TITLE 173 COMMUNICABLE DISEASES

CHAPTER 1 REPORTING AND CONTROL OF COMMUNICABLE DISEASES

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TITLE 173 COMMUNICABLE DISEASES

CHAPTER 1 REPORTING AND CONTROL OF COMMUNICABLE DISEASES

1-001 SCOPE AND AUTHORITY: These regulations apply to the content, control, and reporting of communicable diseases, poisonings, and organisms pursuant to the provisions of Neb. Rev. Stat. §§ 71-501 to 71-514.05, 71-531 to 71-532, and 71-1626.

1-002 DEFINITIONS: When terms are used in 173 NAC 1, the following definitions apply:

Advanced practice registered nurse (APRN) means a registered nurse who holds a current APRN license as a Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, or Nurse Practitioner.

Case means an instance of a suspected or confirmed disease or condition in a person or animal.

Communicable disease, illness, or poisoning means an illness due to an infectious or malignant agent, which is capable of being transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

Confirmed case means a case of reportable disease that meets the case definitions specified and published by the Council of State and Territorial Epidemiologists (CSTE) for each disease, and available at http://www.cdc.gov/ncphi/disss/nndss/casedef/case definitions.htm Confirmed cases generally require a positive laboratory test for the given disease, together with some clinical or epidemiologic data consistent with the clinical signs and symptoms of that disease.

Contact means a person or animal that has been in close proximity/association with a communicable disease, illness, or poison for such a period that they have had an opportunity to become affected.

Department means the Department of Health and Human Services (DHHS).

Epidemic or outbreak means the occurrence of one or more than one case of an illness of similar nature in persons of a community, institution, region, or other geographically defined area which is clearly in excess of normal expectancy.

Laboratory means any facility that receives, forwards, or analyzes specimens from the human body, or referred cultures of specimens from the human body, and reports the results to physicians and public health authorities.

Local public health department means a county, district, or city-county health department approved by the Department of Health and Human Services as a local full-time public health service.

NEDSS means the Nebraska Electronic Disease Surveillance System for manual online reporting.

ORNAO means the Online Reporting of Nebraska-reportable Antimicrobial-resistant Organisms system for electronic reporting.

Suspected case means a person or deceased person having a condition or illness in which the signs and symptoms resemble those of a recognizable disease.

1-003 WHO MUST REPORT

1-003.01 Health Care Providers: Physicians and hospitals must make reports of communicable diseases and poisonings as described in 173 NAC 1-003, 1-004, and 1-005, unless a report is made under 173 NAC 1-003.01A or 1-003.01B.

1-003.01A Reporting by Physician Assistants and Advanced Practice Registered Nurses: A physician assistant or advanced practice registered nurse who in lieu of a physician attends to any patient suspected of having a reportable disease or poisoning must make the report as required by 173 NAC 1.

1-003.01B Reporting Lead Analysis: If a laboratory performing lead analysis provides a report containing the required information to the Department, the physician is not required to make the report to the Department.

1-003.01C Electronic Ordering of Laboratory Tests: For all laboratory tests which may identify a reportable disease (e.g., microbiology tests, hepatitis tests, etc.) and which are ordered through submission of an electronic requisition or other automated electronic mechanism, providers must include the following information at the time the test order is placed to the laboratory so that the laboratory may fulfill reporting requirements:

1. Patient first and last name;
2. Patient address including street, city, and zip;
3. Patient date of birth;
4. Patient gender;
5. Date of specimen collection;
6. Specimen source;
7. Ordered test;
8. Submitting provider's name;
9. Submitting provider's address and telephone number;
10. Pregnancy status, if available and if applicable;
11. Race, if available; and
12. Ethnicity (Hispanic / non-Hispanic), if available.

1-003.02 Laboratories: Laboratories must make reports as described in 173 NAC 1-004, 1-005.02, and 1-006.

1-004 REPORTABLE DISEASES, POISONINGS, AND ORGANISMS: LISTS AND FREQUENCY OF REPORTS: The following diseases, poisonings, and organisms are declared to be communicable or dangerous or both to the public. Incidents of diseases, poisonings, and organisms must be reported as described in 173 NAC 1-004.01 through 1-004.03, 1-005, and 1-006.

1-004.01 Immediate Reports

1-004.01A The following diseases, poisonings, and organisms must be reported immediately:

Anthrax (*Bacillus anthracis*^)* ‡
Botulism (*Clostridium botulinum*^)*
Brucellosis (*Brucella abortus^, B. melitensis^, and B. suis*^* ‡
Cholera *(Vibrio cholerae*^) ‡
Coccidiodomycosis (*Coccidioides immitis/posodasil*^)*
Diphtheria (*Corynebacterium diphtheriae*) ‡
Eastern equine encephalitis (EEE virus^)*
Food poisoning, outbreak-associated
Glanders *[Burkholderia (Pseudomonas) mallei^]** ‡
Haemophilus influenzae infection (invasive disease only)^ ‡
Hantavirus pulmonary syndrome (Sin Nombre virus)
Hemolytic uremic syndrome (post-diarrheal illness)
Hepatitis A (IgM antibody-positive or clinically diagnosed during an outbreak)
Influenza due to novel or pandemic strains (includes highly pathogenic avian influenza virus^)*
Measles (Rubeola)
Melioidosis [*Burkholderia (Pseudomonas) pseudomallei*]* ‡
Meningitis (*Haemophilus influenzae^ or Neisseria meningitidis*^)
Meningococcal disease, invasive (*Neisseria meningitidis*^)
Monkeypox virus infection*
Pertussis [whooping cough] (*Bordetella pertussis*^)‡
Plague (*Yersinia pestis*^)*‡
Poliomyelitis, paralytic
Q *fever (Coxiella burnetii^)** ‡
Rabies (human and animal cases and suspects)
Ricin poisoning*
Rift Valley fever*
Rocky Mountain Spotted Fever (*Rickettsia rickettsii*^)*
Rubella and congenital rubella syndrome
Severe Acute Respiratory Syndrome [SARS] (SARS-associated coronavirus)
Smallpox*
Staphylococcal enterotoxin B intoxication*‡
Staphylococcus aureus, vancomycin-intermediate/resistant (MIC $\geq$ 4 μg/mL) ‡

Tick-borne encephalitis, virus complexes (Central European Tick-borne encephalitis virus, Far Eastern Tick-borne encephalitis virus, Kyasanur Forest disease virus, Omsk Hemorrhagic Fever virus, Russian Spring and Summer encephalitis virus)*
Tularemia (*Francisella tularensis*^)*‡
Typhus Fever, louse-borne *(Rickettsia prowazekii^)** and flea-borne / endemic murine (*Rickettsia typhi*)
Venezuelan equine encephalitis*
Viral hemorrhagic fever (including but not limited to Ebola virus, Marburg virus, and Lassa fever virus)*
Yellow Fever

* Potential agents of bioterrorism (designated as select agents by CDC)
^ Laboratories must submit the isolate and/or specimen to the Nebraska Public Health Laboratory as specified in 173 NAC 1-007.03
‡ Laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C must report any antibiotic susceptibility test results

1-004.01B Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks*: Clusters, outbreaks, or epidemics of any health problem, infectious or other, including food poisoning, healthcare-associated outbreaks or clusters, influenza, or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to unidentified infectious causes; and any unusual disease or manifestations of illness must be reported immediately.

1-004.02 Reports Within Seven Days: The following diseases, poisonings, and organisms must be reported within seven days of detection or diagnosis:

Acinetobacter spp., all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ‡
Acquired Immunodeficiency Syndrome (AIDS), as described in 173 NAC 1-005.01C2
Adenovirus infection (conjunctivitis, respiratory)
Amebae-associated infection (*Acanthamoeba* spp., *Entamoeba histolytica*, and *Naegleria fowleri*
Arboviral infections (including, but not limited to, West Nile virus, St. Louis encephalitis virus, Western Equine Encephalitis virus, and Dengue virus)
Babesiosis (*Babesia* species)
Campylobacteriosis (*Campylobacter*^ species) ‡
Carbon monoxide poisoning (use breakpoint for non-smokers)
Chancroid (*Haemophilus ducreyi)* ‡±
Chlamydia trachomatis infections (nonspecific urethritis, cervicitis, salpingitis, neonatal conjunctivitis, pneumonia) ‡±
Clostridium difficile (antibiotic-associated colitis and pseudomembranous colitis)
Creutzfeldt-Jakob Disease (subacute spongiform encephalopathy [14-3-3 protein from CSF or any laboratory analysis of brain tissue suggestive of CJD])
Cryptosporidiosis (*Cryptosporidium parvum*)
Cyclosporiasis (*Cyclospora cayetanensis*)
Ehrlichiosis, human monocytic (*Ehrlichia chaffeenis)* ‡
Ehrlichiosis, human granulocytic (*Ehrlichia phagocytophila*)

Encephalitis (caused by viral agents)
Enterococcus spp*.,* all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ‡
Escherichia coli gastroenteritis (*E. coli* O157-H7^ and other Shigatoxin-positive *E. coli* from gastrointestinal infection^)
Giardiasis (*Giardia lamblia*)
Gonorrhea (*Neisseria gonorrhoeae*): venereal infection and ophthalmia neonatorum ‡±
Hansen's Disease (Leprosy [*Mycobacterium leprae]*) ‡
Hepatitis B infection (positive surface antigen tests and all IgM core antibody tests, both positive and negative)±
Hepatitis C infection (all positive screening tests [e.g. EIA, ELISA, etc.] to include signal-to-cutoff ratio [S:CO] are reportable; all confirmatory tests [e.g. RIBA, NAT tests such as PCR for qualitative, quantitative, and genotype testing] are reportable regardless of result [i.e., both positive and negative tests])
Hepatitis D and E infection
Herpes simplex, primary genital infection ±
Histoplasmosis (*Histoplasma capsulatum)*
Human immunodeficiency virus infection, as described in 173 NAC 1-005.01C2, Type 1 and suspected cases of HIV Type 2 ±
Influenza deaths, pediatric (< 18 years of age)
Influenza (Antigen or PCR positive or culture confirmed)
Influenza, all tests (applies only to laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C)
Influenza, rapid tests summary report only (laboratories only)
Kawasaki disease (mucocutaneous lymph node syndrome)
Klebsiella sp., all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ‡
Lead poisoning (all analytical values for blood lead analysis must be reported by the laboratory)
Legionellosis (*Legionella* species) ‡
Leptospirosis (*Leptospira interrogans*)
Listeriosis (*Listeria monocytogenes*^) ‡
Lyme disease (*Borrelia burgdorferi*)
Lymphocytic choriomeningitis virus infection
Lymphogranuloma venereum (LGV [*Chlamydia trachomatis*]) ±
Malaria (*Plasmodium* species)
Meningitis, including viral, bacterial, and fungal (all such cases must be reported within seven days except those caused by *Haemophilus influenzae and Neisseria meningitidis*, which must be reported immediately)
Methemoglobinemia / nitrate poisoning (methemoglobin greater than 5% of total hemoglobin)
Mumps
Mycobacteria spp. (including *M. tuberculosis* complex organisms^ [for genotyping] and all "atypical" species, to include culture, nucleic acid tests, or positive histological evidence indicative of tuberculosis infection or disease) ‡
Necrotizing fasciitis
Norovirus infection (laboratories only)
Poisoning or illness due to exposure to agricultural chemicals (herbicides, pesticides, and fertilizers), industrial chemicals, mercury, or radiologic exposures

Psittacosis (*Chlamydophilia psittaci*)
Respiratory syncytial virus infection (laboratories only)
Retrovirus infections (other than HIV)
Rheumatic fever, acute (cases meeting the Jones criteria only)
Rotavirus infection ([all positive and negative tests] applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C)
Salmonellosis, including typhoid fever (*Salmonella* serogroup^) ‡
Shiga toxin-positive gastroenteritis (enterhemorrhagic E coli and other shiga toxin-producing bacteria^)
Shigellosis (*Shigella* species^) ‡
Staphylococcus aureus (applies only to laboratories performing electronic lab reporting as specified in 1-005.02C)
Streptococcal disease (all invasive disease caused by Groups A and B streptococci) ‡
Streptococcus pneumoniae, all isolates (applies only to laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C) ‡
Syphilis (*Treponema pallidum*) RPR and FTA reactive ±
Syphilis, congenital
Tetanus (*Clostridium tetani*) ‡
Toxic shock syndrome
Toxoplasmosis, acute (*Toxoplasma gondii)*
Transmissible spongiform encephalopathies
Trichinosis (*Trichinella spiralis*)
Tuberculosis (see *Mycobacteria*)
Varicella primary infections (chicken pox)
Varicella death (all ages)
Yersiniosis (*Yersinia* species not *Y. pestis*) ‡

^ Laboratories must submit the isolate and/or specimen to the Nebraska Public Health Laboratory as specified in 173 NAC 1-007.03
‡ Laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C must report any antibiotic susceptibility test results
± STD in accordance with Neb. Rev. Stat. § 71-502.01

1-004.03 Reports Once a Month: Laboratories unable to submit individual antibiotic susceptibility date via automated electronic laboratory reporting (ELR) must submit monthly tabular summaries of antibiotic-resistant organisms. Reports must be submitted no later than one week after the end of the reporting month. Reports must be submitted electronically to the ORNAO system. If Internet access is not available, reports may be submitted via postal service, telephone, facsimile, or other secure electronic mail system. Reports must be submitted on or include the same information as Attachment E, incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report. The following antibiotic-resistant organisms must be reported:

Enterococcus spp., vancomycin-resistant (MIC $\geq$ 32 μg/mL and/or resistant by disk diffusion) and intermediate (MIC = 8-16 μg/mL)
Staphylococcus aureus, methicillin-resistant (MIC $\geq$ 4 μg/mL to oxacillin, $\geq$ 8 μg/mL to cefoxitin, and/or resistant by disk diffusion);
Staphylococcus aureus, vancomycin-intermediate/resistant (MIC $\geq$ 4 μg/mL);
Streptococcus pneumoniae

Non-CSF
Penicillin-intermediate (MIC = 4 μg/mL) and
Penicillin-resistant (MIC ≥ 8 μg/mL)
CSF
Penicillin-resistant (MIC ≥ 0.12 μg/mL)

1-004.04 Reporting of Antibiotic Susceptibility: All laboratories reporting via automated electronic laboratory reporting (ELR) must report all antimicrobial susceptibility results, if performed for bacterial isolates listed in 173 NAC 1-004.01 and 1-004.02 (indicated by a ‡). Laboratories not reporting via automated ELR are exempt from this requirement.

1-004.05 New or Emerging Diseases and Other Syndromes and Exposures; Reporting and Submissions

1-004.05A Criteria: The Director of the Division of Public Health or the Chief Medical Officer may require reporting, or a change in method or frequency of reporting, of newly recognized or emerging diseases, syndromes suspected to be of infectious origin, or exposures of large numbers or specific groups of persons to known or suspected public health hazards if:

1. The disease, syndrome, or exposure can cause or is suspected to cause serious morbidity or mortality; and
2. Reporting of the disease, syndrome, or exposure is necessary to monitor, prevent, or control the disease, syndrome, or exposure and to protect public health.

1-004.05B Surveillance Mechanism: The Director of the Division of Public Health or the Chief Medical Officer may describe a specific mechanism for surveillance of the disease, syndrome, or exposure including persons and entities required to report, a time frame for reporting, and protocols for the submission of clinical specimens collected from cases, suspected cases, or exposed persons to referral laboratories designated by the DHHS Division of Public Health.

1-004.06 Sexually Transmitted Diseases: For the purpose of implementing Neb. Rev. Stat. § 71-502.01, sexually transmitted diseases include, but are not limited to, the following diseases:

1. Bacterial vaginosis;
2. Candidiasis;
3. Chancroid;
4. *Chlamydia trachomatis* infection;
5. Genital herpes infection;
6. Gonorrhea;
7. Granuloma inquinale;
8. Hepatitis B infection;
9. Human immunodeficiency virus (HIV) infection;
10. Human papilloma virus (HPV) infection;
11. Lymphogranuloma venereum;
12. Syphilis; and
13. Trichomoniasis.

1-005 METHODS OF REPORTING

1-005.01 Health Care Providers

1-005.01A Immediate Reports of Diseases, Poisonings and Organisms: Health care providers must report diseases, poisonings and organisms, listed in 173 NAC 1-004.01A, by telephone, facsimile or other secure electronic mail system within 24 hours of diagnosis or detection. Reports must be submitted on or include the same information as Attachment A, incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report.

1-005.01B Immediate Reports of Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks: Health care providers must report by telephone, facsimile, or other secure electronic mail system, information relating to confirmed, diagnosed, detected, or suspected clusters, outbreaks, or epidemics of any health problem, infectious or other, including food poisoning, influenza or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to infectious causes; any unusual disease or manifestations of illness. Reports must include the patient's first and last name, date of birth, address, and telephone number; time of onset of symptoms, date of diagnosis, and mode of transmission, name, address, and telephone number of physician; and name and location of hospital or clinic. See 173 NAC 1-006, Where to Report.

1-005.01C Reports Within Seven Days: Health care providers must make reports of diseases, poisonings and organisms listed in 173 NAC 1-004.02, within seven days of diagnosis or detection.

1-005.01C1 Except for lead analysis and AIDS and HIV disease, reports may be made by postal service, telephone, facsimile, or other secure electronic mail system, submitted on or including the same information as Attachment A. Health care providers must report AIDS and HIV as described in 173 NAC 1-005.01C2 and report lead analysis as described in 1-005.01C3. See 173 NAC 1-006, Where to Report.

1-005.01C2 Reporting HIV Disease and AIDS: Health care providers must make HIV disease and AIDS reports by postal service or telephone. Adult cases of AIDS and HIV disease (patients $\geq$ 13 years of age at time of diagnosis) must be submitted on or include the same information as Attachment C, incorporated in these regulations by this reference. Pediatric cases of AIDS and HIV disease (patients < 13 years of age at time of diagnosis) and perinatally exposed HIV cases must be submitted on or include the same information as Attachment D, incorporated in these regulations by this reference. AIDS and HIV case reports are required from health care providers responsible for:

1. Treating or diagnosing a person with HIV-1 or HIV-2 disease, based on the laboratory tests listed in 173 NAC 1-005.02B3a1 as being definitive for HIV infection, or based on clinical criteria, as outlined in the National Centers for Disease Control's (CDC) most recent case definition for HIV;

2. Treating or diagnosing a person with AIDS as outlined in CDC's most recent case definition for AIDS;

3. Providing medical care to a pregnant woman with HIV disease;

4. Providing medical care to a baby under 19 months of age born to a woman with HIV disease (perinatally HIV exposed). The diagnosis of HIV infection or determination of no infection is determined by CDC's most recent case definition for HIV; and

5. Treating or diagnosing potential cases of public health importance related to HIV infection including:

   a. Unusual strains of HIV (HIV-2 or non-B subtype of HIV-1); and
   b. Unusual modes of transmission (such as, but not limited to transplant or artificial insemination; transfusion of blood or blood components, child sexual abuse, occupational, household, or other unusual exposure).

1-005.01C3 Reporting Lead Analysis: Health care providers must report the following information to the Department:

1. The date of sample collection and analysis;
2. Whether the sample is a capillary or venous blood sample;
3. The date of birth, address, and sex of the patient;
4. The name and address of the physician; and
5. The race and ethnicity of the patient, if known.

1-005.01C4 Reporting of Tuberculosis: Health care providers must report positive TB diagnostic tests (culture and nucleic acid amplification) or positive histological evidence indicative of tuberculosis infection or disease.

1-005.01D Reporting to Laboratories: For all laboratory tests which may identify a reportable disease (e.g. microbiology tests, hepatitis tests, etc.) and which are ordered through submission of an electronic requisition or other automated electronic mechanism, providers must include the following information at the time the test order is placed to the laboratory so that the laboratory may fulfill reporting requirements:

1. Patient first and last name;
2. Patient address including street, city, and zip;
3. Patient date of birth;
4. Patient gender;
5. Date of specimen collection;
6. Specimen source;
7. Ordered test;
8. Submitting provider's name;
9. Submitting provder's address and telephone number;
10. Pregnancy status, if available and if applicable;
11. Race, if available; and
12. Ethnicity (Hispanic / non-Hispanic), if available.

