



MISSISSIPPI STATE DEPARTMENT OF HEALTH

GENERAL Agency Manual

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Equal Opportunity in Employment/Service

**General Agency Manual
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MISSION

The mission of the Mississippi State Department of Health is to promote and protect the health of the citizens of Mississippi.

VISION

The Mississippi State Department of Health strives for excellence in government, cultural competence in carrying out its mission, and local solutions to local problems.

VALUES

The Mississippi State Department of Health identifies its values as applied scientific knowledge, teamwork, and service excellence.

Authority Statement

The Board of Health was formed in 1877. MSDH was established in 1982, but was later reconstituted in 2007. The MSDH operates under the authority of Mississippi Code Title 41-3-15, Public Health, which created the department.

Organizational Structure

The Mississippi State Department of Health (MSDH) is a statewide, centralized public health agency governed by a statutorily described Board of Health with eleven members who have staggered six year terms and are appointed by the Governor. The Board of Health provides policy oversight and is responsible for appointing the State Health Officer, who serves a six-year term. MSDH Central Office provides administrative and financial support, as well as many statewide services such as vital records, disease surveillance, and program direction and oversight. Within MSDH are nine public health District Offices that provide services such as outbreak investigation and tuberculosis follow-up and also provide local administrative oversight for 87 public health clinics in 80 of the 82 counties. Mississippi has no independent local or regional health departments. This centralized structure allows for more uniform service delivery, implementation of statewide standards, and reduces redundancies and administrative costs.

Roles and Responsibilities

MSDH accomplishes its objectives through five major programmatic and administrative offices.

- Administrative and Support Services are led by the agency's Chief Administrative Officer. This support area carries out such functions as budgeting and accounting, human resources, information systems technology, and facilities management. The office also includes Vital Records/Health Statistics, Office of Performance Improvement, Office of Policy Evaluation and Governmental Relations, and the Public Health Pharmacy.
- Health Protection oversees licensure of designated healthcare and child care facilities, in addition to certain types of practitioners, ensuring they meet minimum standards and comply with laws and regulations. Health Protection leads environmental health programs, which



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regulate the public water supply, food service and processing establishments, onsite wastewater disposal systems, and other areas of environmental concern. Emergency preparedness and response programs ensure readiness for any public health threat or emergency.

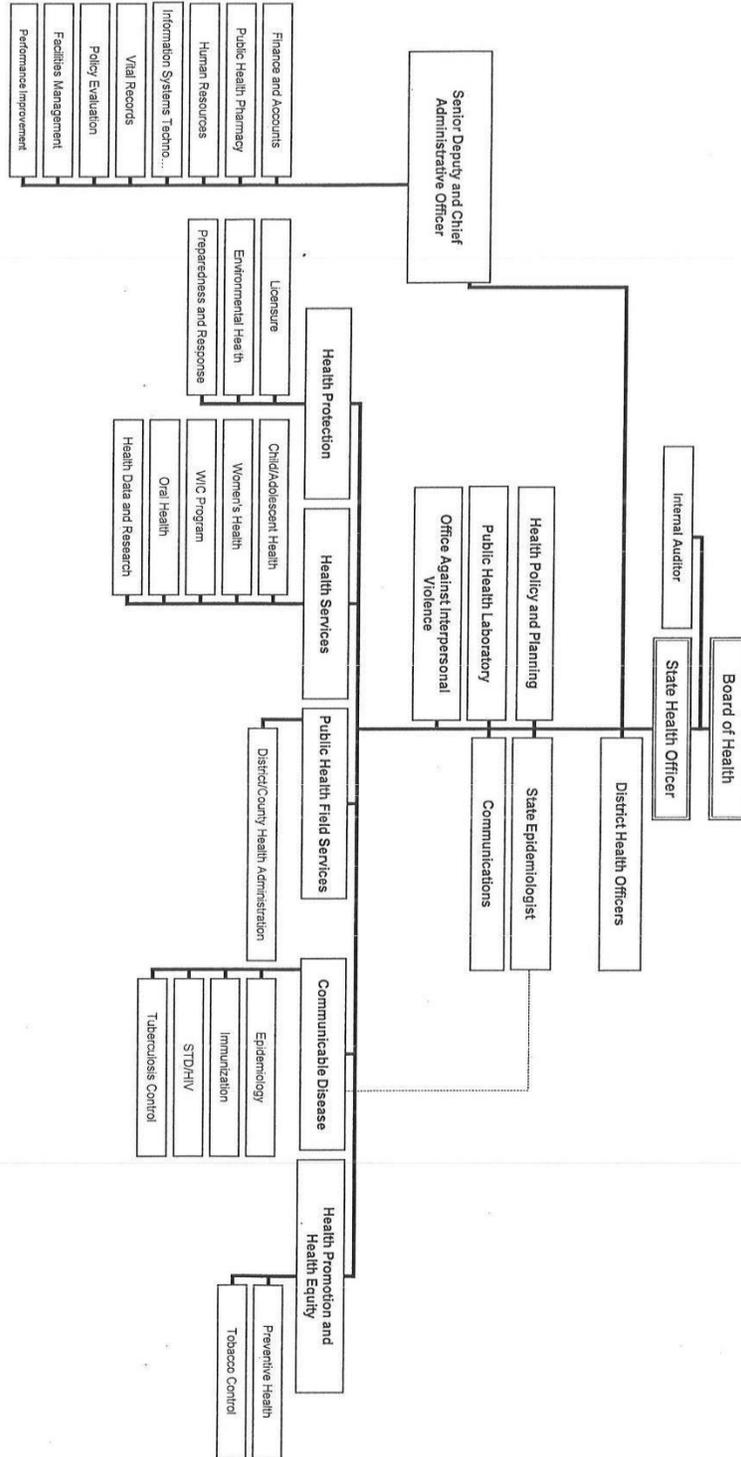
- Health Services oversees programs to improve women's and child/adolescent health in Mississippi.
- Communicable Disease carries out programs to reduce the spread and rate of premature death from these diseases.
- Health Promotion and Health Equity oversees preventive health programs and efforts to reduce the use of tobacco.
- Health Policy and Planning, Communications, the Public Health Laboratory, and the Office Against Interpersonal Violence are under the direct guidance of the State Health Officer. The State Health Officer also works directly with the State Epidemiologist and the District Health Officers.

MSDH carries out numerous functions at the local level through its district offices, county health departments, and other clinics. Each of the nine districts provides direction and support to the county health departments under its supervision. The Director of Field Services leads the district administrative staff through District Administrators. District Health Officers provide epidemiological and medical guidance.



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Mississippi State Department of Health
Functional Organizational Chart



Shirley E. Allen
State Health Officer

Agency: 0301
FY 2017
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2.1 ID Badge Policy

See Health Informatics, Workforce Security section, for employee access/identification badge policies and procedures.

2.2 Requests and Correspondence with the Legislature, Outside Agencies, and Individuals

During the course of carrying out Mississippi State Department of Health (MSDH) responsibilities, staff may be contacted by the public, appointed or elected officials, outside agencies, or the press for information. The following policies should be followed:

- A. Requests for any information about programs or services may be handled by the appropriate office, as expeditiously as possible. Please ensure that any information given is complete, accurate, and timely. When unsure, refer the person to someone who has the correct information. When unsure about the appropriate referral point, route the call to Policy Evaluation. Requests related to MSDH’s position on any issue not already described in writing should be routed to Policy Evaluation.
- B. When information of any nature is requested by a state or federal official, including legislators, agency directors, or any other officials, notify Policy Evaluation within 24 hours of providing the information. Notification should include the name and title of the requestor, date of the request, the nature of the materials or information given, and any follow-up needed.
- C. Requests for information regarding MSDH personnel or personnel-related matters should be referred to Human Resources or to the Chief Administrative Officer. All requests for information from persons identifying themselves as “private investigators” should also be referred to Human Resources.
- D. Correspondence to any federal agency, other state agency directors, or to other official entities should be approved by the respective Office Director and Policy Evaluation prior to its transmission.
- E. Contacts from the media and the press, as well as requests for public records, shall be routed to Communications in accordance with established policy. When necessary, MSDH legal counsel will advise on the applicability of the Public Records Act.
- F. Any requests from state or federal investigatory agencies should be reported to the Chief Administrative Officer.
- G. Reports prepared for the Mississippi Legislature should be routed to and approved by the respective Program Director, Office Director, Policy Evaluation, the Chief Administrative Officer, and the State Health Officer prior to publication or transmission.

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2.3 Solicitation or Acceptance of Gifts by Employees

MSDH employees are not to solicit, request, or accept gifts, gratuities, or anything of significant value from patients, clients, licensees, contractors, subcontractors, grantees, sub grantees, or from anyone or any entity with whom the employee or the MSDH has a relationship arising from their work. Money or any gift of transferable monetary value is considered to have significant value. Any employee who violates this policy will be subject to appropriate disciplinary action. This policy does not prohibit consideration of a patient's personal feelings or the sharing of an article without significant value. Questions about this policy should be routed to the agency's Legal department.

2.4 Public Health Services to MSDH Employees

MSDH employees who seek MSDH services will be treated the same as the public at large (i.e., full pay for services or qualifying for appropriate sliding fee scale services). No employees shall receive free services except for those provided as requirements of employment, such as specific immunizations. This policy also extends to pharmaceuticals, supplies, or other goods and services provided by MSDH programs.

2.5 MSDH Employees Transporting Clients

In the course of providing services to clients, MSDH employees may be called upon to assist with transportation needs. It is the responsibility of the employee to assist the client in accessing resources to assure transportation to needed services and may consult other MSDH employees or outside resources to accomplish this goal. It is not recommended that employees routinely transport clients in personal vehicles. Professional judgment should include consideration of personal safety, unique client circumstances, and client need.

2.6 Policies Regarding City and County Jails

The District Health Officer, upon request from appropriate local officials such as mayors, aldermen, or supervisors, shall investigate and examine sanitary conditions of any city or county jail and shall suggest and recommend suitable sanitary measures for the same. Local health departments will provide the same medical and nursing services to inmates as are offered to the general public. Basic public health services and screening, such as acute communicable disease surveillance and control, TB detection and treatment, STD/HIV screening and follow-up, and food service sanitation, should be emphasized in the inmate population as a high-risk target group. The provision of primary medical and nursing care by MSDH personnel for inmates is not recommended.

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2.7 Criteria for Measuring, Evaluating, and Monitoring Performance

MSDH has established processes for strategic planning, establishing program goals and objectives, monitoring the quality of programs and service delivery activities carried out by the local service delivery units (clinics, WIC distribution centers, and home health units), and for fiscal and internal audit. These processes include review of all dimensions of MSDH (including counties, districts, programs, disciplines, and related or support units). Each major activity implemented at the local level has a quality review component of the internal review process. The desired result of the process is a continuous improvement in the quality of services delivered to the citizens of the state. Specific processes include the following:

A. Strategic Planning

Each year, all MSDH programs work with Policy Evaluation to review their strategic vision and develop objectives for the next five years. The programs report the level of accomplishment of each objective in the Performance Measures submitted to the Mississippi Legislature with the agency's annual budget request.

B. Monitoring and Reviews

Various programs conduct ongoing compliance reviews at the district and county level according to federal and state rules and regulations and program requirements. In addition, district staff monitors performance at the county level, and Policy Evaluation conducts complete program reviews at the request of the State Health Officer. All of these reviews are key to the operations of selected programs and activities and are a significant part of MSDH's total quality management program.

C. Fiscal and Internal Audits

The Internal Auditor is hired by and reports directly to the State Board of Health. Internal Audit staff conduct financial, compliance, and operational and efficiency audits of the agency and evaluate internal controls over all major systems of accounting, administration, electronic data processing, and other systems to ensure accountability.

Audits consist of all nine public health districts and each office unit in the Central Office. The Internal Audit Director reviews all audits, and the director of each office or district receives a copy of the report for response and corrective action. When appropriate, copies of supporting documentation, such as memos or inventory forms, accompany the response. The reports, along with the response and corrective action, are issued to the State Health Officer and the Board of Health each quarter in accordance with the Mississippi Internal Audit Act.

In addition, MSDH is audited by other agencies or entities that provide funds to the agency or contract with the agency for services. Any responses to these audit reports must be reviewed for consistency with other review responses, agency policy, and follow-up requirements and should be coordinated through Finance and Accounts.

D. Complaint Investigation

Complaints from the public or from staff are relayed to the Office of Field Services or to

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Compliance for follow up. Coordination with other offices (i.e., Human Resources or program offices) is planned as required by the nature of the complaint. All complaints are investigated and reports are filed in writing for future reference. Final reports are filed in Compliance.

2.8 Joint District and Central Office Staff Meetings

Joint district staff meetings are conducted on a regularly scheduled calendar coordinated through the Office of Field Services, with designated district staff groups indicated on a calendar schedule. Central office and program staff are responsible for establishing the respective program/discipline agendas. Requests for agenda items from the field and program personnel are encouraged. Program personnel will submit agendas to the Office of Field Services at least two weeks prior to the meeting date so that agendas can be distributed to district and central office staff in a timely manner and room assignments for group meetings can be confirmed.

