evaluation to rule out signs and symptoms compatible with tuberculosis disease to rule out active pulmonary disease.

(H) Individuals with a positive finding presenting evidence of a recent, within one (1) month of the date of admission, chest X ray need not be given a new X ray. However, the results of the X ray must be reviewed in the light of the additional information of the identification of tuberculosis infection as indicated by the Mantoux PPD skin test.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive treatment and those for whom preventive treatment is not medically indicated need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All residents of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(3) Long-Term Care Employees and Volunteers. All new long-term care facility employees and volunteers who work ten (10) or more hours per week are required to obtain a Mantoux PPD two (2)-step tuberculin test within one (1) month prior to starting employment in the facility. If the initial test is zero to nine millimeters (0–9 mm), the second test should be given as soon as possible within three (3) weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one (1) subsequent annual test within the past two (2) years. It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent employees and volunteers from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) Evidence of tuberculosis infection is considered to be a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Employees and volunteers with an initial zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Employees and volunteers with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All employees and volunteers of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All employees or volunteers of these facilities shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(4) State Correctional Centers Residents. All residents of state correctional centers are required to obtain a Mantoux PPD two (2)-step tuberculin test upon admission to rule out tuberculosis. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test should be given within ninety (90) days of entrance into the state correctional system.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent residents from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) A positive test is defined as having a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Individuals with an initial negative zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Individuals with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All residents of state correctional centers who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(5) Missouri Department of Corrections New

Employees and Volunteers. All new employees and volunteers who work ten (10) or more hours per week for the Missouri Department of Corrections are required to obtain a Mantoux PPD two (2)-step tuberculin test within three (3) weeks of starting employment. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test should be given one to three (1–3) weeks after the initial test. It is the responsibility of each state correctional center to maintain documentation of each employee's or volunteer's tuberculin status.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent new employees and volunteers from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a significant reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) A positive test is defined as having a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Employees and volunteers with a negative zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Employees and volunteers with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All employees and volunteers of state correctional centers who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All employees and volunteers shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

AUTHORITY: section 199.350, RSMo 1994. Original rule filed April 17, 1995, effective Nov. 30, 1995. Emergency amendment filed June 14, 2000, effective June 24, 2000, expired Feb. 22, 2001. Amended: Filed June 14, 2000, effective Nov. 30, 2000.*

**Original authority: 199.350, RSMo 1992.*

19 CSR 20-20.200 COVID-19 Vaccine Priority Tier Evaluation Committee

AUTHORITY: sections 192.006 and 192.020, RSMo Supp. 2020. Emergency rule filed Feb. 9, 2021, effective Feb. 25, 2021, terminated March 26, 2021.