1-005.02 Laboratories

1-005.02A Electronic Reporting: Beginning no later than three months after the effective date of these regulations, all laboratories performing clinical testing on Nebraska residents must electronically report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02. This may be accomplished either through manual online data entry into Nebraska's electronic disease reporting system, or through automated electronic laboratory reporting. Paper reports will be accepted only when established electronic transmission methods are inoperable.

1-005.02B Laboratories Using NEDSS Manual Online Reporting

1-005.02B1 Immediate Reports of Diseases, Poisonings, and Organisms: Laboratories must make immediate reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.01A, both by telephone to a live public health surveillance official within 24 hours of diagnosis or detection and by electronic reporting to NEDSS. Reports must include the information specified on Attachment B, incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report.

1-005.02B2 Immediate Reports of Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks: Laboratories must make immediate reports by telephone to a live public health surveillance official within 24 hours of diagnosis or detection, information relating to diagnosed, detected, or suspected clusters, outbreaks, or epidemics of any health problem, infectious or other, including food poisoning, influenza, or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to infectious causes; and any unusual disease or manifestations of illness. Reports must include the same information as Attachment B.

1-005.02B3 Reports Within Seven Days: Laboratories must make reports of diseases, poisonings, and organisms diagnosed or detected, listed in 173 NAC 1-004.02, collected during one calendar week. Reports must be submitted no later than the following Tuesday and must include the same information as Attachment B. Laboratories must make reports by manual online reporting to the NEDSS.

1-005.02B3a For the purposes of reporting AIDS and HIV, the laboratory reporting requirement applies as follows:

1. Any test or combination of tests indicative of HIV-1 or HIV-2 that has acceptable specificity and sensitivity to reliably detect HIV infection is reportable. (At the time of promulgation of these rules, there are no FDA-approved lab tests for HIV-2. Please contact the DHHS Division of Public Health, HIV Surveillance, for further instructions regarding HIV-2 testing.)

2. A laboratory analyzing samples for any of the tests as listed below must report all of the following results:

a. A positive result on a confirmatory test for HIV antibody (e.g. Western blot or immunofluorescence antibody test, usually preceded by a positive screening test for HIV antibody, e.g. repeatedly reactive enzyme immunoassay);

b. An indeterminate result on a confirmatory test for HIV antibody (e.g. Western blot or immunoflurescence antibody test, usually preceded by a positive screening test for HIV antibody, e.g. repeatedly reactive enzyme immunoassay);

c. All quantitative HIV RNA PCR tests regardless of the result. Include the detailed name of the test, detection limits of test, and/or interpretation of results. (This applies only to laboratories performing ELR.);

d. All positive results on any of the following:

(1) Qualitative HIV nucleic acid (DNA or RNA) detection [e.g. DNA polymerase chain reaction (PCR)];
(2) HIV p24 antigen test, including neutralization assay;
(3) HIV isolation (viral culture); and

e. All CD4 counts per microliter and all CD4 percentages.

1-005.02B3b Reporting Lead Analysis: Laboratories must report the following information to the Department:

1. The date of sample collection and analysis;
2. Whether the sample is a capillary or venous blood sample;
3. The date of birth, address, and sex of the patient;
4. The name and address of the physician; and
5. The race and ethnicity of the patient, if known.

1-005.02B4 Reports Once a Month: Laboratories unable to submit individual antibiotic susceptibility date via automated ELR must submit monthly tabular summaries of antibiotic resistant organisms listed in 173 NAC 1-004.03. Reports must be submitted no later than one week after the end of the reporting month. Reports must be submitted by postal service, telephone, facsimile or other secure electronic mail system. Reports must be submitted on or include the same information as Attachment E. See 173 NAC 1-006, Where to Report.

1-005.02C Laboratories Using Automated Electronic Laboratory Reporting (ELR)

1-005.02C1 Beginning no later than 12 months after the effective date of these regulations, clinical reference laboratories in communities with a population greater than 10,000 as determined by the July 1, 2005 U.S. Census Bureau Projections (Beatrice, Bellevue, Columbus, Fremont, Grand Island, Hastings, Kearney, LaVista, Lexington, Lincoln, Norfolk, North Platte, Omaha, Papillion,

Scottsbluff, and South Sioux City) must report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02 via automated electronic laboratory reporting. Such lab tests must be identified by a computer algorithm, and forwarded to public health computer systems in a secure fashion according to the data format and specifications stipulated by the Department. Required data fields include:

1. Patient first and last name;
2. Patient address including street, city, state, and zip;
3. Patient date of birth;
4. Patient sex;
5. Patient ID number;
6. Performing laboratory's name, address, and phone number;
7. Date and time of specimen collection;
8. Date and time the test was performed;
9. Specimen source;
10. Type of test performed;
11. Test result;
12. Result units;
13. Date and time the test was verified;
14. Accession number;
15. Date of report; and
16. Submitting provider's name, address, phone number, and office name; and, if available,
17. Pregnancy status;
18. Ethnicity (Hispanic / non-Hispanic);
19. Code for ordered test;
20. Code for test result;
21. Result flag;
22. High and low result reference range;
23. Provider ID number;
24. Provider office ID number;
25. ELR report date; and
26. The following data elements stored in the PV1 segment of HL7:

Element Name	Sequence	Item Number
Patient Class	2	132
Assigned Patient Location	3	133
Admission Type	4	134
Prior Patient Location	6	136
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A laboratory's test results must be screened via an automated computer algorithm no less than once every 24 hours, and a file or files meeting this reporting requirement must be forwarded electronically to the Department no less than once every 24 hours. Automated computer screening algorithms must be validated initially and once each year to ensure the screening process will capture all reportable disease test results that may be generated by the reporting laboratory. Results of this validation must be documented and maintained on file for two years at the laboratory for review by the Department.

Beginning no later than 24 months after the effective date of these regulations, clinical reference laboratories in communities with a population greater than 5,000 as determined by the July 1, 2005 U.S. Census Bureau Projections (Alliance, Blair, Chadron, Crete, Elkhorn, Gering, Holdrege, McCook, Nebraska City, Plattsmouth, Ralston, Schuyler, Seward, Sidney, Wayne, and York) must report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02 via automated electronic laboratory reporting.

Electronic reporting does not exempt the laboratory from reporting by telephone those diseases that must be reported immediately.

1-005.02C2 Reporting of Antibiotic Susceptibility Results: Laboratories with automated electronic reporting capability which perform antibiotic susceptibility testing (AST) for bacterial diseases listed under 173 NAC 1-004 must report antibiotic susceptibility results for these tests. This requirement includes traditional broth, agar, and newer automated methods of AST, as well as molecular-based methods that assay for the molecular determinants of antibiotic resistance. Reports must include the method used for AST. Clinical laboratories must report AST results to the DHHS Division of Public Health via automated ELR. When necessary for the protection of the public health, the DHHS Division of Public Health may request additional reporting of AST results on other infectious agents that have increased in either incidence or severity.

1-006 WHERE TO REPORT

1-006.01 Cases Reported by Health Care Providers and Laboratories: Except as stated for AIDS and HIV reporting in 173 NAC 1-006.01A and except for reports made through NEDSS, reports must be made to the local health department if the area is served by a local public health department as defined in Neb. Rev. Stat. § 71-1626, and where the health director of the public health department has specified this method of reporting. In all other areas, the reports are to be made directly to the DHHS Division of Public Health.

1-006.01A HIV/AIDS Cases Reported by Health Care Providers and Laboratories: To report an AIDS or HIV case in Douglas or Lancaster County, mail the report form (Attachment C or D) to or contact the local agency listed below, based upon the county in which the health care provider or laboratory is located. In all other areas, the reports must be made to the infectious disease surveillance staff at the DHHS Division of Public Health.

Douglas County
Epidemiologist
Douglas County Health Department
1819 Farnam Street, Room 401
Omaha, NE 68183-0401
402/444-7214

Lancaster County
Communicable Disease Coordinator
Lincoln-Lancaster County Health Department
3140 "N" Street
Lincoln, NE 68510-1514
402/441-8053

Nebraska Department of Health and Human Services, Division of Public Health
DHHS Division of Public Health
Infectious Disease
P.O. Box 95026
Lincoln, NE 68509-5026
402/471-0360

1-006.02 Duties of Local Public Health Departments to Report to DHHS: It is the duty of the local public health department to report all cases of reportable diseases, poisonings, and organisms that occurred within the most recent reporting period in the jurisdictional area of the respective public health department when the local director has specified that such diseases be reported to the local public health department.

1-006.02A Immediate Reports: The local public health department must make immediate reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.01 to the DHHS Division of Public Health. Reports must be made by the health director or authorized representative of the respective public health department by telephone to a live public health surveillance official within 24 hours of diagnosis or detection. Reports must include the same information as Attachments A and B.

1-006.02B Reports Within Seven Days: The local public health department must make reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.02 to the DHHS Division of Public Health. Reports must be made via NEDSS, or in the event NEDSS is not operational, by postal service, telephone, facsimile, or other secure electronic mail system within seven days of diagnosis or detection. Reports must be made by the health director or authorized representative of the respective public health department, no later than Friday of each week. Reports must be submitted on or include the same information as Attachments A, B, C and D.

1-006.02C Reports Once a Month: The local public health department must make tabular reports of antibiotic-resistant organisms listed in 173 NAC 1-004.03 to the DHHS Division of Public Health. Reports must be made via ORNAO or by postal service, telephone, facsimile, or other secure electronic mail system. Reports must be made by the health director or authorized representative of the respective public health department, no later than the fifteenth day of the month following the reporting period. Reports must be submitted on or include the same information as Attachment E.

1-007 CONTROL MEASURES FOR COMMUNICABLE DISEASES: For the information of the public, the latest editions of these publications are used as a reference by the DHHS Division of Public Health, local public health departments, and health care providers in the control of communicable diseases: "Control of Communicable Diseases Manual", published by the American Public Health Association, 800 I Street NW, Washington, D.C. 20001-3710 and disease-specific recommendations of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, as published in the "Morbidity and Mortality Weekly Report."

1-007.01 Public Health Interventions, Noncompliance, and Directed Health Measures

1-007.01A Public Health Interventions: The health care provider attending a case or suspected case of a disease requiring isolation, quarantine, or other public health interventions, must make reasonable efforts to prevent the spread of the disease to others and must report the case to the local public health department or the DHHS Division of Public Health.

1-007.01B Noncompliance: Health care providers must report immediately to the local public health department or the DHHS Division of Public Health, the name, address, and other pertinent information for all individuals with diseases requiring isolation, quarantine, or other public health interventions who refuse to comply with prescribed public health interventions. The DHHS Division of Public Health may order a directed health measure as provided in 173 NAC 6, or in the case of tuberculosis, advise the local county attorney for proceedings under the Tuberculosis Detection and Prevention Act.

1-007.02 Contact Notification in Reportable Communicable Disease and Poisoning Investigations

1-007.02A In order to protect the public's health and to control the spread of disease, in cases of reportable communicable disease or poisonings other than those covered by 173 NAC 1-007.02B, the DHHS Division of Public Health may notify individuals who are determined to be possible contacts of the source of the disease or poisoning by any means reasonably necessary.

1-007.02B Partner Identification and Notification in STD Cases

1-007.02B1 In order to protect the public's health, when an individual is tested and found to have an STD as defined in 173 NAC 1-004.06, the DHHS Division of Public Health or local public health department will conduct partner notification and referral activities in cases of HIV disease and early syphilis, and may conduct these activities as appropriate for other STD's. Other local health-related agencies may conduct these activities if staff have received appropriate training as determined by DHHS.

1-007.02B2 "Partner" is defined as any individual, including a spouse, who has shared needles, syringes, or drug paraphernalia or who has had sexual contact with an individual infected with an STD as defined in 173 NAC 1-004.06. In the case of HIV disease, in accordance with the Ryan White HIV/AIDS Treatment Modernization Act, "spouse" is defined as any individual who is the marriage partner of that person at any time within the ten-year period prior to the diagnosis of HIV disease.

1-007.03 Responsibilities of Laboratories: All laboratories performing clinical testing on Nebraska residents:

1. Must forward to the Nebraska Public Health Laboratory isolates of special public health interest indicated in 173 NAC 1-004.01A and 1-004.02;

2. Which diagnose *E.coli* gastroenteritis with a shiga toxin assay and which do not isolate the shiga toxin-producing organism must forward the stool sample testing positive for shiga toxin to the Nebraska Public Health Laboratory; and

3. Must forward at the direction of the State Epidemiologist or person acting in that capacity isolates or specimens to the Nebraska Public Health Laboratory or the Centers for Disease Control and Prevention laboratories.

1-007.04 Responsibilities of Schools: School nurses or those acting in the capacity of a school nurse must, in accordance with state and federal statutes:

1. Notify the local public health department or the DHHS Division of Public Health of cases or suspected cases of reportable diseases as indicated in 173 NAC 1-004.01 and 1-004.02, or outbreaks and suspected outbreaks of diseases as indicated in 173 NAC 1-004.01B affecting students and/or other school-affiliated personnel and which present a reasonable threat to the safety or health of a student and/or other school-affiliated personnel; and

2. Cooperate with public health authorities in obtaining information needed to facilitate the investigation of cases and suspected cases, or outbreaks and suspected outbreaks of diseases affecting students and/or other school-affiliated personnel.

All information disclosed to a public health authority is confidential and not to be released to outside parties as stipulated by Neb. Rev. Stat. § 71-503.01.

1-007.05 Significant Exposure to Infectious Disease or Condition: Neb. Rev. Stat. §§ 71-507 to 71-513 address the risk of significant exposure of emergency services providers to infectious diseases or conditions, and Neb. Rev. Stat. §§ 71-514.01 to 71-514.05 address the risk of significant exposure of health care providers to infectious diseases or conditions.

1-007.05A For the purpose of implementing these statutes, infectious disease or condition means:

1. Hepatitis B;
2. Hepatitis C;
3. Meningococcal meningitis;
4. Active pulmonary tuberculosis;
5. Human immunodeficiency virus infection;
6. Diphtheria;
7. Plague;
8. Hemorrhagic fevers; and
9. Rabies.

1-007.05B Significant Exposure Report Form for Emergency Services Providers: For the purpose of implementing Neb. Rev. Stat. § 71-508, the form to be used by the emergency services provider to document information necessary for notification of

significant exposure to an infectious disease or condition is Attachment F, incorporated in these regulations by this reference. Emergency services providers are responsible for reproduction of the form for use in the notification procedure.

1-008 RABIES: Cases of human and animal rabies are reportable under 173 NAC 1-004.01. Rabies control is governed by Neb. Rev. Stat. §§ 71-4401 to 71-4412 and 173 NAC 5, Rabies Control Program. Copies of these rules and regulations are available from the DHHS Division of Public Health, Rabies Surveillance, and online at http://www.dhhs.ne.gov/reg/t173.htm.

ATTACHMENTS

Certain attachments to 173 NAC 1 are also available online at http://public-dhhs.ne.gov/FORMS/Home.aspx by searching for the form number (in parentheses following the name of the form below).

ATTACHMENT A	Reportable Diseases, Poisonings, and Organisms – Health Care Provider Confidential Communication (HHS-9)
ATTACHMENT B	Laboratory Summary of Reportable Diseases, Poisonings, and Organisms (HHS-10)
ATTACHMENT C	Adult HIV/AIDS Confidential Case Report
ATTACHMENT D	Pediatric HIV/AIDS Confidential Case Report
ATTACHMENT E	Antimicrobial Resistance Surveillance (Laboratory-Based) (HHS-17)
ATTACHMENT F	Significant Exposure Report Form for Emergency Services Provider or Public Safety Official (PHA-14)

TITLE 173 - NEBRASKA DEPARTMENT OF HEALTH/CONTROL OF COMMUNICABLE DISEASE/REGULATIONS

CHAPTER 2 - RULES AND REGULATIONS GOVERNING CARE OF TUBERCULOUS PERSONS

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TITLE 173 - NEBRASKA DEPARTMENT OF HEALTH

CHAPTER 2 - RULES AND REGULATIONS GOVERNING CARE OF TUBERCULOUS PERSONS

001 DEFINITIONS. As used in these Rules and Regulations, unless the context to be intelligible or to prevent absurdity otherwise requires:

001.01 Department shall mean the Department of Health of the State of Nebraska.

001.02 Drugs or medications shall mean only those types of drugs and other medications specifically authorized by the Department of Health as appropriate for the care, treatment or maintenance of persons afflicted with communicable tuberculosis, or as otherwise approved as necessary and proper by the Department.

001.03 Health Care Facility shall mean any health care facility other than a hospital, licensed by the Department of Health pursuant to Chapter 71, article 20, Reissue Revised Statutes of Nebraska, 1943 and under contract to the Department of Health for the care, treatment or maintenance of communicable tuberculous persons.

001.04 Hospital shall mean any hospital licensed by the Department of Health pursuant to Chapter 71, article 20, Reissue Revised Statutes of Nebraska, 1943 and under contract to the Department of Health for the care, treatment or maintenance of communicable tuberculous persons.

001.05 Third Party Payer shall mean any individual, firm, partnership, corporation, company, association or any other entity responsible for, or otherwise under an obligation to provide, the payment of all or part of the cost of the care, treatment or maintenance or of the transportation of a tuberculous person; but such term shall not mean the tuberculous person himself, any health care practitioner or any hospital or other health care facility providing services to such person, or the Department of Health.

001.06 Tuberculosis Consultant shall mean a physician licensed in the State of Nebraska who, associated with a hospital or other health care facility under contract to the Department of Health for the care, treatment or maintenance of communicable tuberculous persons, well versed in the current tuberculosis management and treatment practices, and acting

under the supervision of the Department of Health, advised the Department on each case of communicable tuberculosis occurring in hospitals and other health care facilities under contract to the Department in his specifically assigned region of the state (or as otherwise agreed upon between the physician and the Department) and on the appropriate method of treatment of the same.

001.07 Tuberculosis Person shall mean a person afflicted with communicable tuberculosis.

002 PROVIDERS OF CARE

002.01 Health Care Facilities. In order to provide an effective program of care, treatment and maintenance for those persons infected with communicable tuberculosis the Department of Health of the State of Nebraska is authorized to contract with qualified licensed hospitals or other licensed health care facilities throughout the State of Nebraska for the provision of immediate acute care and other necessary care for such persons. All such contracting facilities must be able to effectively prevent the transmission of tubercle bacilli through the heating-cooling system of the facility and be otherwise capable of caring for, treating and maintaining tuberculous persons. Only inactive, arrested cases, which are not considered infectious, shall be accepted as residents or cared for in a home for the aged, or infirm unless otherwise specifically authorized by the Department of Health pursuant to prescribed conditions. All such contracting facilities must also comply with all applicable provisions of these Rules and Regulations, including, but not limited to, Sections 003, 004, and 005.

002.02 Tuberculosis Consultants. The Department of Health shall enter into arrangements with physicians who are associated with hospitals or other health care facilities under contract to the Department of Health for treatment, care, or maintenance of the tuberculosis and who are well versed in the Current tuberculosis management and treatment practices, whereby such physicians shall act as regional tuberculosis consultants on behalf of the Department of Health. Such Regional Tuberculosis Consultants shall act under the supervision of the Department of Health.

003 PROGRAM PROCEDURES

003.01 Admission of Patients. The admission of patients into a contracting hospital or other health care facility for tuberculosis services must be authorized by the Regional Tuberculosis Consultant assigned to such participating hospital.

003.01A Diagnostic admissions will be authorized by the appropriate Tuberculosis Consultant. The duration of the patient's admission will be adjudged by the Consultant.