2.9 Tobacco Use in MSDH Facilities

The policies on tobacco use, as outlined herein are to be followed in all MSDH owned or leased facilities (including local clinics, offices, WIC warehouses, or any other locations):

- A. The MSDH Central Office campus, district offices, county offices, and any MSDH office/facility are tobacco-free environments. No tobacco use (including but not limited to: cigarettes, cigars, pipes, smokeless tobacco, and electronic cigarettes (e- cigarettes) or any other form of liquid vaporizing device) is permitted inside or outside of any buildings on any of these campuses, including the parking garage at the Central Office.
- B. "No Tobacco Use" or "Tobacco Free Campus" signs are posted in all of the above areas to inform patients and visitors of this policy.
- C. Tobacco use shall not be permitted inside any vehicle owned or operated by MSDH.
- D. Tobacco use by employees rendering services outside an MSDH facility, such as home visits or sanitation inspections, participation in meetings, conferences and health fairs etc. is prohibited while performing their duties and in contact with patients or the public.
- E. Any MSDH employee who is a tobacco user and desires professional assistance in quitting can contact the agency's Office of Tobacco Control at 1-866-724-6115.
- F. Any exceptions to these policies must be approved by the State Health Officer in writing. Should any local condition suggest the need for an exception, please submit the request through the proper channels for approval. Failure to follow this written policy is a Group II offense and may result in disciplinary action by the agency.

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2.10 Processing Mail in MSDH Facilities

All incoming mail received in MSDH facilities shall be processed as soon as practical. Office managers or other designated clerical employees shall ensure that all mail is opened, sorted, and routed to appropriate personnel or circulated for general information as the contents may dictate. Prior arrangements shall be made to ensure that if the designated personnel are on leave, or temporarily absent, other employees shall process all incoming mail in a timely manner.

MSDH cannot assume the responsibility for processing incoming personal mail for employees. Employees are reminded that personal correspondence should be directed to a residence or a post office box. All mail received at MSDH facilities will be considered official business and shall be processed as indicated herein, unless the envelope is marked “confidential” or “personal” in bold letters. Any mail marked “personal” or “confidential” should be delivered to the proper employee unopened.

MSDH employees are expressly prohibited from using MSDH stationery, supplies, or postage for outgoing correspondence of a personal nature. Such use is considered personal use of state property, which is a Group Two Offense under State Personnel Board regulations and may subject the employee to appropriate disciplinary action.

2.11 Reserved and Handicapped Parking Spaces

Reserved parking spaces for specific MSDH employees or marked parking spaces for handicapped employees, visitors, or clients are not to be utilized by other MSDH employees. This policy extends to all MSDH owned or leased facilities.

2.12 Soliciting in MSDH Facilities

Section 29-5-85 of the Mississippi Code of 1972, Annotated states, “It is forbidden to offer or expose any article for sale in or on such grounds; to display any sign, placard, or other form of advertisement therein; or to solicit fares, alms, subscriptions, or contributions therein.” MSDH policy is that this section is applicable without regard to work status or operating hours and applies to all MSDH facilities, including offices; break rooms, bulletin boards, or other forms of communication, including interoffice mail, memos, or electronic mail.

2.13 Children, Students, and Volunteers in MSDH Facilities

Children

MSDH is a professional organization and children of employees are not allowed to remain in MSDH facilities during operating hours.

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Students

Any institution of higher learning (two-year or four-year College or university) that requests student placements within MSDH shall have a signed agreement with MSDH for such placement, with these agreements routed through the process for reviewing Memoranda of Understanding. Interns who may be paid for their rotation should have an independent contractor/contract worker contract signed, with these agreements routed according to the policy for routing such contracts. The respective office budget will be charged the amount, not to exceed \$1,000 per month. Any other placement of a student or volunteer through a school or work program may be negotiated at the district level. Medical students are approved by the District Health Officers. All applicable MSDH policies will apply. No high school students are allowed to work in MSDH facilities.

Volunteers

MSDH encourages the utilization of volunteers whenever such utilization enhances the ability of programs and clinics to provide services to the public. The following procedures should be followed when utilizing volunteers:

1. Volunteers who are performing duties which require a license, such as physicians or nurses, should have a copy of the license filed in the volunteer's personnel file in the county or unit where serving.
2. Volunteers must agree to abide by all MSDH policies and procedures. The volunteer shall sign the VOLUNTEER DUTIES AND ETHICS form, located at M:\OSHO\Field Service\Volunteer forms. The form outlines a description of the volunteer code of ethics; the position's job duties, orientation and HIPAA training received, and the date's services are to be provided. The form must be kept in the volunteer's personnel file.
3. The volunteer must be able to carry out the volunteer activities at the same level of performance that is expected of MSDH employees who are similarly situated. Any problems noted should be evaluated against their degree of significance. The volunteer arrangement can be terminated by the supervisor of record if chronic problems are encountered with the volunteer's performance or if MSDH policies are violated. The appropriate district health officer, district administrator, or office director should be notified of any adverse actions which occur with volunteers.

2.14 Personal Use of State Property

In general, personal use of any state property is prohibited. Unauthorized use or misuse of state property is a Group Two Offense under State Personnel Board regulations. State law prohibits the use of state property for personal gain. The prohibition on the personal use of state property applies 24 hours a day, seven days a week, and does not end with the close of the workday or when on non-duty status.

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While not intended to be a comprehensive list, the following is provided as guidelines for items which may be subject to personal use.

Computers and Related Hardware and Software

Computers or any data processing equipment (including personal computers, file servers, printers, scanners, modems) purchased by MSDH should be used exclusively for MSDH business. Data stored on computer hard drives should be MSDH data. Games, personal business, and personal software packages and data should not be stored or used on MSDH equipment. Only properly licensed business-related software packages should be used.

Telephones, Fax Machines, and Related Telecommunication Equipment

Telephones, fax (facsimile) machines, and other telecommunications equipment should be used only for MSDH business. A limited number of emergency or urgent personal calls are acceptable; however, the length of the call should be kept to a minimum. Personal long distance calls must be charged to a personal credit card or to a residential phone.

MSDH is charged for long distance service at Central Office locations based on the number of minutes used. Rather than a flat monthly charge, the rate varies based on volume. Each unit is charged for usage regardless of time of day. Jackson locations require an access code for long distance usage. Supervisors should monitor long distance usage by employees. Use or misuse of the telephones and access codes is an individual employee responsibility. Do not share access codes. If an employee makes a call for another individual, the person placing the call should use his/her access code. MSDH staff should obtain state telephone credit cards for making long distance calls when away from their workstation.

Copiers

Most MSDH copiers are under a lease agreement with charges based on the number of copies per month. For MSDH-owned machines, there are expenses for paper and other supplies. Copiers should be used only for business related purposes and not for personal use.

2.15 Personal Cell Phones

The same agency policy related to the use of agency-owned telephone equipment governs the use of personal cell phones. A limited number of emergency or urgent personal calls are acceptable; however, the length of the call should be kept to a minimum. At no time should personal phone calls come before customer service except in extreme emergencies.

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2.16 Fitness, Exercise and Sports Activities – Employee Participation Risks

The Mississippi State Department of Health (MSDH) promotes healthy living and practices for all Mississippi residents, including MSDH employees. Agency employees are routinely exposed to the best public health practices that the agency advocates for healthy living. In addition, the agency has a structured Employee Wellness Program with Wellness Coordinators for each department to help promote and encourage active employee education and participation in programs and activities aimed towards improving employee fitness, health, wellbeing and quality of life. Employee participation, although encouraged, is strictly voluntary.

Employees who elect to participate in physical exercise or sports activities, whether part of a planned program/event or as part of an individual program or regiment, at a MSDH facility or sponsored event do so at their own risk. It is the employee's responsibility to be sure that they fully understand the nature and scope of the physical activities involved and their own physical capability to participate beforehand. By agreeing to participate in any onsite or sponsored voluntary physical activities, the employee further accepts and agrees to the following terms and conditions:

1. Upon entering a MSDH Fitness Center or other MSDH facility for exercise, the employee shall scan in and/or display proof of employment (i.e., an official MSDH ID Badge). Guests and weekend usage are not permitted.
2. The employee fully understands that there may be no attendants or other MSDH employees in attendance while the employee uses these facilities or participate in a voluntary fitness, exercise or sporting event.
3. The employee represents that he/she is or will be completely familiar with the equipment and facilities which he/she will use during visits to the Fitness Center/Facility/Event. The employee agrees to refrain from using any equipment or participating in an activity with which he/she is not completely familiar.
4. The employee represents that any exercises or exercise techniques that he/she chooses to utilize are strictly of their own selection and are not chosen in reliance upon any advice or representation of any MSDH agency or employee.
5. The employee certifies that he/she is in good physical health and is capable of engaging in the intended course of exercise in a safe and healthy manner. The employee fully understands the risks inherent in undertaking a course of physical exercise and acknowledges that it is exclusively their responsibility to seek from their own physician a medical evaluation and clearance before engaging in any physical exercise.
6. The employee agrees that a release of liability shall apply to any right of action that might accrue to him/her, their heirs and personal representatives. The employee agrees to assume all risks inherent in using the Fitness Center, its facilities and equipment, including the risk of injury caused by malfunctioning or improperly maintained equipment. This release is extended to include any MSDH facility used for exercise or MSDH sponsored event involving voluntary physical exercise or sporting activity.
7. The employee acknowledges that any time spent at a MSDH Fitness event is non-

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work time and any injuries sustained while so engaged may not be covered by Mississippi Workers Compensation.

8. The employee acknowledges that rules and regulations pertaining to the use of the premises may be posted or distributed from time to time and may be amended from time to time and that he/she will abide by all posted or distributed operating policies.
9. Lastly, in light of the foregoing, the employee hereby agrees to release, discharge and hold harmless the MSDH and its directors, employees and agents from any and all claims, demands, causes of action, judgments, costs and any liability whatsoever related to the use of any MSDH Fitness Center, facility used for exercise or non-work physical activities or any personal participation in an exercise or sporting event.

Employees engaged in regular exercise or sporting activities should thoroughly read and execute Mississippi State Department of Health Fitness Center/Employee Exercise and Employee Sports Activity Release and Waiver Agreement (Form 109) which incorporates the above terms and conditions. The signed original of Form 109 should be sent to Human Resources to be filed in the employee's personnel file, a copy should be provided to the employee's immediate supervisor and the employee should maintain a copy in their personal file. Human Resources will send a copy to the MSDH Worksite Wellness Council, which monitors MSDH employee wellness activities statewide.

2.17 Inclement Weather

Whenever the Governor declares state offices to be closed due to inclement weather conditions, the Central Office will activate its emergency plan. The Governor's Proclamation, when discretionary, will not apply to county and district health offices statewide because conditions vary within the state. Local weather conditions will be used to determine the status of continuing operations. Implementation of the Emergency Plan, imposing Administrative Leave, and the time Administrative Leave begins will be determined as follows:

Central Office - the State Health Officer or designee;

Districts and Counties - the District Health Officer or District Administrator, with concurrence from the Office of Health Administration.

[Please note that the effective date and time of all proclamations addressing inclement weather conditions may vary according to geographical areas.] Documentation should occur on the Administrative Leave Report - Facility Closure (Form 939).

The following inclement weather policies apply to all MSDH facilities:

- A. Employees previously scheduled to be on leave prior to the issuance of a proclamation closing state offices will be charged the type of leave previously approved.
- B. Employees not reporting to work for a partial day prior to the issuance of a proclamation will be charged applicable leave for the entire day.

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- C. When the proclamation covers more than one day, employees not reporting to work for a partial day prior to the issuance of a proclamation, but reporting the next available work day afterward, will be granted Administrative Leave for all days except the day the proclamation was issued, which will be charged to Personal Leave or Leave Without Pay. For example, the proclamation was issued for Tuesday afternoon until Thursday morning. An employee who did not report for work Tuesday morning, but did report on Thursday, would be granted Administrative Leave for Wednesday. However, Tuesday would be charged to Personal Leave or Leave without Pay.
- D. Employees not reporting to work for a partial day prior to the issuance of a proclamation, and not reporting the next available work day afterward, will assume the same leave status for all intervening days. For example, failure to report on Monday, the first available day prior to a proclamation, and Wednesday, the first available day following a proclamation, will result in a leave status of other than Administrative Leave on Tuesday. However, if the conditions are such that the facility is unsuitable for work activity, Administrative Leave would apply for Tuesday. However, Monday and Wednesday would remain as Personal Leave days.

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2.18 MSDH Employee Dress Code

As a professional organization that serves the public, the appearance of MSDH employees is a direct reflection on the agency. All staff are expected to dress in a neat, clean, professional manner that is in accordance with the standards and circumstances detailed below.