003.01B Therapeutic admissions will be authorized by the appropriate Tuberculosis Consultant. The duration of the patient's hospitalization or other care will be continued as long as medically indicated. A transfer to an extended care or domiciliary type of facility, including a home for the aged or infirm (nursing home), shall be implemented upon the authorization of the Consultant.

003.01C Prior to a patient's admission to the Tuberculosis Consultant will prescribe the tuberculosis services indicated. He may choose to:

003.01C1 require the presentation of the patient for examination,

003.01C2 review medical records or other information pertaining to the case,

003.01C3 consult with the referring physician,

003.01C4 visit with or review medical records of patients currently hospitalized or otherwise cared for other reasons,

003.01C5 if the hospital authorized to do cultures for mycobacterium tuberculosis has a culture identified as positive for mycobacterium tuberculosis, this culture or a subculture is required to be sent to the State Health Laboratory, or

003.01C6 perform any other necessary act that may be medically advisable for the patient's welfare, as authorized by the Department.

003.02 Determination of Consultant. If there is any difference of medical opinion between the Tuberculosis Consultant and the patient's physician, the determinations of the Consultant, insofar as payment for services by the Department is concerned, shall prevail. Continued hospitalization or other care, when not recommended by the Tuberculosis Consultant, shall in all such instances be at the expense of the patient or any responsible third party payer, not the Department. In such cases, payment by the Department shall terminate with the day on which the Patient is considered eligible for discharge by the Tuberculosis Consultant. In any such case of difference of medical opinion, the Tuberculosis Consultant shall transmit notice of his recommendations accompanied by the recommendations of the patient's physician of record to the Department no less than five (5) days before or no more than five (5) days after the date that the disputed services or event is scheduled to occur or has occurred respectively. These statements shall become A part of the patient's record and shall be used primarily to determine action for billing and for payment purposes.

003.03 Eligibility for Admission. There shall be medical, financial and residency requirements for admission.

003.03A Reasonable evidence must be presented that the patient is either bacteriologically active or strongly suspected of being so. Such evidence shall include a positive tuberculin test (10 mm. or more of induration to a 5TU Mantoux), or x-ray evidence compatible with tuberculosis, or the demonstration of acid fast bacilli or M. tuberculosis. The recent exposure of an individual and signs or symptoms in themselves merely warrant consultation rather than admission. However, the Tuberculosis Consultant must be satisfied that in-patient services are required.

003.03B Financial restrictions imposed for admission eligibility on a patient shall be as prescribed in Section 009. The hospital or other health care facility will bill third party payers as applicable. Any payment received by the hospital or other health care facility from such sources will be credited to the hospital or facility charges before a statement is submitted for allowable balances to the Department.

003.03C There shall be no residency restrictions or requirements relative to the length of residency except that a person must be a legal resident of the State of Nebraska. Exceptions may be made in the case of residents of other states who might choose to be cared for in Nebraska provided that financial commitments are first affirmed by the appropriate officials or other responsible persons in the state of legal residency.

003.04 Notice of Admission. A notice of admission for tuberculosis services will be mailed to the Department of Health preferably within forty-eight (48), but no later than seventy-two (72), hours of admission upon forms provided by the Department.

003.05 Physician Services. The patient's private physician shall be encourage to provide primary management during the stay in the hospital or other health care facility consistent with the hospital or facility policies regarding Physician Privileges. However, he may choose to relinquish the tuberculosis case management to the Tuberculosis Consultant. In either case there shall be consultation between the private physician and the Tuberculosis Consultant no less frequently than once every two weeks with notice given to the Department prior to any surgery for tuberculosis or any other surgical procedures except in case of medical emergency, regardless of whether or not the Department will be billed, and also prior to discharge from the hospital or other health care facility or transfer to another level of care.

004 IN-PATIENT SERVICES - HOSPITAL SERVICES

004.01 Follow-up and Support. A nurse from a local health department or one from the Department of Health or both shall visit the patients after

admission and during their stay in order to insure that all appropriate epidemiology is performed and to effect a continuity of care after discharge or transfer from the in-patient tuberculosis service.

The Tuberculosis Consultant and the patient's private physician shall be advised prior to all such visits; the nurses shall provide each physician with a written summary of the results of such visits. The patient's records shall be made available to such public health nurses.

004.02 Medical Services. All services customarily provided by the contracting hospital shall be made available to patients hospitalized for tuberculosis, including services for the management of acute problems which are present at admission or arise during hospitalization for tuberculosis and for maintenance management of pre-existing chronic conditions, except as required by this Section 004.

The Tuberculosis Consultant shall review each case:

004.02A To determine the need for continued hospitalization every two weeks.

004.02B Prior to any surgery and must be consulted prior to any surgical procedure except in case of medical emergency.

004.02C Prior to any elective procedure; certain elective procedures such as herniorraphy shall not be authorized by the Department and if performed must be at the expense of the patient or other responsible party.

004.02D Prior to any extraordinary surgical procedures; extraordinary surgical procedures such as open heart or organ transplants shall not be authorized by the Department and if performed must be at the expense of the patient or other responsible party.

004.02E Prior to the institution of private duty nursing, which must be authorized by the Tuberculosis Consultant before any payment will be allowed by the Department; generally, the provision of private duty nursing shall be limited to those instances in which cardiac or other intensive care facilities are necessary but not available or when, in the opinion of the Tuberculosis Consultant, transfer to such a facility is contraindicated.

004.03 Nursing Services. All customary nursing services provided by the contracting hospital Shall be available to the patient hospitalized for tuberculosis services.

004.04 Rehabilitative Services. The usual rehabilitative services offered by the contracting hospital shall be available to patients hospitalized for

tuberculosis services. Such services shall include physical therapy, occupational therapy, and speech therapy; however, all such services must be authorized by the Tuberculosis Consultant in writing.

004.05 Social Services. Social services customarily provided by the contracting hospital shall be available to patients hospitalized for tuberculosis services. Such services are especially important to many tuberculosis patients such as those patients who are elderly and without funds; hence, such services must be provided whenever available. In many cases there will be a need for continuing assistance in regard to obtaining services from other categorical aid programs and in regard to the subsequent transfer or discharge from the tuberculosis program of care and treatment.

005 IN-PATIENT SERVICES - EXTENDED CARE FACILITIES

005.01 Homes for Aged or Infirm. The nature of each individual patient's problem shall be evaluated in terms of his response to his medical care and to his social and economic background. Those patients requiring some type of extended nursing care rather than hospitalization per se shall be placed in hospitals or homes for the aged or infirm (nursing homes) licensed and approved by the Department for such particular type of care. Such patients or residents shall have the benefit of appropriate medical supervision, clinical laboratory services, and rehabilitative, social and supportive services as necessary.

005.02 Personal Care Homes. Those other patients, such as the homeless patient, who are in need of medication for tuberculosis but are unreliable, for reasons such as alcoholism, and therefore remain as continuing potential hazards to public health, require someone to insure that their evaluations are performed on schedule. Such patients shall be cared for in a Personal care type of home for the aged or infirm, an alcoholic treatment center, or other appropriate health care facility.

006 TRANSFER AND DISCHARGE PROCEDURE

006.01 Authority for Transfer. The Tuberculosis Consultant must give a written recommendation for the transfer to another level of service of any patient admitted to a contracting hospital or other health care facility for either diagnostic or therapeutic tuberculosis services for which any unpaid balances will be the responsibility of the Department of Health. Transfer to another level of care, such as from a hospital to a home for the aged or infirm, will be authorized by the Department only upon recommendation of the Tuberculosis Consultant. The recommendation must be in writing and sent to the administrator or to the social service department or its functional counterpart of the contracting hospital or other health care facility and to the Department of Health at least five days prior to the prospective date of transfer. The department, after affirming such

recommendation, shall arrange for such care as is ordered and advise the social service coordinator of the hospital or other health care facility of the location of the facility to which the patient is to be transferred. Such notice shall be by telephone, but, if required, confirmatory written statements from both parties may be submitted after the fact.

006.02 Notice of Discharge. The Tuberculosis Consultant must have given written recommendation for the discharge from a contracting hospital or other health care facility of any person afflicted with communicable tuberculosis for which any expenses will be the responsibility of the Department of Health. Actual notice of discharge from a contracting health care facility shall precede the event by no less than five days. Notification by the Department following affirmation of the recommendation, may first be made by telephone but it must be confirmed by a written referral. The written referral must include a medical diagnosis, a copy of the laboratory slip if culture is done at admitting hospital, and medical, nursing, and social service recommendations as well as the type and daily amount of drugs ordered. The referral shall also include an outline of the planned medical follow-up care by the patient's physician or by an out-patient clinic; notice of an appointment and its delivery to a patient must be provided.

007 PAYMENT FOR SERVICES

007.01 Arbitration. A contract between the Department of Health and a contracting hospital or other health care facility shall include a provision for arbitration of disputes by third parties. Such arbitration clause shall require each party to the contract to Select an arbitrator within a period of thirty (30) days after both parties agree that an impasse has been reached relative to a disagreement concerning the correct interpretation of a contractual provision. There shall then be another thirty (30) day period in which these two arbitrators shall select a third. neutral person. Within fifteen (15) days after the selection of the arbitration panel, it shall commence its duties.

007.02 Mode of Payment. The Department shall reimburse a contracting hospital or other health care facility for its provision of those services authorized by the Tuberculosis Consultant and the Department, but only after payment by any third party payer responsible for, or otherwise under obligation to provide, the payment of the costs of the care, treatment, or maintenance of a person suffering from communicable tuberculosis. Statements of all inclusive charges must be submitted to the Department no more than thirty (30) days following the day of discharge or transfer, or the day on which hospitalization or other care in a contracting hospital or other health care facility is considered no longer necessary for tuberculosis but is indicated for other reasons. Statements must be submitted on an original billhead. Each statement must contain the name, age, address,

and social security number of the patient, the dates of admission (or service start) and discharge (or service stop), and an itemized listing of charges with balance owed. It shall be the responsibility of the billing office of the hospital or other health care facility to determine the availability of and to submit statements to responsible third party payers. Any applicable third party payer must be billed and its payment received or otherwise acknowledged in manner satisfactory to the Department and the hospital or other health care facility before any final billing showing balance due is submitted to the Department.

007.03 Non-Participating Facility. Payment may be provided by the Department for diagnostic services rendered to a patient in a non-participating and non-contracting hospital or other health care facility which results in transfer of the patient to the tuberculosis service of a contracting hospital or other health care facility. Such situations shall be individually evaluated.

007.04 Rates of Reimbursement. No contract between the Department of Health and a hospital or other health care facility shall be longer than one year in duration. The rate of reimbursement paid by the Department to such hospital or other health care facility pursuant to such contract for care, treatment or maintenance of persons infected with communicable tuberculosis shall not exceed the applicable Medicare (Title XVIII of the Social Security Act) prevailing interim rate or Medicaid (Title XIX of the Social Security Act) prevailing interim rate for such persons.

008 RECORDS

008.01 Medical Records. The medical records of a patient shall be available to Tuberculosis Consultant and to the Department of Health whenever requested. A discharge summary of the period of hospitalization or other care for which the Department is to be billed shall accompany, or shall have been submitted prior thereto, the request of the hospital or other health care facility for payment. Since tuberculosis is a communicable disease requiring epidemiological follow-up, since the Department maintains a registry of all tuberculosis patients, and since the Department is responsible for insuring that all such patients are provided with continuing care, a discharge summary of the period of hospitalization or other care for diagnosis or treatment of any tuberculosis patient, regardless of the source of payment, shall be transmitted by the contracting hospital. or other health care facility to the Department within five days after his discharge.

009 PATIENT FINANCIAL ELIGIBILITY

009.01 Limitations on Assistance. The Department of Health will assist patients within budget limitations, who are unable to pay for their own care in whole or in part.

The Department shall consider each patient's income, age, the ages and physical condition of his dependents, his assets, and his liabilities before authorizing any care, treatment or maintenance in a contracting hospital or other health care facility for which payment can be made. Such determinations shall take into account the medical evaluations of the Tuberculosis Consultant. No payment shall be made for any services not significantly related to the care, treatment or maintenance of an individual infected with communicable tuberculosis, as determined by the Department.

009.02 Patient Resources - Exclusions. The following economic resources of a patient shall not be considered as excluding him from eligibility for assistance by the Department:

009.02A Personal property, such as income-producing equipment, inventory of a small business, or tools shall not be considered as a resource if such property is needed to produce income during or following care, treatment, or maintenance.

009.02B Ownership of a residence and contiguous land will be regarded as the patient's homestead and will not be considered as a resource.

009.02C Personal property such as household furniture, life insurance policies, and an automobile will not be considered in determining economic need.

009.02D Property will not be considered as a resource when it represents an income-producing enterprise and the net income derived therefrom is within the normal living requirements.

In such determinations both the income and the estate of the patient are to be considered. Where there are spouse and children, the estate will not be depleted to the extent that the spouse and children are likely to be pauperized in the case of extensive treatment or care of the patient.

009.03 Third Party Payers. The Department of Health shall not pay for any patient care, treatment, maintenance or transportation to the extent that assistance is available through other sources or that third party payers are required to provide the same.

SOURCE: Section 71-3613(5)

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 3 SCHOOL HEALTH, COMMUNICABLE DISEASE CONTROL, AND IMMUNIZATION STANDARDS

3-001 SCOPE AND AUTHORITY: These regulations are intended to implement Neb. Rev. Stat. §§ 79-217 to 79-223.

3-002 DEFINITIONS: For purposes of these regulations:

Booster dose means a dose of vaccine given after the initial series to enhance waning immunity to specific disease(s).

Child or children means any student or students enrolled in a public or private elementary or secondary school system in Nebraska.

Department means the Department of Health and Human Services.

Local health department means a county, district, or city-county health department approved by the Department of Health and Human Services as a local full-time public health service.

Reportable communicable disease means those diseases which are required by law to be reported pursuant to 173 NAC 1.

3-003 SYMPTOMS OF COMMUNICABLE DISEASE; EXCLUSION FROM SCHOOL: Children showing any signs or symptoms of a contagious or infectious disease are required by law to be sent to their homes immediately, or as soon as safe and proper conveyance can be found.

Teachers are encouraged to observe each child carefully for signs of illness each time the child returns to school. This is particularly important when epidemic diseases are known to be present in the community.

The presence of one or more of the following signs or symptoms should make the teacher suspect a communicable disease:

Fever, flushed face, headache, aches in muscles or joints, unexplained tiredness or listlessness, loss of appetite, stomach ache, nausea or vomiting, diarrhea, convulsions, sore throat, nasal congestion or discharge, unexplained skin eruption, sore or inflamed eyes.

3-004 REPORTING

3-004.01 Suspected Contagious or Infectious Disease: When a child is sent home because of a suspected contagious or infectious disease, the law requires the proper school authority, school board, or board of education to be notified without delay.

3-004.02 Suspected Reportable Disease: When a school nurse or an individual acting in the capacity of a school nurse identifies a case or suspected case of a reportable disease, s/he must report that case to the local public health department or the DHHS Division of Public Health as provided in 173 NAC 1-007.04.

3-005 DURATION OF EXCLUSION PERIOD: Children excluded for a confirmed communicable disease should not be allowed to return to school until the minimum isolation period has elapsed, and all signs or symptoms of acute illness have disappeared. The period of exclusion should extend throughout the period when acute signs of illness are present, or until the student is fever-free for 24 hours without the use of fever-reducing medication.

Minimum isolation periods are shown in the table on Attachment 1, Contagious and Infectious Disease/Condition Chart, which is attached to 173 NAC 3 and incorporated by this reference. School boards and boards of education may observe these periods, or adopt and enforce their own exclusion regulations which may not be shorter or less restrictive than those contained in 173 NAC 3.

3-006 EXCLUSION OF HEALTH CONTACTS: With a few exceptions (which are shown in the table on Attachment 1) there are no restrictions placed upon the health contacts of communicable diseases by these regulations; consequently, they may attend school unless the local health department, board of health, school board or board of education has adopted rules and regulations to the contrary. If officials consider exclusion of health contacts necessary, it is suggested that whenever possible this be confined to the latter portion of the incubation period and enforced only for those children who are not known to be immune.

3-007 (RESERVED)

3-008 IMMUNIZATION STANDARDS: Each student must be protected by immunization against the following diseases, unless otherwise exempted from this requirement under the provisions of 173 NAC 3-010:

Measles	Diphtheria	Invasive pneumococcal disease
Mumps	Tetanus	
Rubella	Pertussis	
Polio	Haemophilus Influenzae type b (Hib)	
Hepatitis B	Varicella	

3-008.01 For the purposes of complying with the requirement of immunization against the diseases listed above:

3-008.01A Students 2-5 years of age enrolled in a school-based program not licensed as a child care provider are considered to be immunized if they have received:

3 doses of hepatitis B vaccine;
4 doses of DTaP, DTP, or DT vaccine;
3 doses of polio vaccine;
1 dose of MMR vaccine given no earlier than 4 days before the first birthday;
3 doses of hib vaccine or 1 dose of hib vaccine given at or after 15 months of age;
1 dose of varicella vaccine; and
4 doses of pneumococcal vaccine or 1 dose of pneumococcal vaccine given at or after 15 months.

3-008.01B Students enrolling for the first time (kindergarten or 1st grade, depending on the school district's entering grade), enrolling in 7th grade, and all transfer students from outside the state regardless of the grade they are entering are considered immunized if they have received:

3 doses DTaP, DTP, DT, or Td vaccine with at least 1 dose given no earlier than 4 days before 4 years of age;
3 doses of polio vaccine;
2 doses of MMR vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days;
3 doses of pediatric hepatitis B vaccine, or, if the alternate hepatitis B vaccination schedule is used, 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age; and
2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.

Students enrolling in 7th grade must provide evidence of having 1 booster dose of a tetanus, diphtheria, and pertussis (Tdap) vaccine, given on or after 7 years of age.

3-008.01C All other students are considered immunized if they have received:

3 doses of DTaP, DTP, DT, or Td vaccine, with at least 1 dose given no earlier than 4 days before 4 years of age;
3 doses of polio vaccine;
2 doses of MMR vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days;
3 doses of hepatitis B vaccine; and
2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.

3-009 REQUIRED EVIDENCE OF IMMUNIZATION

3-009.01 For purposes of compliance with the immunization requirement, the board of education or school board or other governing authority, must require the presentation of

an immunization history which includes the name of the vaccine and the month, day, and year of administration.

3-009.02 Laboratory evidence of circulating antibodies for measles, mumps, or rubella constitutes evidence of immunity against those diseases provided the following information is supplied: name of laboratory, date of test, name of test, test result, signature of laboratory technician performing the test or of the laboratory director, and date of signature. For purposes of compliance with this rule, clinical history of measles, mumps, or rubella without laboratory or epidemiologic confirmation does not constitute evidence of immunity.

3-009.03 Epidemiologic confirmation of a diagnosis means that the clinical history of measles, mumps, or rubella is corroborated by association with laboratory proven case(s) and that such epidemiologic case(s) have been reported to and counted by the Department.

3-009.04 A documented history of varicella disease from a parent or health care provider with the year of infection constitutes evidence of immunity to varicella. The documentation must include one of the following:

1. Signature of the parent or legal guardian and the date (year) of the child's varicella illness, or
2. Signature of a health care provider and the date (year) of the child's varicella illness, or
3. Laboratory evidence of a child's varicella immunity, or
4. A clinical diagnosis of shingles.

3-010 MEDICAL AND RELIGIOUS EXEMPTION; PROVISIONAL ENROLLMENT: Each student must be protected against the diseases listed using the standards described in 173 NAC 3-008 and submit evidence of immunization as described in 173 NAC 3-009. Any student who does not comply with these requirements must not be permitted to enroll in school, except as provided in 173 NAC 3-010.01 through 3-010.03.

3-010.01 Immunization is not required for a student's enrollment in any school in this state if he or she submits to the admitting official either of the following:

3-010.01A A statement signed by a physician, physician assistant, or nurse practitioner stating that, in the health care provider's opinion, the specified immunization(s) required would be injurious to the health and well-being of the student or any member of the student's family or household; or

3-010.01B A notarized affidavit signed by the student or, if he or she is a minor, by a legally authorized representative of the student, stating that the immunization conflicts with the tenets and practice of a recognized religious denomination of which the student is an adherent or member or that immunization conflicts with the personally and sincerely followed religious beliefs of the student.

3-010.02 A student may be provisionally enrolled in a school in Nebraska if he or she has begun the immunizations against the specified diseases prior to enrollment and continues the necessary immunizations as rapidly as is medically feasible. For purposes of complying with these requirements:

3-010.02A A student is considered to have begun immunizations against polio, diphtheria, tetanus, pertussis, hepatitis B, measles, mumps, and rubella and varicella if he or she has had at least one dose of DTaP/DTP/DT/Td, one dose of hepatitis B, one dose of either trivalent OPV or one dose of IPV, either one dose of the combined measles, mumps, and rubella vaccine or one dose of each vaccine for measles, mumps, and rubella, and one dose of varicella vaccine.

3-010.02B Continuation of necessary immunizations as rapidly as is medically feasible must be documented by a written statement from the student's immunization provider which shows the scheduled dates to complete the required immunization series. Failure to receive the necessary immunizations as rapidly as is medically feasible will result in exclusion of the student from attending school until either documentation of immunization or a medical statement or religious affidavit is provided to the school. The time interval for the completion of the required immunization series must not exceed nine months.

3-010.03 A student may also be provisionally enrolled in a school in Nebraska if he or she is the child or legal ward of an officer or enlisted person, or the child or legal ward of the spouse of such officer or enlisted person on active duty in any branch of the military services of the United States, and said student is enrolling in a Nebraska school following residence in another state or in a foreign country.

3-010.03A As a condition for the provisional enrollment of a student under this Section, a parent or adult legal guardian of the student must provide the school with a signed written statement certifying that the student has completed the course of immunizations required by 173 NAC 3-008.

3-010.03B The provisional enrollment of a student qualified for such enrollment under 173 NAC 3-010.03 must not continue beyond 60 days from the date of such enrollment. At such time, the school must be provided, with regard to said student, written evidence of compliance with 173 NAC 3-008. The student must not be permitted to continue in school after such date until evidence of compliance is provided.

3-011 TIME OF COMPLIANCE: Each student must present documentation as outlined in 173 NAC 3-009 and 3-010 prior to enrollment.

3-012 REPORTING REQUIREMENTS: A report to the Department summarizing immunization status is required by November 15 of each year from the board of education or school board of each school district, or other governing authority of the school. The report must include the following information regarding those entering school for the first time (kindergarten or 1st grade), those entering the 7th grade, and all transfer students from outside the state (excluding the entering and 7th grades):

3-012.01 For children in the entering grade (kindergarten or 1st grade depending on the school district's entering grade):

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Diphtheria, tetanus, and pertussis (DTP/DTaP/DT/Td):
   a. The number of students with 3 or more doses of DTP/DTaP/DT/Td, with at least one dose given at or after 4 years of age.
   b. The number of students with medical exemptions on file for diphtheria, tetanus, and pertussis.
   c. The number of students with religious exemptions on file for diphtheria, tetanus, and pertussis.
   d. The number of students provisionally enrolled.
4. Polio (IPV/OPV):
   a. The number of students with 3 or more doses of polio vaccine.
   b. The number of students with medical exemptions on file for polio.
   c. The number of students with religious exemptions on file for polio.
   d. The number of students provisionally enrolled.
5. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
6. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
7. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.

3-012.02 For children entering 7th grade:

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR, with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
4. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
5. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the two doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.
6. Beginning July 2010, and thereafter, one booster dose containing tetanus, diphtheria and pertussis (Tdap):
   a. The number of students with 1 dose of Tdap (tetanus, diphtheria and pertussis).
   b. The number with a medical exemptions on file for Tdap.
   c. The number of students with religious exemptions on file for Tdap.
   d. The number of students provisionally enrolled.

3-012.03 For transfer students from outside the state:

1. The total number of students enrolled.
2. The total number of students with an exemption on file or who are in the process of completing immunizations.
3. Measles, mumps, and rubella (MMR):
   a. The number of students with 2 doses of MMR, with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students presenting laboratory evidence of circulating antibodies or epidemiologic confirmation of measles, mumps, and rubella.
   c. The number of students with medical exemptions on file for MMR.
   d. The number of students with religious exemptions on file for MMR.
   e. The number of students provisionally enrolled.
4. Hepatitis B:
   a. The number of students with 3 doses of pediatric hepatitis B, or, if the alternate hepatitis B vaccination schedule is used, the number of students with 2 doses of a licensed adult hepatitis B vaccine specified for adolescents 11-15 years of age.
   b. The number of students with medical exemptions on file for hepatitis B.
   c. The number of students with religious exemptions on file for hepatitis B.
   d. The number of students provisionally enrolled.
5. Varicella:
   a. The number of students with 2 doses of varicella vaccine with the first dose given no earlier than 4 days before the first birthday and the 2 doses separated by at least 28 days.
   b. The number of students with documented history of varicella disease on file.
   c. The number of students with medical exemptions on file for varicella.
   d. The number of students with religious exemptions on file for varicella.
   e. The number of students provisionally enrolled.
   f. The number of students with a documented clinical diagnosis of shingles.

3-012.04 The abbreviated reporting requirements for entering 7th graders and transferring students do not exempt them from meeting the immunization standards outlined in 173 NAC 3-008.01B.

CONTAGIOUS AND INFECTIOUS DISEASES/CONDITIONS

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Chickenpox	2-3 weeks	Fever, skin eruption begins as red spots that become small blisters (vesicles) and then scab over.	For up to 5 days before eruption until all lesions are crusted.	Exclude until all lesions are crusted; avoid contact with susceptibles. No exclusion of contacts. Alert parents of immune-suppressed child(ren) of possible exposure.
Conjunctivitis (Pink Eye)	24-72 hours	Redness of white of eye, tearing, discharge of pus.	During active phase of illness characterized by tearing and discharge.	Exclude symptomatic cases. Urge medical care. May return when eye is normal in appearance or with documentation from physician that child is no longer infectious. No exclusion of contacts.
Coryza (Common Cold)	12-72 hours	Nasal discharge, soreness of throat.	One day before symptoms and usually continuing for about 5 days.	Exclusion unnecessary. No exclusion of contacts.
Diphtheria	2-5 days	Fever, sore throat, often gray membrane in nose or throat.	Usually 2 weeks or less. Seldom more than 4 weeks.	Exclude cases. Return with a documented physician approval. Exclude inadequately immunized close contacts as deemed appropriate by school officials following investigation by the local and/or Nebraska Department of Health and Human Services. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Enterobiasis (Pinworm, Thread-worm, Seatworm)	Life cycle about 3-6 weeks	Irritation around anal region. Visible in stool.	As long as eggs are being laid; usually 2 weeks.	Exclude until treated as documented by physician. No exclusion of contacts. Careful handwashing essential.
Fifth Disease	Estimated at 6-14 days	Minimal symptoms with intense red "slapped cheek" Appearing rash; lace-like rash on body.	Unknown.	Exclude until fever and malaise are gone. May return with rash; no longer contagious once rash appears. No exclusion of contacts; however, alert any students or staff who are pregnant, have chronic hemolytic anemia or immunodeficiency to consult their physician.
Hand, Foot and Mouth	3-5 days	Fever, sore throat, elevated blisters occurring on hands, feet or in the mouth.	During acute illness, usually one week. Spread through direct contact with nose and throat discharge and aerosol droplets.	Exclude cases during acute phase and until fever-free for 24 hours without the use of fever-reducing medication.
Hepatitis A	15-50 days, average 28-30 days	Fever, nausea, loss of appetite, abdominal discomfort and jaundice.	Two weeks before jaundice until about 7 days after onset of jaundice.	Exclude for no less than 7 days after onset of jaundice. Return with documented physician approval. No exclusion of contacts. Immune globulin (IG) or hepatitis A vaccine prevents disease if given within two weeks of exposure. IG to family contacts only. Careful handwashing essential.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Herpes Simplex (Type 1)	2-12 days	Onset as clear vesicle, later purulent. Following rupture, scabs and in 1-2 weeks, heals. Commonly about lips and in mouth.	For a few weeks after appearance of vesicle.	Exclusion unnecessary. No exclusion of contacts. Avoid contact with immunesuppressed or eczematous persons. Good personal hygiene, avoid sharing toilet articles.
Impetigo	4-10 days	Running, open sores with slight marginal redness.	As long as lesions draining and case hasn't been treated.	Exclude until brought under treatment and acute symptoms resolved. No exclusion of contacts. Good personal hygiene is essential. Avoid common use of toilet articles.
Influenza	24-72 hours	Fever and chills, often back or leg aches, sore throat, nasal discharge and cough; prostration.	A brief period before symptoms until about a week thereafter.	Exclude for duration of illness. No exclusion of contacts.
Measles (Rubeola)	10-14 days	Begins like a cold; fever, blotchy rash, red eyes, hacking frequent cough.	5 days before rash until 4 days after rash.	Exclude for duration of illness and for no less than 4 days after onset of rash. Exclude unimmunized students on same campus from date of diagnosis of first case until 14 days after rash onset of last known case or until measles immunization received or laboratory proof of immunity is presented or until history of previous measles infection is verified as per records or the Nebraska Department of Health and Human Services. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Meningitis (bacterial)	3-4 days with a range of 2-10 days	Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, and altered mental status	Infectious until 24 hours into antibiotic course	Local or state health authorities will determine appropriate follow-up and investigation on a case-by-case basis. Student should be excluded from school until antibiotic course has been initiated and symptoms have fully resolved, and may return with medical clearance.
Meningitis (viral)	3-7 days	Sudden onset of fever, headache, stiff neck, nausea, vomiting, sensitivity to light, sleepiness, altered mental status; rubella-like rash may be present.	Infectious until symptoms have fully resolved.	Active illness seldom exceeds 10 days. Student should be excluded from onset of symptoms until full resolution, and may return with medical clearance.
MRSA (staph bacterial infection)	Variable and indefinite.	Skin lesion; can take on different forms.	As long as purulent lesions drain or the carrier state persists.	Exclusion unnecessary unless directed by physician. Keep lesions covered at school. Good handwashing and sanitation practices; no sharing of personal items.
Mumps (Epidemic Parotitis)	2-3 weeks	20-40% of those infected do not appear ill or have swelling. 60-70% have swelling with pain above angle of lower jaw on one or both sides.	About 7 days before gland swelling until 9 days after onset of swelling or until swelling has subsided.	Exclude 5 days from onset of swelling in the neck. No exclusion of contacts. Inform parents of unimmunized students on campus of possible exposure and encourage immunization.
Pediculosis (Infestation with head or body lice)	Eggs of lice hatch in about a week; maturity in about 2-3 weeks	Itching; infestation of hair and/or clothing with insects and nits (lice eggs).	While lice remain alive and until eggs in hair and clothing have been destroyed. Direct and indirect contact with infested person	Nits are not a cause for school exclusion. Parents of students with live lice are to be notified and the child treated prior to return to school. Only persons with active infestation need be treated. Avoid head-to-head contact. No exclusion of contacts.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
			and/or clothing required.	
Pertussis (Whooping Cough)	7 days – usually within 10 days	Irritating cough – symptoms of common cold usually followed by typical whoop in cough in 2-3 weeks.	About 7 days after exposure to 3 weeks after typical cough. When treated with erythromycin, 5-7 days after onset of therapy.	Exclude until physician approves return per written documentation. Exclude inadequately immunized close contacts as deemed appropriate by school officials following investigation by the local and/or state Department of Health and Human Services. Chemoprophylaxis may be considered for family and close contacts. ***Report immediately by telephone*** all cases to local and/or state health departments.
Poliomyelitis (Infantile Paralysis)	3-35 days; 7-14 days for paralytic cases	Fever, sore throat, malaise, headache, stiffness of neck or back, muscle soreness.	Not accurately known. Maybe as early as 36 hours after infection; most infectious during first few days after onset of symptoms.	Exclude until physician approves return. Report immediately by telephone.
Ringworm (Tinea Infections)	10-14 days	Scaly oval patches of baldness of scalp; brittle and falling hair, scaly oval lesions of skin.	As long as infectious lesions are present, especially when untreated.	No exclusion of contacts. Good sanitation practices and don't share toilet articles. If affected areas cannot be covered with clothing/dressing during school, exclude until treatment started.
Rubella (German Measles)	14-21 days	Low-grade fever, slight general malaise; scattered Measles-like rash; duration of approximately 3 days.	About one week before rash until 7 days after onset of rash.	Exclude for duration of illness and for no less than 4 days* after onset of rash. Exclude unimmunized students on same campus from date of diagnosis of first case until 23* days after rash onset of last known case or until rubella immunization received or laboratory proof of immunity is presented. ***Report immediately by telephone*** all cases to local and/or state health departments.

DISEASE / CONDITION	INCUBATION PERIOD *	SYMPTOMS OF ILLNESS	INFECTION PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Scabies	Infection caused by almost invisible mite. Lesions symptomatic after 4-6 weeks.	Severe itching; lesions around loose fleshy tissue (e.g., finger webs, elbows, crotch, etc.)	Until mites and eggs destroyed.	Exclude until the day after treatment is started. No exclusion of contacts.
Shingles / Herpes Zoster	Latent form after primary infection with chickenpox.	Grouped small blisters (vesicles) often accompanied by pain localized to area	Physical contact with vesicles until they become dry.	Exclude children with shingles / zoster if the vesicles cannot be covered until after the vesicles have dried. Individuals with shingles /zoster should be instructed to wash their hands if they touch the potentially infectious vesicles.
Streptococcal Infection; (Scarlet Fever, Scarlatina, Strep Throat)	1-3 days	Sore throat, fever, headache. Rough rash 12-48 hours later.	Until 24-48 hours after treatment begun.	Exclude until afebrile and under treatment for 24 hours. No exclusion of contacts. Early medical care important and usually requires 10 days of antibiotic treatment. Screening for asymptomatic cases not recommended.
Tuberculosis Pulmonary	Highly variable – depends on age, life style, immune status. Primary: 4-12 weeks. Latent: 1-2 years after infection. Life-long risk.	Weakness, cough, production of purulent sputum, loss of weight, fever. Urinary tract symptoms if this system involved.	Until sputum is free from tuberculosis bacteria. Generally after a few weeks of effective treatment.	Exclude. Physician treatment essential. May return with documented physician approval. No exclusion of contacts. Skin test contacts and chemoprophylaxis with INH if positive (in absence of disease). Exclusion of nonpulmonary tuberculosis unnecessary.

* Day of onset of specific symptom is counted as "day zero;" the *day after onset* is "day **1**;" *second day* after onset is "day **2**;" and etc.

NOTE: ***Careful handwashing*** is the most important thing that can be done to prevent the spread of most infectious diseases.

Questions about this chart may be directed to the DHHS Division of Public Health, Lifespan Health Services, Immunization Program (402-471-6423) or School Health Program (402-471-0160).

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 4 IMMUNIZATION IN LICENSED CHILD CARE PROGRAMS

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TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 4 IMMUNIZATION IN LICENSED CHILD CARE PROGRAMS

4-001 SCOPE AND AUTHORITY: These regulations implement Neb. Rev. Stat. §§ 71-1913.01 to 71-1913.03 of the Child Care Licensing Act by establishing levels of protection for those diseases preventable through immunization and the reporting by licensed child care programs of each child's immunization status.

4-002 DEFINITIONS: For purposes of these regulations:

Program means the provision of services in lieu of parental supervision for children under 13 years of age for compensation, either directly or indirectly, on the average of less than 12 hours per day, but more than 2 hours per week. Program includes any employer-sponsored child care, family child care home, child care center, school-age child care program, school-age services under Neb. Rev. Stat. § 79-1104, or preschool or nursery school. Program does not include casual care at irregular intervals, a recreation camp as defined in Neb. Rev. Stat. § 71-3101, classes or services provided by a religious organization other than child care or a preschool or nursery school, a preschool program conducted in a school approved under Neb. Rev. Stat. § 79-318, services provided only to school-age children during the summer and other extended breaks in the school year, or foster care as defined in Neb. Rev. Stat. § 71-1901.

DTP and DTaP means diphtheria, tetanus toxoid, and pertussis vaccine.

DT means diphtheria and tetanus toxoid vaccine pediatric preparation.

Hep B means hepatitis B vaccine.

Hib means haemophilus influenzae type B vaccine.

MMR means measles, mumps, and rubella vaccine.

MMRV means measles, mumps, rubella, and varicella vaccine.

PCV means pneumococcal vaccine.

Polio means polio vaccine, including oral polio (OPV) and/or injectable polio (IPV).

Td means diphtheria and tetanus toxoid vaccine adult preparation.

Tdap means diphtheria, tetanus, and pertussis vaccine (booster).

VZV means varicella (chickenpox) vaccine.

4-003 REQUIRED IMMUNIZATION INFORMATION; EXCLUSION FROM ATTENDANCE; NOTICE

4-003.01 Each program must require the parent or guardian of each child enrolled in such program to present within 30 days of enrollment and periodically thereafter:

1. Proof that the child is protected by age-appropriate immunization against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenzae type B, hepatitis B, varicella, and invasive pneumococcal disease;
2. Certification by a physician, advanced practice registered nurse, or physician assistant that immunization is not appropriate for a stated medical reason;
3. A written statement that the parent or guardian does not wish to have the child so immunized and the reasons therefor; or
4. Parental or clinical documentation of disease with year of infection for varicella. The documentation must include one of the following:

    a. Signature of the parent or legal guardian and the date (year) of the child's varicella illness, or
    b. Signature of a health care provider and the date (year) of the child's varicella illness, or
    c. Laboratory evidence of a child's varicella immunity.

4-003.02 If one of the documents described in 173 NAC 4-003.01 is not presented within 30 days of enrollment, the program must exclude a child from attendance until such proof, certification, or written statement is provided.

4-003.03 At the time the parent or guardian is notified that such information is required, he or she must be notified in writing of his or her rights to submit a certification or a written statement as described in 173 NAC 4-003.01.

4-004 REQUIRED LEVELS OF PROTECTION: For the purposes of complying with the requirement of immunization against the diseases listed in 173 NAC 4-003 and in recognition of the fact that immunization needs vary depending on the age of the child, the required minimum number of doses of each vaccine is indicated in the Childhood Immunization Schedule, Attachment 1, which is incorporated in these regulations by this reference.

4-004.01 For purposes of compliance with the immunization requirement, the licensee of a child care program must require the presentation of an immunization history which contains:

1. Names of the vaccines;
2. Month and year of administration for DTaP, DTP, DT, Td, Tdap, polio, Hep B, Hib, and pneumococcal vaccine;
3. Day, month, and year of administration of MMR, MMRV, and/or varicella;
4. Name of the health practitioner or agency where the immunizations were obtained; and

5. Signature of the physician, parent, guardian or of other such person maintaining the immunization history of the child, verifying that the child has received these vaccines.

Children with a reliable history of chickenpox (validated by written parental/clinical documentation including year of infection) can be assumed to be immune to varicella and therefore need not receive the varicella vaccination.

4-005 FREQUENCY OF REVIEW AND REPORTS; RECORDKEEPING

4-005.01 Each program must review the status of immunization for all children on entry. The immunization status of children under 20 months of age must be reviewed again in March and September to insure compliance with age-specific requirements. Records of children who are 20 months of age or older need not be reviewed again until kindergarten entry except as noted in 173 NAC 4-005.02.

4-005.02 Parents/guardians submitting written statements refusing immunizations for children are required to resubmit, sign, and date that statement on an annual basis.

4-005.03 Each program must keep as part of each child's file the immunization history, or the certification by the medical provider, or the written statement from the parent or guardian. These records must be available to the Department for inspection and review.