- A. General Appearance. Appropriate dress and personal hygiene are the employee's obligation. Each employee will present an orderly, clean and well-groomed appearance in keeping with the highest standards intended to ensure MSDH continues its reputation for rendering quality services. Hairstyles for men and women should be neat and well-kept. Employees should be careful not to apply too much fragrance that may be offensive to other staff or the public.
- B. Body Art and Modification. Some employees may have tattoos or other forms of body art or modification. Nevertheless, the MSDH expects that the nature, location, prominence and appearance of existing body art is such that it would not bring the professionalism and/or image of MSDH into question. For the purposes of this policy, body art and modification is defined as modifying, decorating, changing or altering the appearance and/or form of the body through attachments to body piercing, tattooing, branding, cutting, insertion of implants and dental ornamentation. This policy is not intended to apply to standard cosmetic tattoos, standard cosmetic or medical modifications, or standard ear piercing. Prohibited body art and/or modifications must be removed or covered during work hours, and include the following:
- a. Any form of body art or modification that is on the face, scalp, ears, neck or hands of an employee is prohibited under this policy.
 - b. Any form of body art and/or modification that a reasonable person would consider offensive.
- All body art will be evaluated on a case-by-case basis by the Office of Human Resources. In the application of this policy, consideration will be given to work health and safety, cultural and/or ethno religious issues where appropriate in accordance with relevant Anti-Discrimination and Work, Health and Safety legislation.
- C. Appropriate Attire. The guidelines for Business Casual Attire shall be followed throughout the year, except for those times when Casual Attire shall be in effect or when specifically identified in Section D. Dress Code Exceptions. When meeting with an outside party, MSDH recommends a more professional look, such as a suit or coat and tie.
- a. **Business Casual Attire.** MSDH defines Business Casual as a classic, clean cut, and put together look where a full suit is not required. Below is an overview of acceptable Business Casual Attire. This list is not intended to be all-inclusive. Rather, these items should help set the general parameters for proper Business Casual wear and allow employees to make intelligent judgments about items that are not specifically addressed. A good rule of thumb is that if unsure an article of clothing is acceptable, choose something else or inquire first. Also, it is generally better to be overdressed than underdressed.
 - i. Pants – Slacks and khakis are acceptable, provided they are clean and wrinkle free. Form-fitting pants are acceptable only when accompanied by a dress or a long (mid-thigh length) jacket or tunic top.
 - ii. Shirts – Casual shirts with collars (for men), polo shirts, sweaters, and turtlenecks are acceptable. Sleeveless tops (for women) must have straps at least two inches wide.

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- iii. Tops with bare shoulders are acceptable only when worn under another blouse or jacket. Avoid tee shirts, sweatshirts, and shirts with large lettering or logos.
 - iv. Dresses/skirts – Casual dresses and skirts with modest hemlines are acceptable. Dresses that are sleeveless but do not leave the shoulders bare are acceptable.
 - v. Footwear – Dress shoes (heels, flats, boots, sandals, dress thong sandals, etc.) are appropriate. However, flat heeled “flip flops”, rubber shoes, house slippers, moccasins, tennis shoes, casual sandals, “crocs” or other recreational shoes are not permitted.
- b. **Casual Attire.** Casual Attire shall be permissible for all Fridays. Furthermore, it is at the discretion of the MSDH State Health Officer to declare certain days, events or periods where Casual Attire is permissible. Participation on Casual Attire days is a personal decision; however, if meeting with the public, the standard dress code will still apply. MSDH defines Casual Attire as clothing that is comfortable and practical for work while still being neat, clean and not overly revealing. Examples would include tee-shirts with non-offensive slogans or images, blue jeans, and athletic shoes in good condition.

D. Unacceptable Attire. As a general rule, clothing that works well for the beach, yard work, dance clubs, exercise sessions, and sports contests is not proper for a professional, casual appearance at work. Clothing that is too tight or reveals too much cleavage, your back, your chest, your stomach or your underwear is not appropriate for a place of business. Clothing should be pressed and never wrinkled. Torn, dirty, or frayed clothing is unacceptable. When permitted, jeans and athletic footwear are acceptable so long as they are in presentable condition.

Listed below are some of the more common items that are never appropriate for the MSDH office environment. This list is not intended to be all-inclusive.

- shorts
- tank tops
- mesh shirts
- cutoff shirts
- strapless or spaghetti-strap shirts and dresses
- flip-flops, rubber shoes, ‘crocs’ and other recreational shoes
- house shoes and slippers
- sweat pants
- mini-skirts or dresses
- jogging suits
- caps
- ripped jeans
- T-shirts with controversial slogans

Styles are changing and will no doubt continue to change. MSDH realizes that new trends should be accepted as long as they are not offensive to clients, claimants, visitors or fellow workers. Questions about specific types of clothing should be directed to the Office of Human Resources.

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E. Dress Code Exceptions.

- c. The official MSDH logo shirt, worn with slacks, is permissible for all staff.
- d. Clinicians and laboratory staff are permitted to wear lab coats and/or scrubs with appropriate footwear.
- e. Public health nurses and aides shall follow the approved standard of dress as outlined in the Public Health Nursing Manual whenever patient care is being rendered.
- f. Environmental Health Inspectors performing inspections in the field and technical personnel installing/servicing equipment are permitted to wear jeans so long as they are in good condition.
- g. Personnel in the areas listed below are permitted to wear an MSDH approved uniform with appropriate footwear.
 - i. Facilities Maintenance
 - ii. Central Supply
 - iii. Mail Room
 - iv. Print Shop
 - v. Pharmacy Warehouse
 - vi. WIC Warehouse
- h. Should the day's activities for the staff exempted above involve office work, public meetings, or training sessions, the standard MSDH dress code will apply.
- i. Tennis/athletic shoes, or modified footwear may be worn if therapeutically required on the recommendation of a physician or while exercising during work breaks. [Note: If therapeutically required, the employee must provide supporting medical documentation to the Office of Human Resources.]
- j. Head coverings worn for religious purposes are permissible.
- k. Exceptions to this dress code may be made at the discretion of the appropriate Office Director/District Administrator for employees with special work assignments requiring different clothing requirements.

l.

F. Enforcement and Disciplinary Consequences. This dress code policy has been developed with employee safety and business image in mind. MSDH is confident that employees will use their best judgment in following this policy. Supervisors are responsible for monitoring and enforcing this policy. Repeated policy violations will result in disciplinary action, up to and including termination. The policy will be administered according to the following action steps:

1. If questionable attire is worn in the office, the respective supervisor will hold a private discussion with the employee to advise and counsel the employee regarding the inappropriateness of the attire.
2. If an obvious policy violation occurs, the supervisor will hold a private discussion with the employee, and in some cases, supervisors may ask employees to return home to change. The employee must use personal leave during this absence.
3. If an employee is verbally counseled and/or sent home multiple times, a written warning will be issued and placed in the employee's personnel file. Failure to follow the dress code policy after the written warning will be treated as a Group Two-Level Offense as defined by MSPB Policies and Procedures.

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2.19 Workplace Bullying Prevention

A safe and civil environment is necessary for employees to achieve the high standards expected of public servants. Demonstration of appropriate behavior, treating others with civility and respect, and refusing to tolerate harassment and bullying are basic to our agency values.

The purpose of this policy is to communicate to all employees and contract workers, regardless of position or level, that the Mississippi State Department of Health (MSDH) will not tolerate bullying behavior. Employees found in violation of this policy will be disciplined, up to and including discharge.

MSDH defines bullying as “repeated inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others at the place of work and/or in the course of employment.” Such behavior violates the MSDH Code of Ethics, which clearly states, “Employees should treat the public and colleagues with good faith, courtesy, respect, and honesty.” The MSDH Code of Conduct also states that all MSDH

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employees must meet public expectations of “displaying fair treatment and respect for all ...”

Bullying may be intentional or unintentional. However, it must be noted that where an allegation of bullying is made, the intention of the alleged bully is irrelevant, and will not be excusable when determining discipline. As in sexual harassment, it is the effect of the behavior upon the individual that is important.

MSDH considers the following types of behavior as examples of bullying:

Verbal and/or Cyber Bullying: slandering, ridiculing or maligning a person or his/her family; persistent name calling which is hurtful, insulting or humiliating; using a person as the butt of jokes; abusive and offensive language or remarks, regardless of the medium used.

Physical Bullying: pushing; shoving; kicking; poking; tripping; assault, or threat of physical assault; damage to a person’s work area or property (Also refer to Workforce Violence Prevention policy statements below.)

Gesture Bullying: non-verbal threatening gestures, glances that can convey threatening messages

Exclusion: socially or physically excluding or disregarding a person in work-related activities. In addition, the following examples may constitute or contribute to evidence of bullying in the workplace:

- Persistent singling out of one person
- Shouting, raising voice at an individual in public and/or in private
- Using verbal or obscene gestures or language
- Not allowing the person to speak or express him/herself (i.e., ignoring or interrupting)
- Personal insults and use of offensive nicknames
- Public humiliation in any form, including screaming at or cursing an employee
- Constant criticism on matters unrelated or minimally related to the person’s job performance or description
- Routinely ignoring/interrupting an individual at meetings
- Public reprimands
- Repeatedly accusing someone of errors which cannot be documented
- Deliberately interfering with someone’s mail and other communications
- Spreading rumors and gossip regarding individuals
- Manipulating the ability of someone to do their work (e.g., over-loading, under- loading, withholding useful information, setting meaningless tasks, setting deadlines that cannot be met, giving deliberately ambiguous instructions, etc.)
- Frequently inflicting menial tasks not in keeping with the normal responsibilities of the job
- Refusing reasonable requests for leave in the absence of valid work-related reasons for not

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- granting the leave requests
- Deliberately excluding an individual or isolating them from work-related activities (meetings, etc.) associated with their job responsibilities
- Unwanted physical contact, physical abuse or threats of abuse to an individual or an individual's property (defacing or marking up property)
- Stealing work credit
- Any behaviors towards others that can be reasonably be interpreted as cruel

Bullying may be committed by written, verbal, graphic, or physical acts (including electronically transmitted acts using the Internet, a cell phone, or a personal communication device). It substantially interferes with the work, opportunities, and benefits of one or more employees, sometimes through actual sabotaging of work, and adversely affects an employee's ability to function at work by placing the employee in reasonable fear of physical harm or by causing emotional distress.

Because bystander support can encourage bullying, MSDH prohibits both active and passive support for acts of harassment and bullying. Employees should either walk away from these acts when they see them or constructively attempt to stop them. In either case, employees should immediately contact their supervisor. If an employee feels that he/she cannot seek help from their immediate supervisor, they should contact a higher-level supervisor or the Director or Assistant Director of Human Resources for assistance.

Reprisal or retaliation against any person who reports an act of harassment or bullying is prohibited and is subject to potential serious disciplinary consequences, up to and including discharge.

Complaints will be investigated and MSDH will protect the confidentiality of complaints to the extent possible. If the investigation determines that bullying has occurred, MSDH will take immediate and appropriate action.

MSDH managers and supervisors must take positive steps to comply with this policy. They are required to monitor the workplace to prevent bullying, resolve bullying issues that arise, and refrain from and prevent retaliation or harassment against any employee involved in the filing, investigation, or resolution of a bullying complaint or grievance.

Managers, supervisors, and all other employees are required to cooperate fully with the investigation and resolution of any bullying complaints or grievances.

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2.20 Workplace Violence Prevention

MSDH is committed to preventing workplace violence and to maintaining a safe work environment and has adopted the following guidelines to deal with intimidation, harassment, or other threats of (or actual) violence that may occur during business hours or on its premises. All employees should review and understand all provisions of this workplace violence policy.

Scope of Policy

MSDH will not tolerate any type of workplace violence committed by or against employees, clients, or visitors to its premises. Employees are prohibited from making threats or engaging in violent activities. All full-time and part-time active employees and contract workers are covered under this policy.

Procedures

All employees, including supervisors and contract workers, should be treated with courtesy and respect at all times. Employees and contract workers are expected to refrain from fighting, "horseplay," abusive language, or other conduct that may be dangerous or threatening to others. Possession of firearms, weapons of any kind, and other dangerous or hazardous devices or substances by an employee, contract worker, or visitor are prohibited from the premises of MSDH.

Conduct that threatens, intimidates, harms, or coerces another employee, a client, or a member of the public will not be tolerated. This prohibition includes, but is not limited to, the following: threats, physical attacks, domestic related violence, stalking, property damage, contributing to a hostile workplace environment, and all acts of harassment, including harassment that is based on an individual's sex, race, age, or any characteristic protected by federal, state, or local law.

All threats of (or actual) violence, both direct and indirect, should be reported as soon as possible to the employee's immediate supervisor or any other member of the agency's management. This includes threats by employees, as well as threats by clients, vendors, solicitors, or other members of the public. When reporting a threat of violence, the employee should be as specific and detailed as possible.

All suspicious individuals or activities should also be reported to a supervisor as soon as possible. Employees who confront or encounter an armed or dangerous person should not attempt to challenge or disarm the individual. Remain calm, make constant eye contact, and talk to the individual. If a supervisor or the Capitol Police can be safely notified of the need for assistance without endangering the safety of the employee or others, provide such notice. Otherwise, cooperate and follow the instructions given.

While employees are not expected to be skilled at identifying potentially dangerous persons,

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employees are expected to exercise good judgment and to inform management or the Capitol Police if any employee exhibits behavior that could be a sign of a potentially dangerous situation. Such behavior includes:

- Discussing weapons or bringing them to the workplace
- Displaying overt signs of extreme stress, resentment, hostility, or anger
- Making threatening remarks
- Sudden or significant deterioration of performance
- Displaying irrational behavior

The Mississippi State Employee Handbook provides additional guidelines for personal safety in the workplace and the safety of personal property, such as wallets.

MSDH will promptly and thoroughly investigate all reports of threats of (or actual) violence and of suspicious individuals or activities. The identity of the MSDH individual making a report will be protected as much as is practical. In order to maintain workplace safety and the integrity of its investigation, MSDH may suspend employees, either with or without pay, pending investigation.