4-005.04 The licensee of each program must report to the Department by November 1 of each year the records of immunization for all children enrolled as of September 30 of that year. Children who have reached kindergarten age and who are enrolled in a public or private school need not be included in the report. Each report must consist of the following items:

1. The name, address, and telephone number of the licensee and the number of children enrolled on September 30;
2. For each child enrolled, a report of the name of the child, the child's date of birth, and the child's immunization record; and
3. Copy of refusal of immunization or medical certification if the child is not up to date.

The copy of the certification from the medical professional must state the medical reason(s) for not immunizing the child. The copy of the written statement from the parent or guardian must state the reason(s) why the parent or guardian does not wish to have the child immunized.

CHILDHOOD IMMUNIZATION SCHEDULE

Child's Age At Entrance or At Time of Record Review	<<<<Minimum>>>> Number of Doses Required of Each Vaccine						
	DTaP/DT/ Td/Tdap Vaccine	Polio Vaccine	MMR/ MMRV Vaccine	Hib Vaccine	Hep B Vaccine	VZV Vaccine	PCV Vaccine
0 but not yet 3 Months	None	None	None	None	None	None	None
3 months but not yet 5 Months	1 Dose	1 Dose	None	1 Dose	1 Dose	None	1 Dose
5 months but not yet 7 Months	2 Doses	2 Doses	None	2 Doses	2 Doses	None	2 Doses
7 months but not yet 16 Months	3 Doses	2 Doses	None	2 Doses **	3 Doses	None	3 Doses ****
16 months but not yet 19 Months	3 Doses	2 Doses	1 Dose *	3 Doses **	3 Doses	1 Dose or Documented History of Disease	4 Doses ****
19 Months to School Entry	4 Doses	3 Doses	1 Dose *	3 Doses **	3 Doses	1 Dose or Documented History of Disease	4 Doses ****
At School Entry	4 Doses	3 Doses	2 Doses *	None ***	3 Doses	2 Doses or Documented History of Disease	None

* First dose must be given no earlier than 4 days before the 1st birthday.

** Hib vaccine is recommended to be given in a multiple dose schedule beginning in infancy. However, any child who has received a single dose of Hib vaccine at or after 15 months of age is appropriately immunized.

*** Hib vaccine is not required after child reaches 5 years of age.

**** If a child is 7 months of age or older when they start the PCV series, they do not need all 4 doses of PCV. Unvaccinated children who begin the PCV series between 7-11 months of age should receive 2 doses 4 weeks apart with a booster at 12-15 months. Unvaccinated children who begin the PCV series between 12-23 months of age should receive 2 doses 8 weeks apart. Unvaccinated children 24-59 months of age need 1 dose of PCV. Children with high-risk conditions age 24-59 months should follow their physician's advice.

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TITLE 173 COMMUNICABLE DISEASES

CHAPTER 5 RABIES CONTROL PROGRAM

5-001 SCOPE AND AUTHORITY: These regulations are intended to implement the law governing the control of rabies, Neb. Rev. Stat. sections 71-4401 to 71-4412.

5-002 DEFINITIONS

Department means the Department of Health and Human Services Regulation and Licensure.

Domestic animal means any dog or cat, and cat means a cat which is a household pet.

Own, unless otherwise specified, means to possess, keep, harbor, or have control of, charge of, or custody of a domestic animal. This term does not apply to domestic animals owned by other persons which are temporarily maintained on the premises of a veterinarian or kennel operator for a period of not more than 30 days.

Owner means any person possessing, keeping, harboring or having charge or control of any domestic animal or permitting any domestic animal to habitually be or remain on, be lodged, or fed within the person's house, yard or premises. This term does not apply to veterinarians or kennel operators temporarily maintaining on their premises domestic animals, owned by other persons, for a period of not more than 30 days.

Rabies control authority means county, township, city, or village health departments and law enforcement officials who must enforce Neb. Rev. Stat. sections 71-4401 to 71-4412 relating to the vaccination and impoundment of domestic animals. These public officials are not responsible for any accident or disease of a domestic animal resulting from the enforcement of these sections.

Vaccination against rabies means the inoculation of a domestic animal with a rabies vaccine as set forth in 173 NAC 5-004. Vaccinations must be performed by a veterinarian duly licensed to practice veterinary medicine in the State of Nebraska.

5-003 SPECIES OF RABID ANIMALS: The following are species of animals capable of harboring and spreading the rabies virus.

5-003.01 Species amenable to rabies protection by immunization:

1. Dogs;
2. Cats;
3. Ferrets;
4. Cattle;
5. Horses; and
6. Sheep.

5-003.02 Species not amenable to rabies protection by immunization:

1. Carnivorous:

   a. Skunks;
   b. Raccoons;
   c. Foxes;
   d. Coyotes;
   e. Bobcats;
   f. Bats; and
   g. Hybrids (offspring of wild species bred with domestic dogs or cats).

2. Non-carnivorous: Regard these animals as rabid unless proven negative by the Direct Fluorescent Antibody laboratory test. This category includes but is not limited to the following species of animals:

   a. Civet cats;
   b. Deer;
   c. Groundhogs;
   d. Beavers;
   e. Opossums; and
   f. Badgers.

5-003.03 Other Species: Call the Department's Rabies Control Program for further information.

5-003.03A Livestock, which includes, but is not limited to, mules, goats and swine.

5-003.03B Rodents and lagomorphs, which includes, but is not limited to, rabbits, hares, squirrels and mice.

5-004 VACCINATION AGAINST RABIES; REQUIRED

5-004.01 Every domestic animal in the State of Nebraska must be vaccinated against rabies with a licensed vaccine. A list of licensed vaccines is available from the Department's Rabies Control Program.

5-004.02 All domestic animals must be vaccinated against rabies commencing at three months of age, one year and three months, and a booster triennially.

5-004.03 Unvaccinated domestic animals acquired or moved into the State of Nebraska must be vaccinated within 30 days after purchase or arrival unless under the age for initial vaccination.

5-004.04 The provisions of Neb. Rev. Stat. sections 71-4401 to 71-4412, with respect to vaccination, do not apply to any domestic animal owned by a person temporarily remaining within the State of Nebraska for less than 30 days; to any domestic animal brought into the State of Nebraska for field trial or show purposes; or to any domestic animal brought into the State for hunting purposes for a period of less than 30 days. Such domestic animals must be kept under strict supervision of the owner. It is unlawful to bring any domestic animal into the State of Nebraska which does not comply with the animal health laws and import rules and regulations of the State of Nebraska which are applicable to domestic animals.

5-004.05 Domestic animals assigned to a research institution or a similar facility are exempt from Neb. Rev. Stat. sections 71-4401 to 71-4412 and Title 173 NAC 5.

5-005 RABIES CONTROL AUTHORITY; SEIZURE; REQUIREMENTS OF RABIES TESTING; POUNDS; IMPOUNDMENT; NOTICE; RELEASE; FEE; DOMESTIC ANIMALS BITTEN BY A RABID ANIMAL; DISPOSITION

5-005.01 Any animal which is owned by a person and has bitten any person or caused an abrasion of the skin of any person must be seized by the rabies control authority for a period of not less than ten days if:

1. The animal is suspected of having rabies, regardless of the species and whether or not the animal has been vaccinated;
2. The animal is not vaccinated and is determined to be a rabid species; or
3. The animal is of a species which has been determined to be a rabid species not amenable to rabies protection by immunization, whether or not the animal has been vaccinated.

5-005.02 If, after observation and examination by a veterinarian, at the end of the ten-day period the animal shows no clinical signs of rabies, the animal may be released to its owner. If federal, state, or local laws prohibit ownership of wild or other animals, release of the animal may be prohibited.

5-005.03 Whenever any person has been bitten or has an abrasion of the skin caused by an animal owned by another person, which animal has been vaccinated in accordance with Neb. Rev. Stat. section 71-4402 and 173 NAC 5-004, or if the injury to a person is caused by an owned animal determined to be a rabid species amenable to rabies protection by

immunization which has been vaccinated, the animal must be confined by the owner or other responsible person, as required by the rabies control authority, for a period of at least ten days and must be observed and examined by a veterinarian at the end of the ten-day period. If no clinical signs of rabies are found by the veterinarian, the animal may be released from confinement.

5-005.04 A vaccinated animal owned by a law enforcement or governmental military agency which bites or causes an abrasion of the skin of any person during training or the performance of the animal's duties may be confined as provided in 173 NAC 5-005.03. The agency must maintain ownership of and must control and supervise the actions of the animal for a period of 15 days following the injury. If during the 15-day period the death of the animal occurs for any reason, a veterinarian must within 24 hours of the death have the tissues of the animal examined for clinical signs of rabies.

5-005.05 Any animal of a rabid species which has bitten a person or caused an abrasion of the skin of a person and is unowned or the ownership of which cannot be determined within 72 hours of the time of the bite or abrasion, must be immediately subject to any tests described in 173 NAC 5-006 to determine whether the animal is afflicted with rabies. The 72-hour period includes holidays and weekends and must not be extended for any reason.

5-005.06 In the case of domestic animals known to have been bitten by a rabid animal, the following rules apply:

5-005.06A If the bitten or exposed domestic animal has not been vaccinated in accordance with Neb. Rev. Stat. section 71-4402 and 173 NAC 5-004, the bitten or exposed domestic animal must be immediately destroyed unless the owner is willing to place the domestic animal in strict isolation in a kennel under veterinary supervision for a period of not less than six months; and

5-005.06B If the bitten or exposed domestic animal has been vaccinated in accordance with Neb. Rev. Stat. section 71-4402, the domestic animal is subject to the following procedure:

1. The domestic animal must be immediately revaccinated and confined for a period of not less than 30 days following vaccination;
2. If the domestic animal is not immediately revaccinated, it must be confined in strict isolation in a kennel for a period of not less than six months under the supervision of a veterinarian; or
3. The domestic animal must be destroyed if the owner does not comply with either 173 NAC 5-005.06B, item 1 or 2.

5-005.07 The rabies control authority may authorize an animal pound or pounds or may enter into a cooperative agreement with a licensed veterinarian for the establishment and operation of a pound.

5-005.08 Any dog found outside the owner's premises whose owner does not possess a valid

certificate of rabies vaccination and valid rabies vaccination tag for the dog must be impounded. The rabies control authority may require the impoundment of domestic animals other than dogs. All impounded domestic animals must be given proper care, treatment, and maintenance. Each impounded domestic animal must be kept and maintained at the pound for a period of not less than 72 hours unless reclaimed earlier by the owner.

5-005.09 Notice of impoundment of all animals, including any significant marks of identification, must be posted at the pound as public notification of impoundment. Any unvaccinated domestic animal may be reclaimed by its owner during the period of impoundment by payment of prescribed pound fees and by complying with the rabies vaccination requirement of Neb. Rev. Stat. sections 71-4401 to 71-4412 and 173 NAC 5 within 72 hours of release. Any vaccinated domestic animal may be reclaimed by its owner by furnishing proof of rabies vaccination and payment of all impoundment fees prior to release.

5-005.10 At the expiration of impoundment, a domestic animal may be claimed by payment of established pound fees and by compliance with the rabies vaccination requirement of Neb. Rev. Stat. sections 71-4401 to 71-4412 within 72 hours of release. If the domestic animal is unclaimed at the end of five days, the authorities may dispose of the domestic animal in accordance with applicable laws or rules and regulations.

5-006 APPROVED TESTS FOR RABIES DETECTION BY LABORATORY EXAMINATION

5-006.01 The Direct Fluorescent Antibody (DFA) test is the only test approved as a non-bioassay method, and must be performed in a manner to include at least the following techniques:

5-006.01A Tissue preparations must include microscope slide brain tissue impressions that are made from the brain stem, cerebellum, hippocampus and cerebral hemisphere. Two methods can be used to collect the tissue samples from the brain, including:

1. The cranium is opened, the brain is dissected and a small piece of each of the tissues identified above is removed and impressed onto a clean glass microscope slide.

2. A sampling tube (clear drinking straw or a clear plastic pipette) is introduced through the occipital foramen and pushed toward one eye. The tube is pulled out containing a sample of the brain cylinder. The brain cylinder will contain material from the brain stem, cerebellum, hippocampus and cortex and medulla oblongata.

5-006.01B The microscope slide tissue impressions from a suspected rabid animal must be examined using a fluorescence microscope. In addition, the examination must include tissue impressions with their respective determinations accomplished as prescribed. No DFA test result is considered valid unless the determinations are accomplished as prescribed below:

5-006.01B1 Determining test specificity must be performed using rabid mouse brain suspension-adsorbed conjugate on any positive brain tissue impressions. Subsequent examination under the fluorescence microscope must result in the confirmation of the absence of fluorescence.

5-006.01B2 Determining test method sensitivity must be performed using positive rabies tissue impressions on a microscope slide for a positive control. Normal mouse brain-adsorbed conjugate must be used. Subsequent examination under the fluorescence microscope must result in the confirmation of the presence of fluorescence.

5-006.01B3 Determining test method true negative reactivity for rabies must be performed using known negative animal impressions on a microscope slide. Subsequent examination under the fluorescence microscope must reveal the absence of fluorescence.

5-006.01C A positive DFA test for rabies is the appearance of specific rabies antibody fluorescence in the brain tissue upon excitation of ultraviolet illumination using a fluorescence microscope.

5-006.01D If the DFA test is inconclusive, additional tests must be performed and must include at least a virus isolation test.

5-006.02 The virus isolation test is approved as a bioassay method and must be performed in a manner to include at least the following techniques:

5-006.02A Pieces of tissue from the brain stem, hippocampus, cerebellum, and cerebral hemispheres taken from both sides of the suspected animal brain, if available, are weighted together. A 20% (w/v) suspension of each brain specimen for inoculation is made in growth medium (EMEM) and is centrifuged at 500 g for 10 minutes. The supernatant is filtered through a 0.2 membrane filter and 0.5 ml is added to 6×10^6 cells suspended in a conical tube.

5-006.02B Cells and virus are incubated for 1 hour at 37 degrees C. mixing every 15 minutes to adsorb virus onto cells in suspension. Cells and virus mixture are centrifuged at 500 g for 5 minutes. Supernatant is discarded and cells are resuspended in 6 ml of growth medium.

5-006.02C Cells are seeded onto flasks and Labtek slides. Approximately 3×10^6 cells are used to seed 3 Labtek slides and 3×10^6 are used to seed 1 T25 tissue culture flask. One of the 3 Labtek slides is fixed and stained with FITC-labeled anti-rabies antibody at 24, 48 and 72 hours.

5-006.02D If one of the initial Labtek slides is positive, the T25 flask can be autoclaved and discarded. If initial slides are negative, the T25 flask is pulled on day 3 and the growth medium discarded and replaced with viral medium. The flask is incubated for 3-

4 days. Medium is discarded, cells are trypsinized and cells are harvested into 6 ml of EMEM. All cells are seeded into Labtek slides as described above. If the DFA is negative with the second set of Labtek slides, the specimen is considered to be negative for rabies virus.

5-007 PREPARATION OF SPECIMENS; TRANSPORTATION: The rabies control authority must assure arrangements for preparation and transportation of specimens for testing are made according to the following procedures:

5-007.01 Preparation of animal for identifying affliction with rabies:

1. Animals larger than one pound weight must be decapitated prior to transport to a testing laboratory.
2. Animal brain tissue for the Direct Fluorescent Antibody test must not be frozen or preserved with formalin or alcohol.

5-007.02 Transportation of potential rabid animal tissue must include the use of approved packaging. Approved packaging consists of the following:

1. Place the specimen in several layers of plastic bags and tie securely to prevent leakage.
2. Place the specimen enclosed in plastic bags into a leak proof container; i.e., Styrofoam.
3. Place frozen gel packs around the specimen. Do not use loose ice as it may leak and cause contamination.
4. Seal the container.
5. Place the leak proof container into another box and seal the box.

5-008 REPORT OF TESTS FOR IDENTIFYING ANIMALS AFFLICTED WITH RABIES: The laboratory must report the results of the test to the rabies control authority which submitted the specimen for testing.

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 6 DIRECTED HEALTH MEASURES TO PREVENT OR LIMIT THE SPREAD OF COMMUNICABLE DISEASE, ILLNESS, OR POISONING

6-001 SCOPE AND AUTHORITY: These regulations are enacted pursuant to Neb. Rev. Stat. §§ 71-502, and 81-601 et seq. and apply to the exercise of authority by the Department to order Directed Health Measures necessary to prevent, limit, or slow the spread of communicable disease, illness, or poisoning.

Nothing in these regulations precludes the Department from requesting voluntary compliance with beneficial health measures.

6-002 DEFINITIONS

Chief Medical Officer means the state Chief Medical Officer appointed pursuant to Neb. Rev. Stat. § 81-3201, if the Department Director is not a medical doctor.

Communicable disease, illness, or poisoning means an illness due to an infectious or malignant agent, which is capable of being transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

Decontamination means the removal or neutralizing of contaminating material, such as radioactive materials, biological materials, or chemical agents, from a person or object to the extent necessary to preclude the occurrence of foreseeable adverse health effects. Decontamination includes remediation or destruction of sources of communicable disease or biological, chemical, radiological, or nuclear agents.

Department means the Department of Health and Human Services Regulation and Licensure or its successor.

Directed Health Measure means any measure, whether prophylactic or remedial, intended and directed to prevent or limit the spread of communicable disease or to prevent or limit public exposure to or spread of biological, chemical, radiological, or nuclear agents.

Director means the Director of Regulation and Licensure, or a person acting on behalf of the Director as his or her designee.

Health care facility means any facility licensed under the Health Care Facility Licensure Act, and such additional clinics or facilities not licensed under that act as may be identified in specific orders issued pursuant to 173 NAC 6.

Health care provider means any credentialed person regulated under the Advanced Practice Registered Nurse Act, the Emergency Medical Services Act, the Licensed Practical Nurse-Certified Act, the Nebraska Certified Nurse Midwifery Practice Act, the Nurse Practice Act, the Occupational Therapy Practice Act, the Uniform Licensing Law, or Neb. Rev. Stat. §§ 71-3702 to 71-3715.

Isolation means the separation of people who have a specific communicable disease, illness, or poisoning from healthy people and the restriction of their movement to stop the spread of that disease, illness, or poison. In circumstances where animals are agents of spread of communicable disease, illness, or poisoning, isolation may apply to such animals.

Local public health department means a local public health department as defined by Neb. Rev. Stat. § 71-1626 and its governing officials.

Municipality means any City of the Metropolitan class (see Neb. Rev. Stat. § 14-101), Primary class (§ 15-101), First class (§ 16-101), Second class (§ 17-101), and Village (§ 17-201) and its governing officials.

Personal protective equipment (PPE) means equipment ordered or used to protect an individual from communicable disease, illness, or poisoning.

Premises means land and any structures upon it.

Public health authority means any individual or entity charged by law with a duty or authority to enforce or carry out a public health function.

Quarantine directed to identified individuals or defined populations means the restriction of, or conditions upon, the movement and activities of people who are not yet ill, but who have been or may have been exposed to an agent of communicable disease, illness, or poisoning and are therefore potentially capable of communicating a disease, illness, or poison. The purpose is to prevent or limit the spread of communicable disease, illness, or poison. Quarantine of individuals or defined populations generally involves the separation of the quarantined from the general population. In circumstances where animals are agents of spread of communicable disease, illness, or poisoning, quarantine may apply to such animals.

Quarantine officer means the statutorily established quarantine officer for a municipality or county, usually the chief executive or top law enforcement officer.

Quarantine of premises means restriction of the movement of all people and animals upon, into, or out from those premises to prevent or limit the spread of communicable disease or illness or to prevent or limit public exposure to or spread of biological, chemical, radiological, or nuclear agents.

6-003 FINDINGS

6-003.01 Director Informed: When the Director receives information that a member or members of the public have been, or may have been exposed to a communicable disease, illness, or poisoning by biological, chemical, radiological, or nuclear agents, the Director will review all information under the following provisions to determine if any Directed Health Measure should be ordered.
This information may come from:

1. The United States Department of Health and Human Services Centers for Disease Control and Prevention;
2. A Local Public Health Department;
3. Communicable disease surveillance conducted by the Department;
4. Treating health care providers or health care facilities; or
5. Other public health, security, or law enforcement authorities.

6-003.02 Director's Findings: Before ordering a Directed Health Measure, the Director:

1. Must find both:

   a. That a member or members of the public have been, or may have been exposed; and
   b. That Directed Health Measures exist to effectively prevent, limit, or slow the spread of communicable disease or illness or to prevent, limit, or slow public exposure to or spread of biological, chemical, radiological, or nuclear agents; and

2. Must find one or more of the following:

   a. That the exposure presents a risk of death or serious long-term disabilities to any person;
   b. That the exposure is wide-spread and poses a significant risk of harm to people in the general population; or
   c. That there is a particular subset of the population that is more vulnerable to the threat and thus at increased risk; and

3. May make further finding, in assessing the nature of the risk presented:

   a. Whether the threat is from a novel or previously eradicated infectious agent or toxin;
   b. Whether the threat is or may be a result of intentional attack, accidental release, or natural disaster; or
   c. Whether any person(s) or agent(s) posing the risk of communicating the disease are non-compliant with any measures ordered by a health care provider.

6-003.03 Affirmative Findings: If affirmative findings are made pursuant to 173 NAC 6-003.02 and the Director further finds that a delay in the imposition of an effective Directed

Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons, the Director may impose any of the Directed Health Measures set out in 173 NAC 6-004.

6-004 DIRECTED HEALTH MEASURES

6-004.01 Directed Health Measures which may be ordered by the Director are:

6-004.01A Quarantine of:

1. Individuals;
2. Defined populations;
3. Buildings and premises, or of defined areas, public and private, or
4. Animals.

The methods of quarantine may require the individual or population to remain within or outside of defined areas *(cordon sanitaire)* or restricted to or from specified activities, which may include "work quarantine" restricting individuals or defined populations to their residence or workplace.

In the event that the quarantine of affected premises posing an immediate threat to the public health and safety is determined to be incapable of effective enforcement, the Department may act alone or in concert with any local jurisdiction having condemnation or nuisance abatement authority, to carry out measures effective to remove the threat, including safe demolition of the premises.

6-004.01B Isolation of individuals:

1. At home;
2. In a health care facility; or
3. In another designated area.

6-004.01C Decontamination.

6-004.01D Such other protocols or measures as may be identified as effective against public health threats by the American Public Health Association and the United States Department of Health and Human Services Centers for Disease Control and Prevention or other similar public health authority.

6-004.02 Any of the Directed Health Measures may include, and are not limited to, any of the following:

1. Periodic monitoring and reporting of vital signs;
2. Use of PPE for the performance of specified tasks or at specified premises; or
3. Specific infection control measures including cleaning and disposal of specified materials.

6-004.03 Any Order of the Director may include temporary seizure or commandeering of personal or real property for public health purposes.

6-004.04 Directed Health Measures may be directed to an individual, group of individuals, or a population, or directed to the public at large with regard to identified premises or activities and may also include health care providers, health care facilities, health care authorities, and public and private property including animals.

6-005 PROCEDURES

6-005.01 In making the finding under 173 NAC 6-003 and determining the measures under 173 NAC 6-004, the Director will consult with the Chief Medical Officer, if the Director is not a medical doctor, or other medical and communicable disease control personnel of the Department. The Director may make use of the expertise and observations of any health care provider who has treated a person for whom a Directed Health Measure is being considered. The Director will also consider the directives and guidelines issued by the American Public Health Association and the United States Department of Health and Human Services Centers for Disease Control and Prevention or their successors, and may consider the directives and guidelines issued by similar public health authorities.

6-005.02 In determining the nature, scope, and duration of the Directed Health Measure ordered, the Director, based on the information available at the time of the determination, will:

1. Assess the situation and identify the least restrictive practical means of isolating, quarantining, or decontaminating an individual that effectively protects unexposed and susceptible individuals;

2. Select a place of isolation or quarantine that will allow the most freedom of movement and communication with family members and other contacts without allowing disease transmission to others and allow the appropriate level of medical care needed by isolated or quarantined individuals to the extent practicable;

3. For communicable diseases, order that the duration of the Directed Health Measure should be no longer than necessary to ensure that the affected individual or group no longer poses a public health threat;

4. Give consideration to separation of isolated individuals from quarantined individuals. However, if quarantine or isolation is possible in the home(s) of the affected individual(s), individuals may be isolated with quarantined individuals; and

5. Give consideration to providing for termination of the Order under the following circumstances:

a. If laboratory testing or examination is available to rule out a communicable condition, the Order may provide that proof of the negative result will be accepted to terminate a Directed Health Measure; or

b. If treatment is available to remedy a communicable condition, the Order may provide that proof of successful treatment will be accepted to terminate a Directed Health Measure.

6-006 ISSUANCE OF ORDERS

6-006.01 Upon a finding pursuant to 173 NAC 6-003 and determination pursuant to 173 NAC 6-004, the Director will issue an Order directed to the affected individual, individuals, entity, or entities.

6-006.02 Orders of the Director imposing Directed Health Measures are effective immediately.

6-006.03 Orders will contain the finding and determination and will order the affected person or persons to comply with the terms of the Order, and will also include the following:

6-006.03A Orders of Isolation will contain the following:

1. Name and identifying information of the individual(s) subject to the order;
2. Brief statement of the facts warranting the isolation;
3. Conditions for termination of the order;
4. Duration of isolation period;
5. The place of isolation;
6. Prohibition of contact with others except as approved by the Director or designee;
7. Required conditions to be met for treatment;
8. Required conditions to be met for visitation if allowed;
9. Instructions on the disinfecting or disposal of any personal property of the individual;
10. Required precautions to prevent the spread of the subject disease;
11. The individual's right to an independent medical exam at their own expense;
12. Provisions to ensure and monitor compliance; and
13. Procedure to request a hearing.

6-006.03B Orders of Quarantine will contain the following:

1. Name, identifying information or other description of the individual, group of individuals, premises, or geographic location subject to the order;
2. Brief statement of the facts warranting the quarantine;

3. Conditions for termination of the order;
4. Specified duration of the quarantine;
5. The place or area of quarantine;
6. Prohibition of contact with others except as approved by the Director or designee;
7. Symptoms of the subject disease and a course of treatment;
8. Instructions on the disinfecting or disposal of any personal property;
9. Precautions to prevent the spread of the subject disease;
10. The individual's right to an independent medical exam at their own expense,
11. Provisions to ensure and monitor compliance; and
12. Procedure to request a hearing.

6-006.03C Orders of Decontamination will contain the following:

1. Description of the individual, group of individuals, premises, or geographic location subject to the order;
2. Brief statement of the facts warranting the decontamination;
3. Instructions on the disinfecting or disposal of any personal property;
4. Precautions to prevent the spread of the subject disease; and
5. Procedure to request a hearing.

6-007 NOTICE OF ORDERS

6-007.01 Orders to Individuals: Orders directed to individuals will be delivered in a manner reasonably calculated to give the individual actual notice of the terms of the Order consistent with the threat of communicable disease, illness, or poisoning. Personal delivery may be attempted, except in cases when personal delivery would present a risk of spread of disease or exposure to agents that cannot be avoided by measures reasonably available. Electronic transmission by e-mail or telefacsimile will be sufficient, provided that any available means of determining and recording receipt of such notice will be made. If electronic transmission is impossible or unavailable under the circumstances, oral communication by telephone or direct transmission of voice will be sufficient, and such communication will be memorialized at the time it is delivered.

6-007.02 Orders to Groups: Orders directed to groups of individuals or populations may be disseminated by mass media.

6-007.03 Quarantine Orders Regarding Areas: Orders directing the quarantine of premises or geographic locations may be disseminated by mass media and will be posted at or near the premises or geographic location in order to be visible and effective to achieve the intended purpose. Copies of the Orders will be delivered to the owners or others in control of the premises, if known, in the same manner as Orders directed to individuals.

6-007.04 Notice to Elected Officials: Copies of all Orders will be provided if reasonably possible to the chief elected official(s) of the jurisdiction(s) in which the Order is implemented.

6-008 HEARING PROCESS

6-008.01 Request for Hearing: Any person subject to an Order under 173 NAC 6 may request a contested case hearing to contest the validity of the Order, in accord with the Department's rules of practice and procedure adopted pursuant to the Administrative Procedure Act.

6-008.02 Scheduling of Hearing: Upon request, the Department will schedule a hearing to be held as soon as reasonably possible under the circumstances. Unless the person subject to an Order requests otherwise, the hearing will be scheduled no sooner than three days after the request is received by the Department. The hearing will be conducted in accord with the Department's rules of practice and procedure adopted pursuant to the Administrative Procedure Act.

6-008.03 Parties to the Hearing: The parties to the hearing will be limited to the Department and the subject person unless:

1. One or more additional persons have requested contested case hearings on substantially identical issues;
2. The interests of administrative economy require that the matters be consolidated; and
3. No party would be prejudiced by consolidation.

The parties may be represented by counsel at their own expense.

6-008.04 Notice and Conduct of Hearing: Reasonable prior notice of the time and place for hearing will be given to the parties. The hearing may be conducted in whole or in part by telephone or videoconference.

6-008.05 Purpose and Decision: The purpose of the hearing is to determine if the factual bases for the Order exist and the reasonableness of the ordered measures. The Director may affirm, reverse or modify the Order by a written Findings of Fact, Conclusions of Law and Order to be issued as soon as reasonably possible after the hearing.

6-008.06 Appeal of Hearing Decision: An appeal to the District Court may be taken from the decision of the Director in accord with the Administrative Procedure Act.

6-009 ENFORCEMENT OF ORDERS

6-009.01 The Department may seek the assistance of the appropriate quarantine officer to enforce any Order.

6-009.02 Department personnel assigned to the enforcement of any Order will promote the need for the Directed Health Measure and encourage individuals to comply with all aspects of the Order.

6-009.03 Any individual subject to an Order may at any time present evidence to the Director to show that the Order should be modified or terminated. The Director may or may not modify or terminate the Order in his or her sole discretion.

6-009.04 In the event of noncompliance with the terms of a Department Order under 173 NAC 6-006, law enforcement and other Municipal and Local Public Health Department personnel will be required to aid the Department in enforcement of the Order, pursuant to 173 NAC 6 and Neb. Rev. Stat. § 71-502.

6-010 COOPERATION AND COORDINATION

6-010.01 The Department may assist or seek the assistance of quarantine officers, Local Public Health Departments, other public health authorities, and others authorized or required by law to carry out Directed Health Measures in carrying out those measures.

6-010.02 Treating Health Care Providers must follow and aid affected individuals and populations in compliance with ordered Directed Health Measures.

6-011 REPORTING OF NONCOMPLIANCE

Treating Health Care Providers, Health Care Facilities, and other persons must report any information known to them concerning any individual or entity subject to an Order of quarantine, isolation, decontamination, or other Directed Health Measure that is not in compliance with the Order. The report must be made to the Department and local law enforcement.

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 7 SCHOOL HEALTH SCREENING, PHYSICAL EXAMINATION, AND VISUAL EVALUATION

SUBJECT	**STATUTORY AUTHORITY**	**CODE SECTION**
SCOPE AND AUTHORITY	NRS 79-101, 79-214 and 79-220, 79-248 to 79-253	001
DEFINITIONS		002
WHO MUST BE SCREENED	NRS 79-248	003
SCREENINGS TO BE PERFORMED	NRS 79-248	004
QUALIFICATIONS OF PERSONS AUTHORIZED TO SCREEN	NRS 79-249, 79-252	005
NOTIFICATION OF PARENTS / GUARDIANS OF SCREENING RESULTS	NRS 79-248	006
TIMETABLE FOR PERFORMING SCREENING	NRS 79-248, 79-250	007
ENFORCEMENT / PENALTIES	NRS 79-253	008
PHYSICAL EXAMINATION AND VISUAL EVALUATION REQUIREMENTS FOR SCHOOL ENTRY	NRS 79-214, 79-220	009

ATTACHMENT 1: DHHS Minimum Required School Health Screenings

ATTACHMENTS: Competencies for Required School Health Screenings
- 2A: Hearing Screening
- 2B: Distant Vision Screening
- 2C: Near Vision Screening
- 2D: Dental Screening
- 2E: Weight/Height Status Screening (BMI)

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 7 SCHOOL HEALTH SCREENING, PHYSICAL EXAMINATION AND VISUAL EVALUATION

7-001 SCOPE AND AUTHORITY

7-001.01 Statutory Authority: This chapter is adopted pursuant to Neb. Rev. Stat. §§ 79-214, 79-220, and 79-248 to 79-253.

7-001.02 Scope: These regulations apply to every public school district in Nebraska and students under their jurisdiction. This includes children aged 3-5 years enrolled in early childhood education or early childhood special education programs as defined in Title 92 Nebraska Administrative Code, Chapters 11 and Chapter 51 respectively. These regulations become operative July 1, 2014.

7-001.03 Role of School Boards: Neb. Rev. Stat. § 79-251 states the boards of education and school boards of the school districts of the state shall enforce the provisions of Neb. Rev. Stat. §§ 79-248 to 79-253.

Neb. Rev. Stat. § 79-252 states that school district boards of education or school boards may employ licensed physicians to conduct screening in lieu of conducting screening.

Neb. Rev. Stat. § 79-214 states that the school board of any school district shall require evidence of a physical examination and visual evaluation for those students in applicable grades.

7-001.04 Role of the Department of Health and Human Services (DHHS)

7-001.04A Neb. Rev. Stat. § 79-248 identifies the prescriptive role of the Department of Health and Human Services in identifying conditions for which to screen the school-aged population. Neb. Rev. Stat. § 79-249 provides the statutory authority to the Department of Health and Human Services to promulgate these rules and regulations. DHHS is to prescribe the schedule for minimum required school health screenings, which shall be based on current medical and public health practice, and to define the qualifications of the person or persons authorized to conduct required screenings.

7-001.04B Pursuant to Neb. Rev. Stat. § 79-249, the School Health Program in the DHHS Division of Public Health provides the School Health Guidelines for Nebraska schools; makes available useful materials to assist schools to implement school health screening programs; and makes available methods for gathering, analyzing, and utilizing data obtained that do not violate any privacy laws.

7-001.05 Purpose of Screening: The purpose of screening is to identify those students needing further evaluation or assistance in the areas screened. A health screening or health inspection is not diagnostic.

7-001.06 Role of Schools: The role of the school in these regulations is to make available required health screening services and carry out compliance activities as described. It is not the role of the school to be a medical provider. Parents/guardians are to be notified of the screening result if the student is found to need further evaluation, as determined by a qualified screener and comparison of individual data with an objective standard. The cost of such evaluation shall be borne by the parent or guardian of the student.

7-002 DEFINITIONS

Health Inspection: Neb. Rev. Stat. §§ 79-248 through 79-253 refer to health inspections conducted at school. For the purposes of these regulations, the term “health screening” shall be used synonymously and interchangeably with the phrase “health inspection.”

Health Screening: Collection of individual-level basic subjective and objective data from observations and interviews. The task includes the recording and reporting of the collected data.

Health screening *does* include: inspection, accurate measurement, and comparison of individual measurement with an objective standard in order to identify the individual student whose parent is to be notified of the need for further evaluation.

Health screening does *not* include: assessment, judgment based on the knowledge base of a regulated health profession, diagnosis, evaluation, examination, investigation, interpretation, treatment, or management of any health condition.

Health screening is not a regulated act reserved for the licensed health professions.

7-003 WHO MUST BE SCREENED

7-003.01 Minimum Required School Health Screening Schedule: The Department prescribes a schedule for screenings based on current medical and public health practice. The schedule is incorporated in these regulations by this reference, as Attachment 1.

7-003.02 Exception: A child is not required to submit to school health screening if his or her parent or guardian provides school authorities with a statement signed by a physician, physician assistant, or an advanced practice registered nurse-nurse practitioner practicing under and in accordance with his or her respective credentialing act or other qualified provider as identified by DHHS in rules and regulations adopted pursuant to Neb. Rev. Stat. § 79-249, and found in 7-005.01C2 of these regulations, stating that such child has undergone such required screening within the last six months preceding the school's scheduled health screening. A child must submit to any required screening at school for which such a statement is not received.

7-003.03 Children with Special Health Care Needs: The student with special health care needs who cannot be screened by usual methods at school must not be excluded or overlooked by the school health screening program.

7-004 SCREENINGS TO BE PERFORMED

7-004.01 Students in Nebraska schools must be screened periodically for vision, hearing, and dental health. In addition, the Department of Health and Human Services prescribes height and weight measurement, with calculation of body mass index (BMI), for the purpose of monitoring weight/height status at intervals for all students. The DHHS Minimum Required Health Screening schedule is shown in Attachment 1. Attachments 2A through 2E, incorporated herein by reference, contain the Competencies for each required screening. Additional resources on school health screening topics are available from the DHHS School Health Program.

7-004.02 Distance vision screening shall be accomplished by measuring a child's vision in each eye separately, using a chart viewed at 20 ft., or equivalent. Near vision screening shall be accomplished by using a chart viewed at 20 ft., both eyes together, using 2.5+ diopter lenses, or equivalent.

7-004.03 Hearing screening shall be accomplished by measuring a child's response to audible tones delivered at 20 decibels, to each ear separately, at 1000 Hz, 2000 Hz, and 4000 Hz.

7-004.04 Dental screening shall be accomplished by inspecting the inner and outer visible surfaces of the teeth for unexplained absence of teeth, erosion or deterioration, or severe discoloration, of the surfaces of the teeth.

7-004.05 Weight/height status screening shall be accomplished by the measurement of height and weight, calculation of body mass index (BMI), and assignment of percentile ranking utilizing age- and gender-specific charts.

7-005 QUALIFICATIONS OF PERSONS AUTHORIZED TO SCREEN

7-005.01 The qualified screener carries out the required screening activity, following the competencies for accurate, reliable measurement as described in 7-004 and found in Attachments 2A through 2E. The qualified screener meets one of the following descriptions:

7-005.01A The screener has been determined competent to perform the screening method by a licensed health care professional within the previous three years. Documentation in writing of such competency determination shall include:

7-005.01A1 The name of the individual who successfully completed the competency determination and the date the determination was conducted;

7-005.01A2 The type of screening with type(s) of equipment used in the competency determination for the respective screenings; and

7-005.01A3 The name and license number of the licensed health professional conducting the competency assessment; OR

7-005.01B The screener will receive direct supervision from a licensed health care professional while screening; OR

7-005.01C Screening is conducted by a licensed health care professional, as follows:

7-005.01C1 A Nebraska-credentialed health care professional registered nurse, licensed practical nurse, advanced practice registered nurse-nurse practitioner, physician assistant, or physician, are authorized to perform health screening at school.

7-005.01C2 Other licensed health professionals authorized to conduct specific screenings in addition to health professionals identified in 7-005.01C1 are:

Hearing: Audiologists and speech-language pathologists.

Vision: Optometrists.

Dental health: Dentists and dental hygienists.

7-005.02 Record of Persons Qualified to Screen: The school must keep on file for a minimum of three years the name, profession, license number, or written verification of competency in the screening method, for each screener permitted by the school to perform health screening.

7-006 NOTIFICATION OF PARENTS / GUARDIANS OF SCREENING RESULTS: Parents / guardians are to be notified in writing of findings in the school health screening indicating a need for further evaluation, and necessity of professional attendance for the child, in accordance with Neb. Rev. Stat. § 79-248.

7-007 TIMETABLE FOR PERFORMING SCREENING

7-007.01 Annual Screening: During each school year the school district must provide a health screening program for children in attendance as outlined in Attachment 1.