Anyone determined to be responsible for threats of (or actual) violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action up to and including termination of employment. Non-employees engaged in violent acts on the agency's premises will be reported to the proper authorities and fully prosecuted.

MSDH encourages employees to bring their disputes or differences with other employees to the attention of their supervisors or the Human Resources Department before the situation escalates into potential violence. MSDH is eager to assist in the resolution of employee disputes and will not discipline employees for raising such issues.

Assistance and Support

Assistance and support will be provided to agency employee victims and their families via the Employee Assistance Program. Other victims will be referred as appropriate.

Police

Capitol Police Officers are assigned to patrol and monitor the premises of the MSDH Central Office Campus. All employees and contract workers are expected to cooperate with these officers and comply with any instructions or commands given by them. Employees and contract workers who fail to comply with their instructions or commands may be subject to arrest and further disciplinary actions from MSDH. For all other locations, local police with enforcement jurisdiction for the site should be contacted for assistance whenever there is a threat of (or actual) violence. Employees and contract workers who fail to comply with the instructions or commands of authorized police officers called to assist in addressing or resolving a potential workplace violence situation may be subject to arrest and further disciplinary actions from MSDH. Each office and supervisor should ensure that the local police contact number(s) are readily available in situations described in this policy.

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2.21 Possession of Firearms

No MSDH employee is authorized to carry any type of firearm, concealed or otherwise, while acting in any official capacity. Under State Personnel Board regulations, unauthorized possession, or use of a firearm, dangerous weapon, or explosive is a Group Three Offense punishable by suspension, demotion, or termination. Violations of this policy will be grounds for appropriate disciplinary action.

2.22 Surveillance Camera Policy

MSDH recognizes the need to strike a balance between the individual's right to be free from invasion of privacy and the agency's duty to promote a safe and secure environment. As such, the agency may install surveillance cameras in select MSDH locations in its efforts to protect the agency's patients, clients, employees, and property.

The purpose of video surveillance at MSDH is to:

- Promote a safe environment by deterring acts of harassment or assault.
- Deter theft and vandalism and assist in the identification of individuals who damage MSDH property.
- Assist law enforcement agencies with the investigation of any crime that may be depicted.
- Assist in the daily operations of various MSDH offices/facilities/properties.

Signs will be posted in appropriate areas, either at the entrance to the area under surveillance or in close proximity to the camera informing the general public of the usage of video surveillance on the site.

At no time will persons other than those designated by the Chief Administrative Officer have access to the monitors or to the recordings made in the course of the surveillance. Personal information contained on the recordings shall not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law.

The focus of cameras used for video surveillance in MSDH locations will not cover areas where there is an expectation of privacy, such as restrooms, dressing areas, or exam rooms.

2.23 Covert Use of Recording Devices

MSDH is a government healthcare entity entrusted with protecting highly sensitive and confidential information, and the privacy of clients, patients and citizens. It is each employee's responsibility to take precautions against disclosures, whether intentional or accidental. Therefore, it is the policy of MSDH that the unannounced or unauthorized use of recording devices to capture audio, visual images and/or video of MSDH employees, patients, clients, vendors, or visitors in a covert manner is strictly

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prohibited. This prohibition is extended to any and all recording devices, regardless of ownership or operation used to capture audio, visual images, or video.

This policy is not intended to prohibit recordings of public events or other official business functions where recording devices are clearly visible and where there is not a reasonable expectation of privacy.

This policy specifically bans secret or covert recordings with the exception of any such surveillance recordings conducted by law enforcement or by MSDH video surveillance cameras pursuant to the above MSDH Surveillance Camera Policy.

2.24 Federal False Claims Act

Under the federal Deficit Reduction Act of 2005, MSDH is required to provide employees, contractors, and agents with information regarding federal and state false claim laws, administrative remedies under those laws, whistle-blower protection to employees who report incidents of false claims, and MSDH's programs for detecting and preventing fraud, waste, and abuse in Medicaid programs.

The False Claims Act prohibits any person from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval of government funds. The False Claims Act imposes civil liability on any person who:

- Knowingly presents a false or fraudulent claim for payment or approval
- Knowingly makes or uses a false record or statement to get a false or fraudulent claim paid or approved
- Conspires with another to get a false or fraudulent claim paid or allowed
- Knowingly makes or uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property
- Commits other fraudulent acts enumerated in the statute

Definitions

“Knowingly” is defined to mean that a person (1) has actual knowledge of false information on the claim, (2) acts in deliberate ignorance of the truth or falsity of the information, (3) acts in reckless disregard of the truth or falsity of the information.

“Claim” is defined to include any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

“Contractor” or “Agent” includes any contractor, subcontractor, agent, or other person who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, or performs billing or coding functions.

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The Federal False Claims Act does not require proof of a specific intent to defraud the government. A wide variety of conduct may lead to the submission of fraudulent claims to the government including knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

The federal False Claims Act includes a “qui tam”, or whistleblower provision, to report misconduct involving false claims. The qui tam provision allows any private person with actual knowledge of allegedly false claims to file a lawsuit on behalf of the United States government.

The federal government has the opportunity to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing, or settling the action. If the federal government decides to intervene, the private person (Qui Tam Relater) who initiated the action may be eligible for a portion of the proceeds of the action or settlement of the claim. If the federal government does not proceed with the action, the Qui Tam Relater may continue with the lawsuit or settle the claim and he or she may receive a portion of the proceeds of the action or settlement. The Qui Tam Relater may also receive an amount for reasonable expenses, including reasonable attorney fees and costs incurred in connection with bringing the lawsuit.

Violations of the Federal False Claims Act can result in penalties of not less than \$5,500 and not more than \$11,000 per claim, plus three times the amount of damages that the government sustains.

2.25 Whistleblower Protection Laws

In addition to the Employee Grievance Policy, as found in MSDH’s Administrative Manual, Section 8.0, both the federal and state laws protect individuals who investigate or report possible false claims made by their employer against discharge or discrimination in employment because of such investigation. Employees who are discriminated against based on whistleblower activities may sue in court for damages. Under either the federal or state law, any employer who violates the whistleblower protection law is liable to the employee for (1) reinstatement of the employee's position without loss of seniority, (2) two times the amount of lost back pay, (3) interest and compensation for any special damages, and such other relief necessary to make the employee whole.

2.26 Medicaid False Claim Act

The Medicaid False Claim Act, in part, prohibits fraud in the obtaining of benefits or payments in connection with the Medicaid assistance program and provides for civil actions to recover money received due to fraudulent conduct.

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Definitions

“Claim” means any attempt to cause the Mississippi Division of Medicaid or other agency or entity to pay out sums of money under the Federal Medicaid Act.

“False” means wholly or partially untrue or deceptive.

“Knowing” and “knowingly” means that a person is in possession of facts under which he or she is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a Medicaid benefit. “Knowing” or “knowingly” does not include conduct which is an error or mistake unless the person's course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present.

The State of Mississippi has not adopted any false claims acts or statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. It has, however, adopted a generally applicable Medicaid Fraud Control Act that makes it unlawful for a person to submit false and fraudulent claims to the Mississippi Medicaid program. Violations of the Act are both civil and criminal offenses and are punishable by imprisonment and significant monetary penalties.

Detection of Potential Fraud or Abuse

MSDH combats Medicaid fraud, waste, and abuse by investigating complaints, raising awareness of anti-fraud initiatives, and assuring compliance with state and federal laws. A quality assurance program is also used to detect and prevent potential fraud, waste, or abuse that includes the following:

- Proactive review of claims and other types of data
- Recommending and implementing claims processing safeguards
- Conducting employee education on fraud and abuse prevention, recognition, and reporting
- Encouraging and promoting the reporting of fraud or abuse by employees and contractors

If any employee has knowledge or information that fraud or abuse activity as prohibited by federal or state law may have taken place, the employee must notify the State Health Officer, the Executive Director of the Mississippi Division of Medicaid, or the Office of the Mississippi State Attorney General as follows:

Mississippi State Department of Health
570 East Woodrow Wilson
P. O. Box 1700
Jackson, MS 39215-1700
601 576-7634

or

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Mississippi Division of Medicaid Walter
Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201-1399
601 359-6050
or

Mississippi State Attorney General's Office Walter Sillers
Building
550 High Street, Suite 1200

P. O. Box 220
Jackson, MS 39205
601 359-3680

2.27 Reporting of Suspected Illegal Activity

MSDH is committed to protecting employees from any form of reprisal, retaliation, or discrimination if they, in good faith, report suspected illegal activity. An employee who believes he or she has suffered reprisal, retaliation, or discrimination shall immediately report the incident(s) to the Director of Human Resources, State Health Officer, or the Mississippi State Board of Health. MSDH and the Mississippi State Board of Health consider retaliation to be a major offense that will result in disciplinary action against the offender, up to and including termination of employment. The State Health Officer shall establish the necessary rules to implement this policy.

CROSS REF: Mississippi State Department of Health's Employee Grievance Policy, as found in the MSDH Administrative Procedures Manual

LEGAL REF: 31 U.S.C. §3729 et seq., "False Claims Act"
MS Code Sections 25-9-171 thru 25-9-177, "Whistleblower Protection"

2.28 The Americans with Disabilities Act (ADA) and the Americans with Disabilities Amendments Act (ADAAA)

The Americans with Disabilities Act (ADA) and the Americans with Disabilities Amendments Act (ADAAA) are federal laws that require employers with 15 or more employees to not discriminate against applicants and individuals with disabilities and, when needed, to provide reasonable accommodations to applicants and employees who are qualified for a job, with or without reasonable accommodations, so that they may perform the essential job duties of the position.

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It is the policy of the Mississippi State department of health (MSDH) to comply with all federal and state laws concerning the employment of persons with disabilities and to act in accordance with regulations and guidance issued by the Equal Employment Opportunity Commission (EEOC). Furthermore, it is MSDH's policy not to discriminate against qualified individuals with disabilities in regard to application procedures, hiring, advancement, discharge, compensation, training or other terms, conditions and privileges of employment.

Procedures

Employees may self-identify themselves as having a disability and request specific accommodations that would assist or enable them to successfully perform the essential functions of their position at any time. The Section 504 Assurance/Compliance Questionnaire (Form 504) should be completed by the requesting employee and sent to the Director of Human Resources along with appropriate medical certification of the disability and requested accommodation. (Forms are available on the MSDH Intranet under the *Forms* Tab.)

When an individual with a disability requests accommodation and can be reasonably accommodated without creating an undue hardship or causing a direct threat to workplace safety, he or she will be given the same consideration for employment as any other applicant. Applicants who pose a direct threat to the health, safety and well-being of themselves or others in the workplace when the threat cannot be eliminated by reasonable accommodation will not be hired.

MSDH will reasonably accommodate qualified individuals with a disability so that they can perform the essential functions of a job unless doing so causes a direct threat to these individuals or others in the workplace and the threat cannot be eliminated by reasonable accommodation or if the accommodation creates an undue hardship to MSDH.

All employees are required to comply with MSDH and state safety standards. Current employees who pose a direct threat to the health or safety of themselves or other individuals in the workplace will be placed on leave until an organizational decision has been made in regard to the employee's immediate employment situation.

Individuals who are currently using illegal drugs are excluded from coverage under the MSDH ADA policy.

The Office of Human Resources is responsible for implementing this policy, including the resolution of reasonable accommodation, safety/direct threat and undue hardship issues. Contact human resources (HR) with any questions or requests for accommodation.

Terms Used in This Policy

As used in this ADA policy, the following terms have the indicated meaning:

- **Disability:** A physical or mental impairment that substantially limits one or more major life activities of the individual, a record of such an impairment, or being regarded as having

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such an impairment.

- **Major life activities:** Term includes caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.
- **Major bodily functions:** Term includes physical or mental impairment such as any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine. Also covered are any mental or psychological disorders, such as intellectual disability (formerly termed “mental retardation”), organic brain syndrome, emotional or mental illness and specific learning disabilities.
- **Substantially limiting:** In accordance with the ADAAA final regulations, the determination of whether impairment substantially limits a major life activity requires an individualized assessment, and an impairment that is episodic or in remission may also meet the definition of disability if it would substantially limit a major life activity when active. Some examples of these types of impairments may include epilepsy, hypertension, asthma, diabetes, major depressive disorder, bipolar disorder and schizophrenia. An impairment, such as cancer that is in remission but that may possibly return in a substantially limiting form, is also considered a disability under EEOC final ADAAA regulations.
- **Direct threat:** A significant risk to the health, safety or well-being of individuals with disabilities or others when this risk cannot be eliminated by reasonable accommodation.
- **Qualified individual:** An individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.
- **Reasonable accommodation:** Includes any changes to the work environment and may include making existing facilities readily accessible to and usable by individuals with disabilities, job restructuring, part-time or modified work schedules, telecommuting, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.
- **Undue hardship:** An action requiring significant difficulty or expense by the employer. In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include:

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- The nature and cost of the accommodation.
 - The overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation, the number of persons employed at such facility, the effect on expenses and resources, or the impact of such accommodation on the operation of the facility.
 - The overall financial resources of the employer; the size, number, type and location of facilities.
 - The type of operations of the company, including the composition, structure and functions of the workforce; administrative or fiscal relationship of the particular facility involved in making the accommodation to the employer.
- **Essential functions of the job:** Term refers to those job activities that are determined by the employer to be essential or core to performing the job; these functions cannot be modified. The examples provided in the above terms are not meant to be all-inclusive and should not be construed as such. They are not the only conditions that are considered to be disabilities, impairments or reasonable accommodations covered by the ADA/ADAAA policy.

[Also refer to *the MSDH Administrative Manual, Section 5.0; Topic: Insurance/Benefits; Employee Assistance Services; American Disability Act (ADA) Section 504 Assurance.*]

2.29 Fragrance Sensitivity

The Americans with Disabilities Act (ADA) does not contain a list of medical conditions that constitute disabilities. Instead, the ADA has a general definition of disability that each person must meet.

A person has a disability, under ADA, if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having impairment. Therefore, fragrance sensitivity, in some cases, can be considered a disability, which may require reasonable accommodations.

Fragrance sensitivity is defined as either an irritation or allergic reaction to some chemical or a combination of chemicals in a product.

Below are suggestions for accommodating employees with fragrance sensitivity:

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Implement a *fragrance-free workplace policy* in offices as a reasonable accommodation for an employee with a qualifying chemical/fragrance sensitivity disability under the ADA. Such a policy might include:

- Maintain good indoor air quality.
- Discontinue the use of fragranced products.
- Use only unscented cleaning products.
- Provide scent-free meeting rooms and restrooms.
- Modify the workstation location.
- Modify the work schedule.
- Allow for fresh air breaks.
- Provide an air purification system.
- Modify communication methods to reduce the employee's exposure to fragrances.

[Reference: *The Job Accommodation Network* (<http://askjan.org/empl/index.htm>)]

Any office policy, implemented as a reasonable ADA accommodation, must be approved by the Office District/District Administrator, at a minimum, and the Director of Human Resources. Policies should be tailored to fit the circumstances and needs of the party for whom the accommodation was granted.

MSDH has a basic responsibility of maintaining an environment in which all employees can work without undue risks to their health and safety.

Although relatively rare, chemical/fragrance sensitivity can cause serious physical reactions that could result in hospitalization and even death. Therefore, any medical certification of such disabilities shall be taken seriously.

Use of fragrance products and chemicals in the workplace are not protected rights, but rather a privilege. MSDH maintains the right to regulate or to prohibit use of fragrances and certain chemical agents in the workplace that MSDH finds are objectionable or the potential source of harm to others.

Employees may self-identify as having a disability by completing *The Section 504 Assurance/Compliance Questionnaire* (Form 504).

Employees requesting an accommodation under the ADA shall not be harassed or retaliated against for requesting an accommodation. Such behaviors will not be tolerated on any level.

Managers and employees share responsibility for fostering an environment that breeds respect of others and acceptance of individual differences, including chemical/fragrance sensitivities.

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2.30 Breastfeeding

In recognition of the well-documented health advantages of breastfeeding for infants and mothers, MSDH provides a positive environment that recognizes a mother's responsibility to both her job and her child when she returns to work by acknowledging that a woman's choice to breastfeed benefits the family, MSDH, and society. MSDH strives to provide a supportive environment to enable breastfeeding employees to express their milk during work hours. This includes an agency- wide lactation support program administered by the Women, Infants, and Children's Nutrition Program (WIC).

MSDH subscribes to the following worksite support policy. This policy shall be communicated to all current employees, included in new employee orientation training and the Family and Medical Leave Act (FMLA).

Breastfeeding employees who choose to continue providing their milk for their infants after returning to work shall receive:

- Milk Expression Breaks: Breastfeeding employees are allowed to breastfeed or express milk during work hours using their normal breaks and meal times. For time that may be needed beyond the usual break times, employees may use personal leave or may make up the time as negotiated with their supervisors. Infants are not allowed to remain in the workplace outside of these brief periods for breastfeeding.
- A Place to Express Milk: A private room (not a toilet stall or restroom) shall be available for employees to breastfeed or express milk. The room will be private and sanitary, located near a sink with running water for washing hands and rinsing out breast pump parts, and have an electrical outlet. If employees prefer, they may also breastfeed or express milk in their own private offices, or in other comfortable locations agreed upon in consultation with the employee's supervisor. Expressed milk can be stored in refrigerators or in the employee's personal cooler.
- Education: Prenatal and postpartum breastfeeding classes and informational materials are available for all mothers and fathers, as well as their partners. Examples of classes to be offered would include Lunch and Learn breastfeeding sessions and WIC breastfeeding classes.
- Staff Support: Supervisors are responsible for alerting pregnant and breastfeeding employees about the company's worksite lactation support program and for negotiating policies and practices that will help facilitate each employee's infant feeding goals. It is expected that all employees will assist in providing a positive atmosphere of support for breastfeeding employees.

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Employee Responsibilities

- Communication with Supervisors: Employees who wish to breastfeed or express milk during the workday shall keep supervisors informed of their needs so that appropriate accommodations can be made to satisfy the needs of both the employee and the agency.
- Maintenance of Milk Expression Areas: Breastfeeding employees are responsible for keeping milk expression areas clean using anti-microbial wipes to clean the pump and area around it. Employees are also responsible for keeping the general lactation room clean for the next user. This responsibility extends to both designated milk expression areas, as well as other areas where expressing milk will occur.
- Milk Storage: Employees should label all milk expressed with their name and date collected so it is not inadvertently confused with another employee's milk. Each employee is responsible for proper storage of her milk using the MSDH- provided refrigerator/personal storage coolers.
- Use of Break Times to Express Milk: When more than one breastfeeding employee needs to use the designated lactation room, employees can use the sign-in log provided in the room to negotiate milk expression times that are most convenient or best meet their needs.

2.31 Employee Recognition Policy and Procedures

Purpose of Policy

To provide opportunities to recognize and acknowledge MSDH employees for their contribution and commitment to the Mississippi State Department of Health.

Principles

MSDH managers and supervisors may use a number of mechanisms to acknowledge, recognize, award and reward employees. This is achieved through non-monetary means.

- **Non-monetary** recognition is acknowledgement provided to employees in recognition of their contribution to MSDH. It includes awards that are presented to honor achievements made by an employee or group of employees.

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- **Monetary** rewards are payments to employees in recognition of their performance and contribution to the MSDH. **Monetary rewards are outside the scope of this policy and procedures.**

Managers and supervisors are empowered and encouraged, as an integral part of good management practice, to promptly recognize and acknowledge the exceptional contributions of their employees. Offices and districts may establish local recognition programs within the framework of this policy.

Examples of Acceptable Employee Recognition Programs

- **Peer to Peer** based informal recognition program that encourages and empowers all employees to recognize the contributions of others in the workplace. This program is a non-monetary recognition program that provides employees with a range of options and tools to acknowledge colleagues for their contributions and/or commitment to their office, department, district, team or to a specific MSDH initiative. Colleagues can include other employees, supervisors, managers or teams and recognition and acknowledgement are encouraged multi-directionally and cross-functionally.
- **Employee Achievement Awards** may be established to recognize a range of employee achievements (e.g., perfect attendance, service longevity, productivity or client satisfaction goals, cost savings, quality improvements, originality, extraordinary personal efforts, etc.).
- **Public acknowledgement** is one of the most effective methods of recognizing employees. The MSDH also acknowledges that one of the most effective methods of recognizing employees is by way of formal public acknowledgement of particular efforts and achievements. This may be through:
 - o written feedback/congratulations (e.g. letters or emails to colleagues in the Office, District or Department or the wider MSDH community)
 - o congratulations/acknowledgements at team or committee meetings
 - o publication on the MSDH Intranet or Internet websites
 - o MSDH publications in newsletters, including *Health Beat*.

Managers and supervisors are encouraged to utilize these acknowledgement channels and should contact the Office of Communications for assistance with regard to features in the *Health Beat*.

- **Other recognition initiatives** may be established at the discretion of each Office or District which falls within the purpose and guidance of this policy.

The above examples are not meant to represent all possible forms of acceptable employee recognition programs. Rather, they are listed simply as examples. If in doubt about the appropriateness of any

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recognition program under consideration, please consult with the Director of Human Resources.

The Board of Health, the State Health Officer or other officials and executive-level managers may elect to recognize employees in a non-monetary fashion for contributions or achievements which support or promote their respective visions, missions or strategic goals.

2.32 Longevity Service Award Program

The MSDH participates in the State of Mississippi's *Longevity Service Award Program*. This program was established to recognize full-time employees for service to the State of Mississippi. The program is established based upon Mississippi Code § 25-9-151 which states that *awards shall be made upon attainment often (10), twenty (20) and thirty (30) years of full- time service in state government, and shall be the same for all personnel regardless of position or title.*

2.33 The Employee Benefits and Services Division of the Human Resources

Department is charged with the responsibility of monthly certifying the names of eligible MSDH employees by submitting the Longevity Service Award Program request form, which is available on the MSPB website at <http://www.mspb.ms.gov>, to the MSPB Executive Director.

Employee Benefits & Services is also responsible for the distribution of the awards to the awardees' respective Office Director or District Administrator.

Recipients of the award will receive a Certificate of Recognition signed by the Governor and the State Health Officer, and a coordinating lapel pin indicating their years of state service.

Offices and districts are encouraged to make the award presentations in a dignified manner, preferably at group or team gatherings.

This award program does not provide for the presentation of gifts or monetary bonuses to employees. Employees and public servants should be especially careful to avoid using, or appearing to use, an official position for personal gain, giving unjustified preferences, or losing sight of the need for efficient and impartial decision making. No act should be committed which could result in questioning the integrity of the Mississippi State Department of Health (MSDH). This section has been developed to address as many of the potential areas of conflict as possible, but is not meant to be all inclusive. For questions/issues not answered or discussed herein, or situations that may have the appearance or potential of being a conflict of interest, please consult Policy Evaluation or the MSDH legal staff.

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3.1 Ethical Practice

MSDH’s basic philosophy is that if the application of professional ethics is to be effective, it cannot be simply directed toward “policing” employees engaged in unacceptable behavior. The basic goal is more fundamental and intended to spur development of professional integrity. This calls for assisting employees at all levels in being self-reflective about their expressed values and how they coincide with the values actually applied in their daily conduct. The following points have been developed as the MSDH Employee Code of Ethics:

1. Employees should maintain high standards of personal conduct and professional integrity.
2. Employees should uphold the constitution, laws, and regulations of the state and federal governments.
3. Employees should not reveal confidential information or use confidential information for personal gain, profit, or the detriment of others.
4. Employees should not accept gifts, gratuities, or favors that might be construed as biasing decisions made on the job.
5. Employees should continually seek to gain knowledge as related to the performance of duties.
6. Employees should treat the public and colleagues with good faith, courtesy, respect, and honesty.
7. Employees should be dedicated to serving the public with competent service, compassion, and respect for human dignity.
8. Employees should use public resources for the public good and should not convert such resources to personal use or gain.
9. Employees should report unethical conduct of others to the State Health Officer.
10. Employees who are members of or officers of non-governmental associations, organizations, or boards should remove or disqualify themselves from any activities that are in conflict with their official state position or agency mission.

3.2 Conflicts of Interest under the State Ethics Law

Definitions of a Public Servant Under the State Ethics Law

1. An elected official, appointed official, or one who is, among others, an “agent” of an entity which is funded by public funds.
2. An agent of a public entity created by or under the laws of Mississippi, or created by an agency which is funded by public funds, staffed by public funds, or which expends, authorizes, or recommends the use of public funds.
3. Any individual who receives a salary, per diem, or expenses paid in whole or in part out

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of funds authorized to be expended by the government.

In turn, any employee of the MSDH, or a member of a commission, committee, advisory board, council, task force, or other such similarly situated body that meets the preceding guidelines is considered to be a public servant. Independent contractors are not considered employees or public servants. For further clarification, see §25-4-103(p) of the Mississippi Code of 1972, Annotated.

3.3 Prohibitions under the State Ethics in Government Law

The state's Ethics laws (with certain exceptions) prohibit the agency from contracting with one of its employees or its public servants. This applies whether the contract includes payment for services or services for gratis. A contractor, for purposes herein, includes one who has material financial interest in the contracting business or entity. Likewise, the contractor cannot subcontract with any employee of MSDH.

A contractor shall not pay any MSDH employee any additional compensation, stipend, honorarium, or such similar remuneration for any work done or presentations made outside of MSDH if such work or presentation constitutes all or part of the usual and customary duties of the employee or such work or presentation is of such a nature that MSDH would normally provide the same as part of the services it offers to the public. For further clarification, see §25-4-105 of the Mississippi Code of 1972, Annotated.

Political Activity Guidelines

MSDH employees are subject to state and federal laws which place limitations on political activities. The most restrictive of these, which applies to all agency employees, are the federal statutes at 5 CFR 151.101, also known as the "Hatch Act." The Hatch Act defines what political activity may be engaged in by employees of agencies which receive Federal funds.

The purpose of this policy is not to describe all possible interpretations of the laws placing limitations on the types of permissible political activities. Its intent is to briefly provide policy guidance to help agency employees exercise their rights and responsibilities as both good citizens and agency employees, and at the same time to avoid problems under the applicable state and federal laws. Any questions not specifically answered by these guidelines should be referred to Policy Evaluation.