7-007.02 Screening for New Enrollees: As children enter school during the year, health screening must be confirmed upon their entrance to school. If prior screening results corresponding to the schedule in Attachment 1 are not available, the student must be screened as identified in the minimum required schedule.

7-008 ENFORCEMENT / PENALTIES

7-008.01 The boards of education and school boards of the school districts of the state are responsible under Neb. Rev. Stat. § 79-248 for enforcement of the provisions of the school health screening statutes and these regulations.

7-008.02 Any person violating any of the provisions of Neb. Rev. Stat. §§ 79-248 to 79-252 is guilty of a Class V misdemeanor, as provided in Neb. Rev. Stat. § 79-253.

7-009 PHYSICAL EXAMINATION AND VISUAL EVALUATION REQUIREMENTS FOR SCHOOL ENTRY

In accordance with Neb. Rev. Stat. § 79-214, the school board of any school district, before admitting a child, shall require evidence of the following:

7-009.01 Physical Examination Required: Physical examination by a physician, physician assistant, or advanced practice registered nurse-nurse practitioner within the six months prior to the entrance of a child into the beginner grade and the seventh grade, or in the case of a transfer from out of state, to any other grade of the local school, is required. Either a completed, signed, and dated physical exam report, or a printed or typewritten form signed by a qualified examiner indicating that a physical examination was administered on a specific date within the previous six-month period on a specifically named individual, provided to the school by the parent/guardian, constitutes sufficient evidence of compliance.

7-009.02 Visual Evaluation Required: Visual evaluation by a physician, a physician assistant, an advanced practice registered nurse-nurse practitioner, or an optometrist within six months prior to the entrance of a child into the beginner grade or, in the case of transfer from out of state, to any other grade of the local school, is required. The visual evaluation must consist of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity. The visual evaluation report inclusive at a minimum of the specific tests named above, signed and dated by the qualified examiner, provided to the school by the parent/guardian constitutes sufficient evidence of compliance.

7-009.03 Notification of Right to Refuse Physical Examination or Visual Evaluation: At the time a parent/guardian is notified of the requirements for physical examination and

visual evaluation for school entry, that parent/guardian must also be notified of his or her right to submit a written statement refusing such examination or evaluation.

7-009.04 Parent/Guardian Objection to Physical Examination or Visual Evaluation: No such physical examination or visual evaluation as described in 7-009.01 and 7-009.02 is required of the student whose parent/guardian submits a written statement of objection to the school.

ATTACHMENT 1: DHHS MINIMUM REQUIRED ANNUAL SCHOOL HEALTH SCREENINGS

SCREENING by Grade or Age Level *For procedural guidelines and competencies for each screening, see DHHS School Health Guidelines for Nebraska Schools.*	**Age 3-5 yrs**	**K**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
HEARING: pure tone audiometry	**annually**	**X**	**X**	**X**	**X**	**X**			**X**			**X**		
VISION: distance	**annually**	**X**	**X**	**X**	**X**	**X**			**X**			**X**		
VISION: hyperopia (near vision)			**X**		**X**									
DENTAL: inspection of teeth	**annually**	**X**	**X**	**X**	**X**	**X**			**X**			**X**		
WEIGHT/HEIGHT STATUS: body mass index percentile	**annually**	**X**	**X**	**X**	**X**	**X**			**X**			**X**		
Physical Examination *By physician, physician assistant, or advanced practice registered nurse*		**X**							**X**					
Visual Evaluation *By physician, physician assistant, advanced practice registered nurse, or optometrist.*		**X**												

Additional Indications for Screening:

1. New to district at any time, with no previous screening results available.
2. Student enters the Student Assistance Process, with no recent or current screening results available.
3. Periodic screenings as specified by the student's Individualized Education Plan (IEP)
4. Nurse concern, i.e. sudden wt. loss/gain, change in stature or appearance; parent or teacher concern; audiologist referral.
5. Unremediated concerns from previous year.

Notes:

1. The student with known hearing or vision deficits may not need periodic screenings for these conditions. This will be determined on an individual basis by the child's Individualized Education Plan (IEP) and/or school personnel following the student.
2. Screening results may be taken from physical examination, visual evaluation, or dental examination reports if equivalent screening results are available and documented.
3. If parent/guardian wishes to refuse school health screening, parents/guardian must submit written statement(s) from a qualified examiner that the child has received the minimum required screenings within the previous six months, or the child will be screened at school.
4. Parents/guardians may waive physical examination and visual evaluation requirements by submission of written statement of objection to the school.

ATTACHMENT 2A: HEARING SCREENING COMPETENCIES

HEARING SCREENING (PURETONE AUDIOMETRY) COMPETENCIES
Essential Steps for Accurate Measurement

COMPETENCY	KEY POINTS
1. Assess environment for ambient background noise that will disrupt screening.	*Conduct screening in an environment with minimal visual and auditory distractions. Ambient noise levels must be sufficiently low to allow for accurate screening. If a suitable environment cannot be located for screening, the screening results are not valid. The parameters of screening should NOT be changed in order to accomplish screening at sound levels other than 20dB.* *For screening environments, ambient noise levels should not exceed 49.5 dB at 1000 Hz, 54.5 dB at 2000 Hz, and 62 dB at 4000 Hz when measured using a sound level meter with octave-band filters centered on the screening frequencies. These levels are derived from consideration of ANSI (1991) standards for pure-tone threshold testing, and are adjusted for the 20 dB screening level.* *In practical terms, if the screener is unable to hear all screening frequencies at 20dB, the screening environment should be reassessed. Of the first 20 children screened, if 2 or more do not pass (i.e. no-pass rate of 10% or higher), the screening environment should be reassessed for excessive ambient noise.*
2. Assemble equipment in desired location.	*The audiometer should be on for five minutes (minimum) prior to use. A table and two chairs are required. The student should be positioned to face away from the machine, within view of the screener. The student should not be able to see the examiner's hands or movements.*
3. Check the audiometer: ✓ Check cords, cushions, and headbands for excessive wearing or cracking. ✓ Check dials and switches for alignment and ease of movement. ✓ Listen for the tone through each earphone. ✓ With the audiometer set for continuous tone, slide the entire length of the cords between the thumb and index finger noting any change in output signal. ✓ Gently shake the cords. There should be no static, hum, or interruption of the signal. ✓ Make sure when tone is directed to one earphone, no sound is heard from the other earphone. ✓ Make sure a steady tone is present at all frequencies. With the tone switch in "normal-off" position, press the interrupter switch several times to make sure the tone is present each time. ✓ Listen to the frequencies at 20 dB to make sure the tones are audible to the screener with normal hearing.	*The audiometer should always be stored with the cords loosely bundled into the box. Wrapping the cords around the head phones damages the wires and will affect the instrument.* *The audiometer should be professionally serviced and calibrated on an annual basis (minimum).*

4. Give simple but complete instructions to the student: "Listen very carefully. You will hear one tone at a time, sometimes very soft and sometimes louder. When you hear a sound, raise your hand so I can see you have heard that sound, then put your head down and wait for the next sound."	*While many students are "trained" to do so, it is not necessary (or significant) for the validity of the screening that the student raises only the hand on the side he or she hears the sound. For the purposes of screening, the student and the screener agree on the reliable signal the student will make indicating he or she has heard a sound.*
5. Place earphones comfortably and securely on the student's head: red earphone on the right, blue on the left. The center of the ear pad should be centered over the opening of the ear.	*Push hair behind ears. Make sure headbands or other hair decorations, eyeglasses, and/or earrings are not interfering with the correct placement of the earphones.* ***Head Lice Precautions*** *Use of the audiometer for one student after another may provide a mechanism for physical transport of head lice between students. In school settings where head lice are known to be a concern, the school nurse may consider conducting school wide head checks prior to the screening activity, conducting head checks concurrently with the screening, using a shower cap barrier for each child, and/or having supplies to physically clean (with damp cloth and disinfectant) head phones between children*.
6. Offer a test sound of 40 dB at 4000 Hz to confirm the student demonstrates understanding of the instructions.	*Set the tone switch in the "normal-off" position so the tone will sound only when the screener presses the interrupter switch.*
7. Proceed with offering screening tones as follows each delivered separately to the right and left, all at 20 dB, for 2 seconds' duration (say, "hearing test" to yourself). Vary time intervals and sequence between tones. Each tone may be offered up to three times to determine response. Testing frequencies are: 1000 Hz, 2000Hz, 4000 Hz. Pass if the child's responses are judged to be clinically reliable at least 2 out of 3 times at the criterion decibel level at each frequency in each ear.	*Work quickly, offer praise. Children with hearing problems may "Pass" due to anticipating patterning by the screener.* *It is not necessary to continue screening in order to determine the decibel level at which the student does indicate hearing the sound ("threshold screening".)* *It is sufficient for the purposes of screening to identify whether the student does or does not indicate hearing at desired frequencies at 20 dB.*
8. Record results.	*The screening procedure identifies the child apparently not hearing the given frequencies at 20 decibels*. *Record results by identifying for the Right and Left sides the results for each frequency at 20dB: P (pass) or NP (not passed).* *For example:* *R: 1000/P L: 1000/P* *R: 2000/P L: 2000/NP* *R: 4000/NP L: 4000/P*
9. Identify the student who should be rescreened, if available, and/or parent notified.	*The student who misses any of the frequency tones at 20dB should be rescreened and, if missed tone or tones persist, referred for further evaluation by physician or audiologist.* *Rescreening should be performed 2-4 weeks following the initial screen. The rescreening validates the initial finding and*

	also allows resolution of transient congestion or inflammation which might temporarily affect hearing – while not allowing excessive delay before further evaluation if indicated. *Referrals may be made either to a community medical provider or community audiologist of the parent/guardian's preference, or to the district audiologist. Post treatment screening is indicated to obtain the final outcome of the screening process.*

Additional technical information and resources are available from the DHHS School Health Program, 402-471-0160.

ATTACHMENT 2B: DISTANT VISION SCREENING COMPETENCIES

VISION SCREENING COMPETENCIES: DISTANT VISION
Essential Steps for Accurate Measurement

COMPETENCY	KEY POINTS AND PRECAUTIONS
1. Assemble required equipment and supplies. Prepare screening environment. Measure a distance of 20 ft. or 10 ft. from the chart to the location where students will stand for screening. (The correct distance is determined from information on the screening chart.) Mark the distance clearly. The screening area should be quiet and free from distraction. The chart should be fully illuminated, either with backlighting or in a fully lit room. No glare should fall on the chart. If the wall used the hang the chart is crowded with stimuli, create white space around the chart (flip chart paper) to reduce visual distraction.	*Chart should be placed at height so passing line is at child's line of sight.* *For younger children, it may be helpful to have a second screener next to the child, in order to better observe and to hear the child's spoken identification of the symbol.* *For all children, screeners must be positioned in such a way as to view the child's face throughout the screening in order to detect unusual positioning or squinting, or attempts to use both eyes to see.* *If using Titmus, Optec, or Keystone telebinocular or other technologies: obtain equivalent screening results, expressed in acuity measure at 20 ft. for each eye separately. Note: Some types of screening equipment may not be recommended for all ages. Follow manufacturer directions closely for accurate measurements.*
2. Students place their heels on the mark.	*Students who have been prescribed glasses or contacts should wear them during screening. A notation that corrective lenses were worn should be included in documentation of the screening result.* *Glasses should be inspected and cleaned if necessary prior to the screening. Notification of parent of need for further evaluation is indicated if the fit of the glasses is inadequate or they are in need of repair.*
3. Prescreen: before screening, confirm the child can reliably identify symbols presented. The primary screener stands at the chart and begins prescreening by pointing to the largest symbols at the top of the chart and asking the child to identify each. .	*The older child very familiar with screening practices may need little preparation for screening.* *Prescreen with both eyes uncovered* *A student's confidence may be encouraged by interacting with and receiving praise from the screener.* *The student can use any name for a symbol as long as it's used consistently.* *Very young children: screen in a setting with minimum distractions. Use handheld response cards if available to allow the child to point to the matching symbol.*
4. For screening, have the student cover the left eye first. Repeat with the right eye covered.	*Suggestion for occluders: child's hand, palm cupped over eye (avoid pressure on eye).* *Consistency in this technique helps assure accuracy in recording right eye results first, followed by left eye results.* *Varying the order of letter or symbol presentation may help*

	identify the child who has memorized (but may not actually see) a line.
5.Start the screening. For the young child, start the screening at the 20/80 line or above, pointing directly under the symbol, using a vertical pointer, without obstructing the symbol. Proceed pointing to symbols randomly as you work down the chart until reaching the passing line (one symbol per line). (i.e. 20/30 for ages 6+). For the older student, who needs little preparation for screening, consider starting at three lines above passing for age (20/60).	*For a young child, starting at the top of the chart and moving down may help the child accommodate and focus their vision for screening.* *Observe the eye is covered. Observe and note whether the child is squinting.* *To pass a line, the child must correctly identify at least one more than half the symbols on that line.* *If the child struggles or hesitates, go to a larger line. If the child passes the larger line, offer the next smaller line again.* *Move steadily at the child's pace. For some children, vision screening is a challenging exercise of manual dexterity and/or letter comprehension. Offer encouragement and praise as the screening progresses.* *Proceed with screening to the smallest line the child can pass (referred to as screening to threshold).*
6. Record results	*Results are expressed as a fraction, with the numerator representing the distance of screening (20 ft., or 10 ft. expressed as 20 ft. equivalents using the measures found on the chart). The denominator is the smallest-sized line the student successfully passed by correctly reading one more than half of the symbols for that line.* *Notations should be made if the student is screened wearing glasses or contact lenses.* *Parents should be notified of need for further evaluation if screener observes behaviors or signs indicating vision concern, for example persistent squinting; head-tilt or other positioning trying to see the vision chart; unusual appearance of the eyes.*
7. Carry out rescreen and notification procedures per local school practice/policy.	*Students who do not pass the initial screening should be rescreened within 2-4 weeks to verify results.* *Parents of students aged 3-5 years and in kindergarten are notified of need for further evaluation when screening result in either eye is 20/50 or worse.* *Parents of students in all other grades are notified of need for further evaluation when screening result in either eye is 20/40 or worse.* *Parents of students in all grades are notified of need for further evaluation when screening results show a two line difference between the passing acuity of each eye.*

Additional technical information and resources are available from the DHHS School Health Program, 402-471-0160.

ATTACHMENT 2C: NEAR VISION SCREENING COMPETENCIES

VISION SCREENING COMPETENCIES: NEAR VISION
Essential Steps for Accurate Measurement

COMPETENCY	KEY POINTS AND PRECAUTIONS
1. Assemble required equipment and supplies. In addition to eye chart and accurate floor distance measurement, as required for distant vision screening, this screening also requires the use of +2.50 diopter lenses, suitable for the student holding in front of their eyes to view the vision chart.	*Hyperopia screening can be conducted smoothly and efficiently as a final step in distant vision assessment, taking very little additional time and preparation.*
2. After the child completes distant vision screening, instruct him or her to remain in place, heels on the line of measurement from the chart, and briefly close and rest the eyes. The child is instructed (or provided demonstration) of holding up the diopter lenses in front of the eyes as one would hold opera glasses. Correct recognition of more than half the letters, pictures or symbols on the 20/30 line, viewed through the diopter lenses, constitutes a "**non-passing"** result.	*Screening under poor lighting will affect screening results.* *Monocular testing for distant vision may fatigue the eyes, so many students benefit from briefly closing both eyes.* *Some nurses find it helpful, on noticing that a child is struggling or straining to read letters on the chart, to simply ask the question: "Are the letters clear or are they blurry?" (Students who pass the test often comment that the letters are blurry.)* *If the student wears glasses, the glasses remain on for near vision screening and the diopter lenses are held in front of the student's own glasses.* *The inability to read the 20/30 line is considered **passing** and the child likely has no treatable hyperopia.*
3. Record results	*A child who can successfully read through the diopter lenses **does NOT pass** the screening.* *Rescreening should be conducted in 2-4 weeks to verify results prior to referral.*
4. Carry out rescreen and notification procedures per local school practice/policy	*Parents should be notified of need for further evaluation by a vision professional if rescreening results in non-passing outcome.*

Additional technical information and resources are available from the DHHS School Health Program, 402-471-0160.

ATTACHMENT 2D: DENTAL SCREENING COMPETENCIES

DENTAL SCREENING COMPETENCIES
Essential Steps for Accurate Measurement

COMPETENCY	KEY POINTS
1. Plan for a smooth flowing screening activity: Notify families of dental screening day. Plan logistics of student flow.	*Coordinate scheduling of dental screening with building administrators and teachers. If efficiently organized for traffic flow, each inspection will take one minute or less.* *If available, for infection control purposes, team each screener with a person to record results of inspection for each student.* *Try to avoid screening immediately after a meal or snack. If necessary offer sugar free gum to help remove food particles before screening.*
2. Assemble necessary supplies and equipment: • Good light source (flashlight or goose-necked lamp) • Gloves • Single-use disposable tongue blades (optional), • Trash can with liner, • Alcohol-based sanitizer. • Student roster, pen, and writing surface for each recorder at each station; or alternative method for recording results.	*A good light source is essential: An LED light source is preferred!* *Tongue blades are used to move tongue or cheek as needed to see teeth; discard after each student, and used at the discretion of the screener.*
3. Glove, or prepare for "no-touch" screening.	*Gloves are not required unless contact is to be made with student's skin, lips, teeth, or saliva. Most dental inspections will not necessitate physical contact.* *Change gloves as needed between students or after coming into contact with anything that has touched skin, lips, teeth, or saliva.* *Masks are optional at the discretion of the screener.* *Hand sanitizer or hand washing between students is strongly recommended if contact occurs, and/or between glove changes.* *Prepare for proper disposal of all contaminated materials.*
4. The examiner positions him or herself in a comfortable face-to-face position with the child. The child bares teeth for inspection of outer surfaces. Have the child open mouth as wide as possible for inspection of chewing and inner surfaces of teeth. Child lifts and moves tongue so screener can see inner, outer, and top surfaces of all teeth, or screener may use	*Look for gross, obvious problems in this brief visual inspection.* *See color plate examples of significant findings for comparison.*

tongue blade to gently maneuver tongue. Utilizing light source, observe teeth for irregularities: • areas where teeth are eroded or not the usual shape, • unusually-colored teeth: severe discoloration	
5. Record results. Assign student to one of the following categories: 0 = no obvious irregularities of the teeth 1 = observable irregularities with the teeth in one or two areas. Parents are notified of need for further dental care. 2 = observable irregularities with the teeth in three or more areas. Parents notified of need for further dental care.	*Indicate location of areas of concern by quadrant (upper right, lower right, upper left, lower left) – oriented to the student's right and left sides.* *Incidental observations about the gums or oral mucosa are noted and reported to the school nurse or communicated to parents at the screeners' discretion.* *Note date, and name of qualified screener.*
6. Carry out rescreen and notification procedures per local school practice/policy.	*Parents are notified of the need for further evaluation for "1" and "2" results.* *Urgent notifications should be made to parents if/when there are severe changes to any teeth, any complaints of mouth or tooth pain, and/or any areas of apparent swelling or drainage, indicating possible active infection or injury.*

Additional technical information and resources are available from the DHHS School Health Program, 402-471-0160.

ATTACHMENT 2E: WEIGHT/HEIGHT STATUS SCREENING COMPETENCIES

WEIGHT/HEIGHT STATUS SCREENING COMPETENCIES: Body Mass Index Essential Steps for accurate measurement.