1. Employees may not solicit support (financial or otherwise) for any candidate (including themselves) from other employees, patients, or members of the public while at work or in work status. Campaign activities for any candidate (including themselves) may only be conducted away from work or when not in work status. Campaign activities include, but are not limited to, attending political or campaign rallies, door- to-door solicitations, fundraising, and working at phone banks.
2. Employees may not use their position of employment to influence or attempt to influence the vote of the employees they supervise.

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3. Employees may not circulate political advertisements or literature at work. Political advertisements include, but are not limited to, banners, push cards, handouts, bumper stickers, yard signs, sample voting guides, and other types of campaign literature.
4. Employees may make financial contributions to political candidates, within the limitations prescribed by state and federal election and campaign laws.
5. The behavior and activities of MSDH employees, whether on or off the job, reflects on the MSDH; therefore, employees should use good judgment in conducting or participating in political activities. MSDH receives funding from all Mississippi counties and from state and federal sources. It is important that MSDH maintain good relationships with governmental officials at all levels of government.
6. Employees should make every effort to vote in local, state, and national elections.

Employees as Political Candidates

Under the Hatch Act, MSDH employees whose employment is in connection with a program or activity which is funded (even partially) by federal monies may not be a candidate in any partisan election. Partisan means that the candidate(s) must declare a party affiliation such as, but not limited to, Democrat or Republican, in order to qualify for the election. Any employee who wishes to run as a candidate in any election must follow these guidelines prior to qualifying for the elected office:

1. The office for which the employee desires to be a candidate must not be a full-time position.
2. The employee desiring to be a candidate must advise, in writing, his/her
 - a. immediate supervisor; and
 - b. District Health Officer, District Administrator, or Office Director; and
 - c. State Health Officer.
3. The employee's request shall be routed through the MSDH legal department to ensure compliance with any and all applicable state and federal laws and regulations, and to verify that if the employee is allowed to qualify, there would be no direct conflicts between the employee's role or position with the agency and the elected office.
4. The employee must receive approval, in writing, from the MSDH legal department and from the State Health Officer that he/she, while employed by the agency, is eligible to qualify for the position and that no apparent conflicts exist.

Improper Participation in the Political Process

1. For possible Hatch Act violations, the agency is required to notify the Office of Special Counsel, U.S. Department of Justice (DOJ), of possible criminal violations of the law. This is required by the agency in order to protect the agency's status of eligibility to receive federal funds. In the event that criminal violations have been committed, as

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determined by the DOJ, MSDH reserves the right to take appropriate personnel actions that may result in a reprimand, suspension, demotion, or termination.

2. For possible violations of state statutes or MSDH regulations, MSDH reserves the right to take appropriate personnel actions that may result in a reprimand, suspension, demotion, or termination.

3.4 Participation in the Legislative Process

Coordination of Legislative Activities and Contacts

To ensure proper coordination of Mississippi State Department of Health (MSDH) legislative activities, MSDH employees should notify their director whenever they visit the Legislature in an official capacity, talk with a legislator in an official capacity, or receive a legislative request, orally or in writing. For a visit to be considered in an official capacity, the visit must be requested by a Legislator or the employee's program director. Employees visiting the Legislature during the workday on matters not related to their official duties are required to take personal leave. When visiting in an unofficial capacity, employees must refrain from any display of MSDH affiliation (logo shirts, MSDH badge).

1. Introduction of Legislation

The Legislative Liaison, with assistance from program directors, develops the MSDH Legislative Agenda to present to the State Board of Health each year at its October meeting. Requests for inclusion in the agenda must be submitted to the Legislative Liaison a minimum of four weeks before the October meeting. Recommendations are presented to the Chairman of the Board for consideration of a vote by the board.

2. Requests for Legislation

Copies of legislation that relate to program area(s) will be sent to the appropriate office or program. It is suggested that the office and/or program review the legislation and notify the Legislative Liaison of any potential problems so that appropriate actions related to the legislation can be taken. Requests for information from the Legislative Liaison for a fiscal note or other legislative request shall be considered high priority since most of these requests must comply with tight deadlines. If a new document or letter must be developed to satisfy a legislative request, notify the program director and submit a copy of the document or letter. If the information requested is contained in an existing manual, provide a copy to the program director.

Office Directors and program directors are requested to keep the Legislative Liaison informed on bills of interest to MSDH or its employees, which may be added to this list. Copies of bills may be requested from the Legislative Liaison.

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3.5 Outside Employment

Purpose

In an effort to avoid a conflict of interest or even the appearance of a conflict of interest, Mississippi State Department of Health (MSDH) employees engaging in outside employment must have the recommendation of the employee's Office Director or District Administrator and the specific written approval of the MSDH Director of Human Resources.

Guidelines

Outside Employment is a job or task performed outside of MSDH employment for which any form of compensation is received. An exception is made with respect to assignments with a reserve component of the United States Military for which the employee has valid military orders.

Outside Activity is defined as any direct or indirect interest or activity that may pose or appear to pose a conflict of interest.

MSDH Outside Employment Approval Request (Form 102) should be submitted: (1) prior to employment with MSDH; (2) when previously approved outside employment or activity is being permanently discontinued or the nature and/or scope is being changed; (3) when an employee plans to enter into outside employment or activity; or (4) when requested to do so by the MSDH Director of Human Resources or the employee's supervisor.

Except for outside employment or activity that began and was approved prior to employment with MSDH, employees shall submit a Form 102 and obtain approval before beginning any outside employment or activity. In regard to previously approved employment or activity, a Form 102 must be submitted before the nature and/or scope of the employment or activity is to change.

If the outside employment or activity constitutes a conflict of interest, detracts from the employee's responsibilities, or has the appearance of a conflict of interest, the request will be denied.

Responsibility

Failure to comply with this policy may result in disciplinary actions up to and including termination of the offending employee from employment with MSDH.

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3.6 Ethics Committee and Process

Purpose

This policy is intended to provide a mechanism for the MSDH to identify and resolve ethical issues that arise from programs, policies, interventions, or employee/employer relations. MSDH recognizes that our goal of protecting and promoting the public's health has inherent ethical challenges and understanding the ethical dimension of policies and decisions is important for the provision of effective public health and public health management.

Definitions

Ethics-Identifying principles to guide action and then using these principles to determine what the right thing to do is, given a particular set of circumstances, in which the right thing to do is hard to determine.

Public Health Ethics-The mandate of public health to promote and protect the health of the public is fundamentally a moral one. Public Health Ethics should guide decision making about the health of groups of people.

Ethical Code- A statement of ethical or prudential principles to help a person who has to make a decision to do the best or right thing in that particular situation. An ethical code outlines those things that a prudent or just person would consider in making a decision within the context of the agency or organization.

Deliberative Process- Procedures for ensuring fairness and just outcomes where there is a conflict between the rights of an affected party and the powers of the public health authority. Such a process would typically include: ensuring the affected party has adequate notice of the law or rule being invoked to justify an intended act by the public health authority; a real opportunity to respond to the notice; and a transparent and accountable decision making process. The overall goal is to provide for due process in public health decision making.

Ethics Advisory Committee

The MSDH Ethics Advisory Committee (EAC) is formed as the foundation of efforts to expand the ethics infrastructure in MSDH. The main purpose of the EAC is to assist MSDH Executive Leadership and staff in making decisions about ethical issues using a standardized, transparent and deliberative process that applies MSDH values. The EAC is charged with and given the authority to:

- Adopt an ethical code for MSDH
- Oversee a deliberative Ethics Review Process for MSDH providing opportunity for input from affected parties
- Represent the interest of their respective offices and programs in deliberations.

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- Conduct ethics reviews for MSDH and make recommendations to the Final Action Committee (FAC).

The FAC will make all final decisions and determinations regarding the proper course of action. All issues involving individual employees and their individual actions will be referred to the MSDH Human Resources Department and not handled by this committee.

The EAC operates under the *Principles of the Ethical Practice of Public Health*, as developed by the Public Health Leadership Society. These principles support the core elements of public health and align with the 10 Essential Public Health Services. The skills necessary to convey public health ethics include the following:

- the ability to identify an ethical issue;
- the ability to conduct ethical decision-making, including identification and weighing of harms and benefits of the potential action;
- understanding the full spectrum of the determinants of health;
- understanding basic ethical concepts such as justice, virtue, and human rights; and
- building and maintaining public trust.

The EAC consists of members with a basic understanding of core ethical concepts, including determinants of health, and the time and commitment to actively participate. Membership is determined by the State Health Officer and includes, but is not limited to:

EAC Chair/Coordinator-to provide overall guidance for the EAC in completing its purpose and work and to ensure that all EAC members have the opportunity for input and are equally valued. The Chair will organize, facilitate, and schedule meetings and manage the logistics of the meetings and the deliberative process. The chair acts as the EAC liaison to MSDH Leadership.

Legal Counsel – to ensure that the EAC is aware of relevant authorities and limitations on those authorities based on statutes, rules, and precedents.

Ethics Advisor – to provide the EAC with guidance regarding ethics theory and practice, including the development of appropriate codes and frameworks. The Chair of the Institutional Review Board, or his/her designee, will serve in this capacity.

Ethics Review Process for External Concerns

Individuals from the community with an issue of ethical concern regarding MSDH should contact the District Administrator or the Program/Office Director, whichever is applicable, to discuss the concern and possible solutions. If a mutually satisfactory resolution is not reached, the Director will present the issue to the EAC Chair. The District Administrator will review the issue with the Director of Field Services before presenting the issues to the EAC Chair. The EAC Chair will provide an Initiation Form (Form 1011) to the complainant. The complainant has 10 days to complete and return the form. The EAC Chair will submit the completed form to the Director of Human Resources (HR) who will make a determination if it is a HR issue, and if determined to be a HR issue, the process ends. If the

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HR Director determines that it is not an HR issue, an EAC opinion will be sought. However, prior to conducting a review, EAC Legal Counsel will provide a legal assessment to determine if the EAC and, by extension, MSDH, has the legal authority and precedent to address the matter as presented. In the instance that the Initiation Form is not received from the complainant in 10 days, a legal review will determine if any further action is needed.

If EAC Legal Counsel determines that an EAC opinion is not warranted, the EAC Chair will notify the State Health Officer and Program/Office Director and proceed to Final Action. If EAC Legal Counsel determines that an EAC opinion is necessary, two types of ethics reviews are possible: an expedited review or a full review.

Expedited Review – For issues requiring immediate action, the EAC will conduct an expedited ethics review convening at least five committee members as soon as schedules permit.

Possible outcomes are:

1. The EAC reaches a final conclusion on the matter based on its review findings with no further action recommended;
2. The EAC decides to gather additional secondary information on the matter; reconvenes to review the new pertinent facts; and then reaches a final conclusion with no further action recommended; or
3. The EAC convenes a hearing or other public meeting to engage the requester, other impacted community member or stakeholders, and /or (internal or external) subject matter experts. The EAC then reaches a final conclusion based on its review finding with no further action recommended.

In each outcome, the Chair will complete the Ethics Review Closure Form (Form 1012) for putting forth findings and conclusions to the Final Action Committee and the State Health Officer. The matter will then proceed to Final Action.

Full Review – For issues not requiring immediate action, the EAC will conduct a full review, with the goal of completing the review within 90 days.

Possible outcomes are:

1. The EAC reaches a final conclusion on the matter based on its review findings with no further action recommended;
2. The EAC decides to gather additional secondary information on the matter; re-convenes to review the new pertinent facts; and then reaches a final conclusion with no further action recommended; or
3. The EAC convenes a hearing or other public meeting to engage the requester, other impacted community members/stakeholders, and /or internal or external subject matter experts. This option is most likely if the lead reviewer(s) did not hold a public meeting during the

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information gathering process. The EAC then reaches a final conclusion based on its review finding with no further action recommended.

In each outcome, the Chair will complete the Ethics Review Closure Form (Form 1012) for putting forth findings and conclusions to the Final Action Committee and the State Health Officer. The matter will then proceed to Final Action.

Final Action – The Final Action Committee is comprised of Legal Counsel, Director of Human Resources, and the appropriate members of the Executive Team.

Possible Outcomes are:

1. Final Action Committee agrees with the EAC’s conclusion; and the concern is considered resolved;
2. The FAC returns the matter to the EAC with additional specific questions to consider and an Expedited Review;
3. The FAC adds pertinent facts to the EAC’s findings and proposes a revised conclusion; or
4. Once a matter reaches Final Action, the Chair submits to the State Health Officer and the Office/Program Director the closure form and a Final Action Implementation Plan (Form 1013) and closes the matter in disposition.

The State Health Officer has ultimate and final authority on conclusions reached by the EAC as a result of an ethics review.

Ethics Review Process for Internal Concerns

Individuals from within MSDH with an issue of ethical concern regarding MSDH should contact the Director of Human Resources to discuss the concern and possible solutions. The Director of Human Resources will make a determination. If the matter is determined to be a HR issue, the process ends. If the HR Director determines it not to be an HR issue, an EAC opinion will be sought. However, prior to conducting a review, EAC Legal Counsel will provide a legal assessment to determine if the EAC and, by extension, MSDH, has the legal authority and precedent to address the matter as presented. If EAC Legal Counsel determines that an EAC opinion is not warranted, the EAC Chair notifies the State Health Officer and Program/Office Director and it moves to Final Action. If EAC Legal Counsel determines that an EAC opinion is necessary, two types of ethics reviews that apply to the External Review Process are applicable: an expedited review or a full review.

The same steps for the External Review Process will be followed resulting in the same possible outcomes as listed above and the same Final Actions steps will be followed.

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4.1 Composition and Purpose of the MSDH Institutional Review Board

The purpose of the agency Institutional Review Board (IRB) is to conduct an ethical review of human subjects research activities (including those research activities attached to agency grants) to determine whether the potential benefits of the research outweigh the risk that may be associated with the research.

The approval of the IRB will be required for all initial or continuing research involving humans subjects and courses of treatment, medications, and vaccines; research including surveys and questionnaires which require the agency to expend resources in either staff time or money; research in which the agency's name will be used in the citation of the findings; and research in the epidemiological or vital statistics area in which groups or large data files are involved or which fall into one of the other categories. Unlike in a medical or academic institution, an IRB review is not applicable for any public health practice activity that is mandated or authorized by law. The IRB shall have at least five members with varying backgrounds that include medical, nursing, and legal representation and at least one public member who is not otherwise affiliated with the agency. The chair of the IRB will be appointed by the State Health Officer.

4.2 Procedures for Submission of Requests

Proposals shall be submitted to the chair of the IRB at least 60 days prior to the initial time of subject enrollment in order for adequate consideration to be given to the request. The IRB shall review and have authority to approve, require modifications to secure approval, or disapprove all research activities. The IRB shall require the investigator to provide information that describes the research purpose and methodology and information given to subjects to obtain their informed consent. Research activities led by a non-MSDH employee must identify an MSDH employee who serves as a research co-investigator. The IRB will conduct an initial review and an annual review for ongoing research according to the following categories (more descriptive definitions for each of the categories may be found in the interpretation of federal regulations handbook available from the chair of the IRB):

- 1) Exempt identifiable data that are acquired for public health practice can be collected under different legal and ethical structures and are exempt from IRB review. The responsible public health practitioners must be employed by the MSDH and shall adhere to MSDH privacy regulations including advance written and informed consent of subjects. The chair of the IRB may also consider, among other factors, the following additional public health activities for exemption:
 - a. Common educational practices in educational settings;
 - b. Educational tests, surveys, or observations of public behavior that are not recorded in any identifiable format and could not place the subject at any risk for liability or damage;
 - c. Evaluations involving existing data, documents, records, or pathological

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specimens if these sources are publically available or if the information is recorded by the investigator without identifiers that link to the participants;

- d. Evaluations conducted by agency/department heads or their designees to measure the public's benefit from MSDH service programs, the methods for obtaining benefits/services, and the outcomes of these services.
- 2) Expedited review shall be used for research that presents no more than minimal risk to human subjects and involves only procedures authorized by Title 45 CFR 46 federal rules and regulations (accessed at <http://www.hhs.gov/ohrp/policy/ohrpreulations.pdf>), and for minor changes in previously approved research during the period (of one year or less) for which approval is authorized. Additionally, some protocols may be eligible for expedited review if the protocol was previously approved by the fully convened IRB. Expedited review may be carried out by the chair of the IRB or an experienced member of the IRB designated by the chair.
 - 3) Full IRB review shall be used for all other research not covered in items (1) and (2) above. To approve research by full review, the IRB shall determine that all of the following requirements are satisfied:
 - a. No more than minimal risk to human subjects.
 - b. Selection of subjects is equitable.
 - c. Informed consent will be sought from each prospective subject or their legal representative.
 - d. When appropriate, there are adequate provisions to protect the privacy and rights of subjects and to maintain the confidentiality of data.

In some cases, the funding source for a grant that includes research may require that the project director secure a separate Office for Protection of Research Risks (OPRR) application and number. When this occurs, the project director is responsible for completing the appropriate paperwork and submitting a copy to the MSDH IRB for its files.

4.3 Research Approved by Other Institutional IRB Committees

Research investigators involved in multicenter clinical research may find multiple reviews by multiple IRBs, in many cases, results in unnecessary duplication of efforts, delays, and increased expenses in the conduct of multicenter research activities. To improve efficiencies in the review process, the MSDH may enter into agreements with other medical or academic institutions for the use of a centralized IRB review process. The requirement stated in 21 CFR 56.107(a) notes that the IRB must be sensitive to community attitudes, have a familiarity with the standards of professional conduct and practice where the research takes place, and knowledge about local laws and regulations applicable to the study. Centralized IRB review agreements should be considered for medical or academic IRBs when these requirements are fulfilled. Without such agreements, individual institutional IRB review must be performed.

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4.4 Special Requests for Access to MSDH Databases

Research proposals that require access to data collected by the MSDH shall demonstrate current data sharing agreements as part of the IRB submission application. Data sharing agreements may be negotiated with the head of the department that collects the requested data. Data requests must conform to MSDH HIPAA privacy and security requirements. Examples of common requests of this nature include, but are not limited to, the following:

- 1) Vital Statistics – Graduate students do not generally request individual records, but do request de-identified information (tabulated statistics). For institution approved or sponsored research, the Bureau of Vital Statistics requires a study protocol which must include statements on assurances of confidentiality, security, family or medical provider follow back, and records disposal method and timeframe. If IRB approval is required by the institution, then a copy of the approval is included. If follow back is included, the follow back instruments or questions must be included with the request. If the death is identified through a National Death Index (NDI) search, the documentation submitted for NDI approval is sufficient because it includes all the necessary information. All information is reviewed and approved by the State Registrar prior to records being provided. Requests of this nature that do not involve MSDH patients may be reviewed and approved by the State Registrar and are not reviewed by the MSDH IRB. However, research requests that involve MSDH patients, patient files, and vital statistics require the approval of both the State Registrar and MSDH IRB.
- 2) Patient Information Systems – Requests to access de-identified data from the MSDH Patient Information Management System (PIMS) shall require a current data sharing agreement from the PIMS Director before an IRB review can be conducted. Request for identified data will require full IRB committee review.
- 3) Requests to access data from long-term care MSDH data sets are covered under the federal Privacy Act of 1974. The Centers for Medicare and Medicaid Services (CMS) has mandated that state agencies must maintain strict policies in the handling of MSDH data due to the confidential nature of the information. Guidelines covering the procedures for requesting such access may be obtained from the MSDH Bureau of Licensure and Certification. In general, approval of both the Bureau and CMS is required. The MSDH IRB review will not be initiated until this approval has been submitted by the investigator.

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4.5 Suspension or Termination of Research

All activities of the IRB will be conducted in compliance with the final Rule of the Public Health Service Act (45 CFR Part 46, Subparts IQ B, C, and G) as published at 56 FR 28003, June 18, 1991, and 54 FR 32445, and will otherwise comply with 45 CFR 46.101-46.409. An impartial process will be maintained by the IRB for receipt of reports of any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or 45 CFR Part 46 subject to A, B, C, and D. The researcher/principal investigator shall report any protocol changes or unexpected occurrences, including unanticipated risks to subjects as soon as possible but no later than 15 days from the change or event occurrence. Completion of each inquiry will be accomplished within 60 calendar days from receipt of the report, including preparation of written findings. Detailed documentation of inquiries will be maintained for at least three (3) years, and upon request will be provided to personnel of the DHHS who have authorization to review. An investigation will be initiated within 30 calendar days of the completion of an inquiry, if findings from that inquiry provide sufficient basis for conducting an investigation. Completion of an investigation will occur within 60 calendar days.

Impartial experts will be selected by the IRB to conduct inquiries and investigations. All precautions will be taken to ensure no real or apparent conflicts of interest will occur in an inquiry or an investigation. The affected individual(s) will be afforded confidential treatment to the maximum extent possible, a prompt and thorough investigation, and an opportunity to comment on allegations and findings of the inquiry and/or investigation. Notification will be supplied to the OPRR at the National Institutes of Health; then an investigation will be conducted. Notification will be provided to OPRR within 24 hours of obtaining a reasonable indication of possible criminal violations. The documentation to substantiate an investigation's findings will be prepared and maintained for at least three (3) years after DHHS acceptance of the final report. Appropriate interim administrative action will be taken to protect federal funds and to ensure that the purposes of the federal financial assistance are being carried out. The OPRR will be promptly advised of any developments in the course of the investigation that disclose facts that may affect current or potential DHHS funding for the individual(s) under investigation or that the DHHS needs to know to ensure appropriate use

Of federal funds and otherwise protect the public interest. The chair of the IRB shall report any allegations of scientific misconduct to the State Health Officer immediately. Appropriate sanctions (in accordance with federal regulations and state law) will be imposed on individuals should the allegation of misconduct be substantiated.

The State Health Officer will be notified of the final outcome of the investigation with a written report that thoroughly documents the investigative process and findings. Specific questions may be addressed to the chair of the IRB.

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5.1 Review and Approval of Agency Policies and Procedures

Purpose

This set of processes is to provide a formal means for new policy development and policy revision for agency wide dissemination and conformance. It is to ensure that:

- ✓ only authorized changes are made to approved documents
- ✓ all changes are reviewed and approved before use
- ✓ all stakeholders have the opportunity to contribute to the revision and development process
- ✓ effected staff are apprised of process changes in a timely manner.

Each office and region will ensure that policies and procedures are issued, maintained, and updated on a regular basis. Technical assistance may be requested from Policy Evaluation when developing policies and procedures. Internal policies and plans for use within a specified unit or program area may be formatted and approved as defined by the Office Director or Regional Administrator.

Definitions

Document

A document is any recorded item of a factual or informative nature.

Draft

A draft is a document under revision and open for change suggestions/comments. Draft documents must be accepted or rejected by all approvers. All rejections must include a descriptive summary of what document corrections need to occur for acceptance to be achieved.

Active Document

An active document has been approved by appropriate staff and is considered enforceable.

Document Approval

Document approval is the process by which a document is reviewed and authorized for activation by appropriate supervisors and directors.

Document Approver

A document approver is an individual responsible for reviewing assigned documents for adequacy and conformance prior to activation.

Policy

A policy is a documented statement of overall intentions and directions defined by those in the organization and endorsed by management.



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Procedure

A procedure is a specified way to carry out an activity or process.

Process Owner

The process owner is the office or program with responsibility for writing, reviewing and issuing the written policies and procedures used in providing control and consistency for designated processes. The individual with supervisory and managerial authority for the office or program will be responsible for written policies and procedures. This is usually the Office Director or Program Director. This individual is responsible for the overall integrity of the document.

Issue Date

The issue date is the date a policy or procedure is **first** approved and put into use and becomes enforceable.

Revision Date

The revision date is the date **changes** to an existing policy or procedure are finalized, available for use and become enforceable. For manuals, policies and procedures that have never been revised, i.e., NEW, the revision date will be completed with the word INITIAL.

Revision Number

All documents in force on July 1, 2016 will be assigned a Revision Number of 0. Each revision made after this date will be numbered consecutively.

Transmittal

A transmittal is an email notification sent to all agency employees that a change has been approved for an existing manual or policy or that a new manual or policy has been approved for enforcement.

Transmittal Number

A transmittal number is a number assigned when a notification of revision is broadcast through agency email for forms, manuals and sections of manuals.

Manual

A manual is the name assigned to a group of related policies and procedures i.e. *Immunization Manual* contains all policies and procedures used by the Immunization Program office.

Electronic Signature

Symbols or other data in digital form attached to an electronically transmitted document as verification of the sender's intent to sign the document. See Section 11.28 of this manual.

Employee Responsibilities

1. All employees are responsible for performing duties and assigned tasks in conformance with



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- approved policies and procedures.
2. All employees are responsible for notification of supervisory staff when policies or procedures become inadequate or inaccurate.
 3. All employees shall adhere to any and all revisions to policies and procedures when presented with written notification by supervisory staff.

Process Owner Responsibilities

1. Obtain comments and/or suggestions from relevant regional and central office personnel and community stakeholders incorporating them into the document as appropriate.
2. Attach comments and/or suggestions that are not incorporated into the document to the route sheet along with an explanation as to why each comment or suggestion was not incorporated.
3. Ensure that policy changes affecting regional staff, or regional operations have full review by appropriate Field Services staff.
4. If the routed document is a revision to an existing policy or procedure, develop and attach a Gist of Changes for this revision. A Gist of Changes is a brief summary of the changes made for this revision.
5. Ensure that policies or procedures are technically correct, are written in a clear, concise, and organized manner, and are free from grammatical errors.
6. Determine whether new policies or procedures require orientation training for effected staff and, if so, arrange for appropriate training and scheduling through Professional Enrichment. See Section 17.0 of the Administration Manual.
7. Ensure that the document has been reviewed to conform to the Health in All Policies strategic plan goals and the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare by completing the HiAP-CLAS Internal Policy Assessment (Form 115) available on the MSDH Intranet Forms page.

Approval Process

All new or revised policies will be implemented following the defined approval process, including approval by the State Health Officer or his/her designee. A Gist of Changes list must be included with all revisions. All policies, including program manuals, will be reviewed for Health in All Policies and National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare conformance with documentation using HiAP-CLAS Internal Policy Assessment (Form 115).

Twenty working days are optimal for routing of manuals, policies, or procedures. Routing should begin early enough to allow adequate time for review by each approver and incorporation of comments and corrections. Policies, procedures and manuals are entered into the electronic document control and storage application for approval. The approval process must be completed and all approvers must have responded with “accept”. The application will forward the document to the next approver indicated in the pre-determined approval queue. Each approver can reject a document or revision by choosing “reject” from the drop down box in the application and including a



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short narrative as to the reason for rejection as a comment. The application will notify the document owner that the document has been rejected by email. The document owner and all approvers are expected to collaborate in the approval process to achieve consensus. Detailed instructions for using the application can be found on the MSDH Intranet Documents/Technical Support page.