COMPETENCY	KEY POINTS AND PRECAUTIONS
1. Assure students' privacy needs are met.	*A cubicle or stall-style approach to provide visual privacy is suggested. Making a line for students to stand behind while waiting helps reduce crowding and teasing around the scale Avoid statements about a student's weight that others will be able to hear.*
2. Assemble equipment and prepare environment for measurements.	
3. Assure scale balances correctly at "0" pounds, or scale shows "0" when empty.	
4. Stadiometer is correctly placed with "0" at floor level	
5. Students remove shoes and heavy outer clothing prior to measurement.	*Excessive shoes and excessive clothing will affect accuracy of measurement.* *When BMI is calculated, height is used in the denominator. Errors in measurement can have a larger effect on accuracy than expected.*
6. For weight measurement, student stands in center of weighing platform, bearing full weight equally on both feet, no shoes.	
7. Measure weight in pounds to nearest quarter pound (0.25).	
8. For height measurement, student stands straight and looking straight ahead with back touching stadiometer surface.	*Measurement surface touching student's head should be at least 3" wide. Press down sufficiently to flatten hair on top of head. Have student look straight ahead, ears in (horizontal) line with nose.*
9. Immediately recheck height. If second measure is not within ¼" (.25 ") of first measure, recheck a third time.	*Accurately measure height in inches to nearest ¼ (0.25)".*
10. Record results.	*BMI is calculated from height and weight measurements, gender, birth date and date of measurement.The CDC group BMI calculator is found at www.cdc.gov. Use the search field to locate "BMI group calculator".*
11. Carry out rescreen and notification procedures per local school practice/policy.	*See guidelines for more information. Aggregate information about weight/height status of students may be useful for evaluating School Wellness Policies, or contributing to community-level efforts to promote healthy living.*

Additional technical information and resources are available from the DHHS School Health Program, 402-471-0160.

TITLE 173 COMMUNICABLE DISEASES

CHAPTER 8 CONCERNING THE ESTABLISHMENT AND OPERATION OF THE NEBRASKA STATE IMMUNIZATION INFORMATION SYSTEM

8-001 SCOPE AND AUTHORITY: The purpose of these rules is to implement Neb. Rev. Stat. §§ 71-541 to 71-541.01 which authorizes the Department of Health and Human Services to establish an immunization information system (IIS) for the purpose of providing a central database of immunization information which can be accessed and used pursuant to these rules and regulations.

8-002 DEFINITIONS: When terms are used in 173 NAC 8, the following definitions apply:

Authorized user means all health care professionals, health care facilities, health care services, schools, postsecondary educational institutions, electronic health-record systems, public health departments, health departments of other states, Indian health services, and tribes who are permitted access to immunization records in the State Immunization Information System.

Data encryption means the electronic obfuscation of data within an electronic message using industry standard practices for encryption.

Department means the Department of Health and Human Services.

Electronic health record (EHR) system means any computerized or electronic system used to capture and store patient identifying health information including immunization data.

Health care facility means any facility licensed or exempt from licensure under the Health Care Facility Licensure Act.

Health care professional means any person authorized by law to order or administer an immunization.

Health care service means any service licensed or exempt from licensure under the Health Care Facility Licensure Act.

Health department of other states means any State Health Department established to promote the health and well-being of all residents within its jurisdiction.

Immunization standard message means a standard electronic message meeting specifications as identified by current versions of the Nebraska State Immunization Information System *Flat File Specifications* or *HL7 Specifications for Immunization*.

Licensed child care facility means any facility or program licensed under the Child Care Licensing Act.

Postsecondary educational institution means any organization or business enterprise which offers courses or subjects for which tuition is charged, and at the place of business of which a course of instruction is available through classroom instruction, home study, or both to a person for the purpose of training, preparing, or improving the person for an occupation even though the organization's or business enterprise principal efforts may not be exclusively educational in nature.

Local public health department has the same meaning as in Neb. Rev. Stat. § 71-1626.

Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Real-time message means the transmission of discrete standard electronic messages to the Department as they are generated by the EHR system.

Restricted immunization information means all information contained within an immunization record in the IIS is restricted by the patient or, if the patient is a minor, the patient's parent or legal guardian, from access from everyone other than the professional or entity that provided the immunization(s).

School means any approved or accredited school under Neb. Rev. Stat. §§ 79-318 or 79-1601 offering courses of instruction to its students on the school's premises.

Secure message transport protocol means a method of sending electronic data to the department in a way that prevents unauthorized access to the data as specified by the Department.

8-003 ESTABLISHMENT

8-003.01 The following may be entered in the State IIS:

8-003.01A All children born in the state will be entered in the IIS through information from Vital Records of the Department. This information will include: the child's name (first, middle and last); date of birth, gender, address, including zip code, mother's maiden name, mother's or other responsible party's name (first, middle and last); address, including zip code.

8-003.01B Any person who receives an immunization in the state may be enrolled in the IIS.

8-003.01C Nothing in these rules requires the consent of a parent, guardian or individual prior to entering in the registry.

8-003.02 Restriction

8-003.02A The records of an individual entered in the registry may be restricted by signing and submitting a non-disclosure form by the patient, parent, or guardian. The non-disclosure form must be submitted to both the immunization provider and the Department.

8-004 WHO MAY REPORT AND HOW TO REPORT

8-004.01 Any person who provides immunizations may submit to the Department immunization information as follows:

8-004.01A Immunization data may be manually entered or electronically submitted as an Immunization Standard Message, using secure message transport protocols and data encryption.

8-004.01B Electronic data must be submitted as an Immunization Standard Message. Real-time messages must meet the Department's HL7 specifications. File formats must be approved and agreed upon by the Department prior to submission of messages.

8-001.01C The minimum dataset should be manually entered or electronically submitted within 14 calendar days of the date of immunization administration.

8-004.01D Authorized users may submit data directly to the Department or through a third party acting as their agent. Authorized users selecting this option are responsible for ensuring that all data specifications conform to the requirements of this rule.

8-005 ACCESS TO IMMUNIZATION RECORDS

8-005.01 An authorized user may only access unrestricted information in the IIS as follows:

8-005.01A An authorized user will be given a unique user ID, password, and system role which will determine the level of access to unrestricted immunization information on an individual who is presently under that authorized user's care, or enrolled in the authorized user's facility, school, post-secondary educational institution, program or health plan, except as otherwise provided by law.

8-005.01B An authorized user that is a state or local public health authority may, in addition to accessing unrestricted information described in subsection 8-005.01A of this rule, access unrestricted information on an individual within the public health jurisdiction for authority's assessment, evaluation, surveillance and outreach related to immunization promotion and vaccine-preventable disease prevention.

8-005.01C The Department may require any authorized user who has accessed an individual's record to provide evidence that such individual was under the care of the authorized user or enrolled in the authorized user's facility, school, post-secondary educational institution, program or health plan at the time the individual's record was accessed.

8-005.01D The Department may report violations of these rules by any authorized user who has accessed an individual's record to the appropriate licensing or regulatory authority.

8-005.02 Individuals, parents, and guardians are authorized access to their own or their child's immunization record. To ensure data confidentiality the Department shall:

8-005.02A Require that the first name, last name, date of birth, and social security number be populated in the IIS in order for the record to be accessed by the individual, parent, or guardian.

8-005.02B Require the individual, parent, or guardian to search for a record using the first name, last name, date of birth, and social security number of the Individual for whom they are searching.

8-005.02C Display, upon successful search, first name, middle name, last name, date of birth, gender, race, ethnicity, mother's maiden name (first and last), date of immunization, immunization type, and immunization recommendations, and shall not display social security numbers and address information.

8-005.02D A licensed child care facility may access the immunization record of a child under its care.

8-006 DATA CONFIDENTIALITY AND SECURITY

8-006.01 Identifiable immunization information from the IIS shall only be disclosed to authorized users or as otherwise stated in these rules.

8-006.02 An authorized user shall not disclose information from the IIS except to another authorized user or as otherwise stated in these rules.

8-006.03 All authorized users shall abide by such security policies and procedures to safeguard information in the IIS deemed necessary by the Department. Such policies and procedures may include, but are not limited to, confidentiality agreements, the use of computer passwords, and user identification codes. The Department shall provide copies of the policies and procedures to all authorized users who participate in the IIS. Policies and procedures may be supplied electronically through the IIS.

8-006.04 No authorized user shall be subjected to civil or criminal liability, or be deemed to have engaged in unprofessional conduct for reporting to, receiving from, or disclosing information relating to the IIS when made reasonably and in good faith and in accordance with the provisions of these rules or any regulation adopted thereto.

8-006.05 The Department must secure the data within the IIS in a manner that will ensure the confidentiality and security of said data.

8-006.06 The Department must maintain a secure message transport protocol which ensures the confidentiality and security of said data.

TITLE 173 CONTROL OF COMMUNICABLE DISEASE

CHAPTER 9 ELECTRONIC REPORTING OF ELECTRONIC HEALTH RECORD (EHR) DATA FOR PUBLIC HEALTH SYNDROMIC SURVEILLANCE

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TITLE 173 CONTROL OF COMMUNICABLE DISEASES

CHAPTER 9 ELECTRONIC REPORTING OF ELECTRONIC HEALTH RECORD (EHR) DATA FOR PUBLIC HEALTH SYNDROMIC SURVEILLANCE

9-001 SCOPE AND AUTHORITY: This rule establishes procedures for secure electronic reporting of electronic health record data by licensed hospitals and emergency care facilities to the Nebraska Department of Health and Human Services for the purpose of detecting, tracking and controlling infectious and non-infectious conditions, including poisonings, injuries, and chronic diseases, to protect and safeguard the health of the citizens of Nebraska as pursuant to the provisions of Neb. Rev. Stat. §§ 38-178, 38-182, 71-448, and 71-552.

9-002 DEFINITIONS: When terms are used in 173 NAC 9, the following definitions apply:

Acute care hospital encounter means patients seen in the following settings: emergency room, urgent care and inpatient admissions of a hospital.

Acute care hospital inpatient encounter means patients admitted to a hospital.

Batch message file means the transmission of a file containing multiple discrete standard electronic messages to the Department from the hospital data system on a periodic basis less than real time.

Data encryption means the electronic obfuscation of data within an electronic message using industry standard practices for encryption.

Department means the Department of Health and Human Services.

De-identified patient data means electronic health record information that does not identify an individual and to which there is no reasonable basis to believe that the information can be used to identify an individual.

Director means the Director of the Department's Division of Public Health.

ER/UC standard message means a standard electronic message as specified in the most current version of the Syndromic Surveillance Event Detection of Nebraska (SSEDON) *Emergency Department Syndromic Surveillance HL7 Implementation Guide*.

Health Care Facility means any facility licensed under the Health Care Facility Licensure Act, and such additional clinics or facilities not licensed under that act as may be identified pursuant to 173 NAC 9-016.

Hospital means any hospital licensed by the Department pursuant to Neb. Rev. Stat. § 71-401 et seq., and including critical access hospitals and general acute hospitals as defined by Neb. Rev. Stat. §§ 71-419, 71-409, and 71-412.

Public Health Authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Real time message means the transmission of discrete standard electronic messages to the Department as they are generated by the hospital data system.

Secure message transport protocol means a method of sending electronic data to the Department in a way that prevents unauthorized access to the data as specified by the Department.

9-003 WHO MUST REPORT: Hospitals which treat patients in an emergency department/urgent care setting shall submit to the Department a minimum data set on all acute care hospital ER/UC encounters.

9-004 IMPLEMENTATION SCHEDULE: Hospitals must implement the electronic data exchange specified in these regulations no later than January 1, 2016.

9-005 DATA STANDARDS AND SPECIFICATIONS: The data content and format for **emergency rooms and urgent care encounters** shall conform to the ER/UC standard message; the minimum set of ER/UC data elements is listed in Attachment 1 (attached and incorporated in these regulations by this reference).

9-006 DATA EXCHANGE:

9-006.01 Data exchange will employ industry standard secure message transport protocols and data encryption.

9-006.02 Timing of ER/UC Reports: Encounter data shall be submitted a minimum of once per day as a batch message file containing the previous day's ER/UC encounters and updates.

9-007 SUBMISSION OF REPORTING PLAN FOR ACUTE CARE HOSPITAL ER/UC ENCOUNTERS: Beginning no later than six months after the effective date of these regulations, every hospital which treats patients in an emergency department/urgent care setting shall submit to the Department for approval an implementation plan that specifies how and when they will submit ER/UC encounter data to the Department in compliance with section 9-004 of this rule. Amendments to a previously approved plan require Department approval. The plan shall include at a minimum:

1. Timing of messages (either real time or batch);
2. Secure message transport protocols to be used when submitting data to the Department;
3. Proposed format of data if the hospital is not able to conform to the standard electronic message as specified in 9-005 of this rule;
4. Proposed format code set domain values if the hospital is not able to conform to the code sets defined in standard electronic messages as specified in 9-005 of this rule;
5. Hospital technical contact(s) and contact information for the Department to utilize in the event technical assistance or support is necessary;
6. Expected date to begin sending messages; and
7. If a change request, the reason for change.

9-008 SUBMISSION OF DATA THROUGH A THIRD PARTY: Hospitals may submit data directly to the Department or through a third party acting as their agent. Providers selecting this option are responsible for ensuring that all terms of these regulations are met by the third party.

9-009 RELEASE OF DE-IDENTIFIED PATIENT DATA AND PATIENT CONTACT: The Department may release de-identified patient data on hospital encounters to a public health authority (e.g. US Centers for Disease Control and Prevention) to assist the agency in fulfilling its public health mission. These data shall not be re-released in any form by the public health authority without the prior authorization of the Department. Authorization for subsequent release of the data shall be considered only if the proposed release does not identify a patient, physician or provider. To protect and safeguard the health of the citizens of Nebraska the Director or the Director's designee may authorize the collection of information as to enable contact with a patient, physician or provider based upon data authorized and submitted under these regulations.

9-010 INABILITY TO COMPLY: Any hospital which determines it will be temporarily unable to comply with any of the provisions of this rule or with the provisions of a previously submitted plan or plan of correction can provide the Department with written notification of the expected deficiencies and a written plan of correction. This notification and plan of correction shall include the section number and text of the regulation in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

9-011 NOTIFICATION OF NONCOMPLIANCE: Any hospital, which is not in compliance with these rules, may be notified in writing by the Department. Such notification if deemed necessary shall specify the deficiency and the action, which must be taken to be in compliance. The hospital must provide the Department with a written plan for correcting the deficiency within the timeframe specified in the written notification of noncompliance. The plan of correction shall specify the

means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

9-012 DEPARTMENT ACCEPTANCE OF PLAN OF CORRECTION: Upon receipt of a required plan of correction, the Department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the Department shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the Department shall notify the hospital's chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. If such notification is provided, a revised, acceptable plan of correction must be provided to the Department within the timeframe specified in the notice of non-acceptance.

9-013 CONTINUED AND SUBSTANTIAL NONCOMPLIANCE: Any hospital in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the Department to its Health Licensure and Investigations Section. At the discretion of the Director of the Department, the Department shall notify the noncompliant facility of proposed Departmental actions as authorized in Neb. Rev. Stat. § 71-552.

9-014 REPORTING AND SUBMISSION OF ACUTE CARE HOSPITAL INPATIENT ENCOUNTER DATA BY HOSPITALS: Hospitals which treat patients in an inpatient setting may submit to the Department a data set on all acute care hospital inpatient encounters. Such submissions shall conform pursuant to specifications as defined by the Department. The Director may require reporting of acute care hospital inpatient encounter data by hospitals if deemed necessary to detect diseases, syndromes, or exposures that can cause or are suspected to cause serious morbidity or mortality and such other reporting as necessary to protect public health.

9-015 REPORTING AND DATA SUBMISSION BY PROVIDERS OTHER THAN HOSPITALS: Other Health Care Facilities may submit electronic health record data to the Department. Such submissions shall conform pursuant to specifications as defined by the Department. The Director may require reporting of providers other than hospitals if deemed necessary to detect diseases, syndromes, or exposures that can cause or are suspected to cause serious morbidity or mortality and such other reporting as necessary to protect public health.

Syndromic Surveillance Event Detection of Nebraska (SSEDON)

Data Element List for Emergency Department Syndromic Surveillance

Document Version 1.1

July 2013

This data element list contains a description of the demographic and clinical elements contained in the inpatient data set to be sent from hospitals. These messages are sent to the Syndromic Surveillance Event Detection of Nebraska system as a part of the Nebraska Department of Health and Human Services for syndromic surveillance purposes.

Emergency Department Data Element List

Element Name	Element Description	Element Requirement
Treating Facility Identifier	Code identifying treating facility from which the patient encounter originated.	**Required**
Treating Facility Address	Address of Treating Facility	**Required if Recorded**
Facility Type	Category of Facility or Encounter	**Required**
Patient Identifier	Uniquely identifies a patient and his/her medical record/information for the facility identified in Treating Facility Identifier.	**Required**
Patient encounter identifier	Unique identifier for this patient's encounter at the facility identified in Treating Facility Identifier.	**Required**
Date of admission	Date and time when the patient was admitted to the emergency department.	**Required**
Mode of Arrival	Indicates how the patient arrived at the health care facility	**Required**
Patient Class	Patient classification within facility. Limit values to E:Emergency, I:Inpatient, O:Outpatient	**Required**
Date of discharge	Date when the patient was discharged from this care facility	**Required**
Discharge disposition	Code indicating the place or setting to which the patient was discharged.	**Required**
Patient encounter reason	Short description of the patient's self-reported chief complaint or reason for visit	**Required**
Triage Note	Initial triage assessment of the patient	**Required**
Admit Reason	Provider's reason for admitting the patient	**Required**
Type of patient encounter	Code identifying type of patient encounter.	**Required**
Current Problem List	List of current illnesses as reported by patient at the time of the patient encounter.	**Required**
Active Medication List	List of active medications at the time of admission (name only)	**Required**
Discharge Medications	List of discharge medications (name only)	**Required**
All Diagnoses Codes	All diagnoses codes associated with encounter to include but not limited to diagnosis code, type, and date of diagnosis	**Required**
Date of Onset	Date of illness onset as reported by patient	**Required**

Element Name	Element Description	Element Requirement
Height	Patient body height and associated unit of measure	**Required**
Weight	Patient body weight and associated unit of measure	**Required**
Temperature	Patient body temperature and associated unit of measure	**Required**
Pulse Oximetry	Oxygenation percentage of the patient's hemoglobin	**Required**
Blood Pressure (BP)	Initial blood pressure reading including date/time of observation	**Required**
Smoking Status	Smoking Status	**Required**
Pregnancy Status	At the time of the encounter was the patient pregnant	**Required if Recorded**
Cause of Death	Preliminary cause of death	**Required**
Lab Orders	Lab tests ordered for the patient	**Required if Recorded**
Lab Test Results	Lab results for the patient to include test result, test date, and reference range	**Required if Recorded**
ED Acuity Assessment	Assigned value for ED acuity on patient encounter	**Required if Recorded**
Transferred to/from ICU	During the encounter was the patient transferred to/from the ICU	**Required if Recorded**
Orders	Were special orders given during the patient encounter (e.g. chest x-ray, ventilator, or precautions)	**Required if recorded**
Patient Gender	Code indicating gender of patient	**Required**
Patient Date of Birth	Patient date of birth	**Required**
Patient Race	Code indicating race of patient	**Required**
Ethnic Group	Code indicating ethnicity of patient	**Required**
Patient city/town of residence	Name city/town of residence	**Required**
Patient state of residence	Code indicating state of home residence.	**Required**
Patient zip code of residence	Zip Code portion of the patient's home address.	**Required**
Census tract	Census Tract information based on patient address of residence	**Required if Recorded**
Patient county of residence	Code indicating county of residence	**Required**
Patient country of residence	Code indicating country of residence	**Required if Recorded**
Type of primary payer	Code indicating primary source of payment	**Required**

Element Name	Element Description	Element Requirement
Total charges	Total charges to patient from facility related to encounter	**Required if Recorded**
Education Level	Highest level of education attained by patient	**Required if Recorded**
Hospital Unit	Hospital Unit where patient is at the time the message is sent	**Required if Recorded**
Occupation/Industry of patient	Descriptive name of patient's occupation/industry	**Required if Recorded**
Employment Indicators	Information related to the patient's job to include but not limited to employment status, employer, activity level, work hazards, etc.	**Required if Recorded**