Approver responsibilities include the following:

Program Director

The responsible Program Director will review all proposed policies and procedures for compliance and consistency with programmatic office and department goals, objectives, and applicable statutes or regulations. The Program Director will signify approval in the document routing application by providing an electronic signature.

Office Directors or Designees

The responsible Office Director will review all proposed policies and procedures for compliance and consistency with programmatic office and department goals, objectives, and applicable statutes or regulations. The Office Director will signify approval in the document routing application by providing an electronic signature.

Field Services Staff

The Director of Field Services will assign policies to Field Services staff for review in alignment with subject matter expertise. Reviewers will also provide comments and feedback regarding:

1. The effect on Field Services, programmatic or support units, or other regional or central office services.
2. Overlapping of, duplication of, or conflict with existing agency policies or procedures.
3. Field Services staff will also ensure that appropriate field staff have an opportunity to review the policy and make comments. Field Services approvers will signify approval in the document routing application by providing an electronic signature.

Policy Evaluation Staff

Policy Evaluation staff will review policies and procedures based upon several criteria, including, but not limited to, the following:

1. Conformance and consistency with overall agency policies, procedures, goals, and objectives, including review for conformance with the Health in All Policies, compliance and consistency with applicable federal and/or state laws, rules, and/or regulations.
2. Proper structure for placement into the respective agency manuals.

Policy Evaluation staff will coordinate their review with other appropriate operational units of the agency as necessary. Policies and procedures will be approved following the incorporation of applicable comments or corrections. Policy Evaluation staff will signify approval in the document routing application by providing an electronic signature. Policy Evaluation staff will provide either electronic or



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written initials on Form 115 to signify review.

Chief Administrative Officer

Upon approval by the Chief Administrative Officer, the policies and procedures will be electronically forwarded to the State Health Officer.

State Health Officer or Designee

The State Health Officer or his/her designee will review policies and procedures and will signify approval in the document routing application by providing an electronic signature. Documents and polices become effective upon signature by the State Health Officer or designee.

If this process is not followed and the approval of the State Health Officer or designee is not documented for policies and procedures, they are not official agency documents and will not be transmitted.

Local Maintenance and Retention

Each Central Office program and field location will designate an individual to be responsible for receiving policies and procedures, informing appropriate staff, updating appropriate manuals, and maintaining them in locations accessible to all staff at all times either printed or electronically. This individual is responsible for removing retired policies from the work areas and informing appropriate staff. At the regional level, the Regional Administrator is responsible for ensuring that all hard copies of manuals are updated and hard copies of retired policies removed within **3 working days** of the transmittal.

Time-Limited Policies and Procedures

Policy by memorandum is prohibited. Emergency policies and procedures may be temporarily implemented by memorandum but will still require all approvals and signatures. Such policies and procedures will be clearly marked as being “time- limited,” and upon transmittal will be placed within the respective manual into an appended section entitled “Time-Limited Policies and Procedures.” The time-limited policies and procedures will contain an effective termination date and a notice of whether a manual change will follow after the termination date. Routing and distribution of time-limited policies and procedures will follow the same process as for normal policies and procedures. Time-limited policies and procedures should be used infrequently.

Review Process

As forms, policies and procedures reach the one-year mark without a revision, the Process Owner is responsible for a thorough review of the document to determine continued relevance, conformance, and assure that the policy is technically correct.

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The review process is accomplished by accessing the document in the Active Registry in the electronic document storage application. The review is documented by choosing an option from the review outcome drop down list. If the document is currently relevant and concordant then a choice of “no change” should be made. Policy Evaluation staff will add or update the Last Reviewed Date box for manuals. If the document requires updating the “change required, move to draft” choice will be made. This choice will allow the document to be moved to the Draft Register for updating. If the document is obsolete and should be retired, a choice of “retirement requested” will allow the document to be moved from the Active to the In-active Register. Only the Process Owner is required to perform a review.

Policy Concordance

No policies or revision to policies will be approved as discordant with existing MSDH policies and procedures.

No policies or revision to policies will be approved as discordant with federal or state regulatory requirements.

Document Retirement

Policy retirement will be implemented following Office and Program Director written or electronic request submitted to Office of Policy Evaluation. Policy Evaluation will send a transmittal notification of policy retirement.

Page Placement and Formatting

Policies and procedures submitted for approval will be in the approved format.

1. Margins will be 1 inch on the left side and 0.5 inches on right, top and bottom.
2. The font used for the header will be Arial 11 Bold. Font used for text will be Times New Roman 12.
3. The agency logo will be centered in the footer, using the following format:



4. The document header box will be in the header section of the document, bolded and in the following format:

Mississippi State Department of Health <i>Manual name and number</i>	Topic:
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See *Definitions* for correct use of terms.

Retention

Document retention and storage will be in compliance with the requirements of the Mississippi Department of Archives and History Approved Records Schedule for the Department of Health or applicable federal and state regulations whichever is longer. MDAH requirements can be accessed at <http://records.mdah.ms.gov>



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5.2 Contracts

SPECIAL NOTE:

These policies and procedures specify the internal review process that all Mississippi State Department of Health (MSDH) units must follow when entering into a formal agreement with another organization to provide specified services for a specified fee, i.e. a contract, including all contracts, sub-grants, and memoranda of understanding. Any agreement involving an exchange of anything of value (funding, staff time, supplies, use of equipment, buildings, or any goods or services) is a formal agreement and requires the review process and approval of the State Health Officer or his/her designee.

The terms “Program Director” and “Office Director” for all routing and approval processes refers to the person responsible for the document, whether it is initiated by a regional or a central office program

For contracts, sub-grants, and MOUs the term “Implementation Date” refers to the date that the contract, sub-grant, and MOU begins.

Determination of Document Type

Before drafting any agreement, staff should complete the MSDH Contractor/Sub-grantee Determination Worksheet (Form 593) located on the agency’s intranet site. This completed worksheet must be included as part of documentation for each agreement. If the worksheet indicates that an agreement is a sub-grant, use the Sub-Grant Agreement (Form 607) located on the agency’s intranet site and follow the procedures for sub-grants in Section 5.3 of this manual.

If the worksheet indicates that an agreement is a vendor/contractor relationship, complete the second worksheet, MSDH Contract Worker/Independent Contractor Determination Worksheet (Form 594). Use the contract agreement indicated by the worksheet conclusion and follow the procedures for that agreement. Both the Independent Contractor Agreement (Form 605) and the Contract Worker Agreement (Form 606) are located on the agency’s intranet site.

Independent Contracts – Fee for Service

SPECIAL NOTE:

This process is for Fee for Service contracts only. All other independent contracts should follow the guidelines outlined in subsection 5.2.2 of this manual.



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Preparation of Contracts

Staff shall use ONLY the most current contract documents located on the agency’s intranet site. Documents should be saved to a hard drive with completed information only for archival purposes. **DO NOT save blank copies of the contract documents from the intranet to a hard drive and continue to use those documents for future contracts.** If the most current revision of the contract documents is not used, contracts will be returned to the originator for resubmission on the most current document revision. Form 1022, Human Resources Contract Checklist, can be used to facilitate this process.

All contracts must include the following components:

1. Contract between department and contractor
2. Attachment A: Terms of Contract
3. Attachment B: Conflicts of Interest
4. Form 115: Ensure that the document has been reviewed to conform to the Health in All Policies strategic plan goals and the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare by completing the HiAP-CLAS Internal Policy Assessment.

Other components may include the following, if needed:

1. Attachment C: additional contractual terms
2. IRS Form W-9

Do not change or delete any part of the contract’s wording. If change is required by a vendor, consult with the Legal Division about including changes as Attachment C: Additional Contractual Terms; for example, “Section 5 is hereby deleted” or “Additional contractual terms are as follows.” All parties must sign Attachment C if any changes are made, which should duplicate the signatures of the Independent Contract.

Complete the information in all sections of the contract or indicate as Not Applicable (NA). If the sections are not completed or marked as “NA,” the contract will be returned for completion. Include a summary of services in the Contractual Agreement (Section I) and a more detailed description in the Contracted Services section (Attachment A). Contracts should also include a fee schedule and, if applicable, an attachment detailing the work plan and activities to be performed, a detailed budget, and a budget narrative.

Ensure that contracting organizations complete **all** sections of Attachment B: Conflicts of Interest, disclosing board members, any relationship of board members to MSDH staff, and other current contracts with MSDH. It is MSDH policy not to contract with staff, their spouses, their children, parents,



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or any organization in which the staff member has a material interest (see Conflicts of Interest). If the contractor is new or has implemented a name or address change, include a completed IRS Form W-9, located on the agency's intranet.

Initiating the Review Process

Allow at least 30 days for the review process, beginning with approval by the appropriate office director. To initiate the review process, the program director shall:

1. Load all related documents into the electronic document routing and storage application. For instructions on entering information into the system, refer to the application instructions located on the MSDH Intranet under Documents/Technical Support.
2. Include the MSDH Contractor/Grantee Determination Worksheet (Form 593) and the MSDH Contract Worker/Independent Contractor Determination Worksheet (Form 594) if indicated, in the contract file.
3. Submit for approval. The application has the predetermined approval queue for each document already programmed.

Contract Review

Each reviewer must ensure that all changes requested are made before approving the document. Upon approval, the application will forward the contract to the next person indicated in the approval queue.

Program Director/Originator

Ensures that the contract:

1. Follows the standard agency contract;
2. Includes all required attachments, properly completed by the contractor.

Office Director or Regional Administrator

Ensures that the contract is in compliance with office policies, goals, and objectives. Further ensures that the contract:

1. Follows the standard agency contract format;
2. Includes all required attachments, properly completed by the contractor.

Policy Evaluation Staff

Ensures that the contract complies with agency policies, procedures, goals, and objectives as well as all attachments are properly completed.



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HIPAA Officer or designee

Ensures that all agreements and contracts are HIPAA compliant.

Finance & Accounts Staff

Conduct a technical review to ensure financial accuracy and appropriateness of the contract's budget. Ensure that the proposal includes an acceptable auditing procedure of the contracting entity.

Human Resources Director

Ensures that the determination of the Independent Contractor or Contract Worker is appropriate and that the contract is on the correct contract agreement form. Ensures that the appropriate classification and hourly rate are used for any contractual staff positions.

Director of Health Informatics

Ensures that all proposed expenditures related to information technology and telephones are appropriate.

Legal Department Staff

Ensures appropriate form and legality of each sub-grant and independent contract.

Chief Administrative Officer

Reviews the contract for overall appropriateness.

State Health Officer

Reviews the contract of overall appropriateness.

Contractor Signature

When all needed corrections have been made and all reviewers have approved, the Program Director will send two original contract documents to the contractor for signature. Returned contractor signed documents will then be signed by State Health Officer or Designee. After the agreement is signed by the above referenced parties, the program director will submit one of the original signed contract(s) back to the contractor and send the second original document to Finance and Accounts **after uploading a copy to the electronic storage application.**

Contracts must be signed prior to the beginning date of the award period. MSDH will not forward funds to the contractor and no services may begin until a contract has been fully executed. The contract terms will be binding until such time as they are revised by an appropriately executed contract modification, the contract period ends, or the contract is terminated. A performance bond may be required as a condition of the contract.



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5.2.2 Competitive Contracts

The Personal Service Contract Review Board’s (PSCRB) Personal Service Contract Procurement Regulations govern all processes and procedures for preparing, advertising, and awarding competitive contracts. Offices/programs involved in competitive contracts should review these regulations, in detail, which may be accessed via the State Personnel Board’s website at:

<http://www.mspb.ms.gov>

An Invitation for Bids and Request for Proposal (RFP) are two different methods of procurement. MSDH will make the determination as to which method is most appropriate for the services required.

A Request for Proposal is advantageous when there is a need for:

- Flexibility
- Discussions with respondents
- Comparative evaluations (scope not developed)

The RFP process, also referred to as the “competitive sealed proposal process”, differs from the “competitive sealed bid process” in two important ways.

Competitive sealed proposals:

- Permit discussions with competing offers and allows changes in their proposals including price, and
- Allow comparative judgmental evaluations to be made when selecting among acceptable proposals for award of the contract.

Where evaluation factors involve the relative abilities of offerors to perform, including degrees of technical or professional experience or expertise, use of competitive sealed proposals is the appropriate procurement method. Similarly, such method is appropriate where the type of need to be satisfied involves weighing artistic and aesthetic values to the extent that price is a secondary consideration.

Invitation for Bids (Competitive Sealed Bidding):

1. Conditions for Use: Contracts shall be awarded by competitive sealed bidding when a determination is made that this method is the best suited for a particular service.
2. Invitation for Bids: An Invitation for Bids shall be issued and shall include a purchase description and all contractual terms and conditions applicable to the procurement.
3. Public Notice: Public notice of Invitation for Bids, when anticipated expenditure is more than



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\$75,000, shall be made in compliance with PSCRB regulations. All personal and professional services contract procurements must be posted on the Mississippi Contract/Procurement Opportunity Search Portal.

4. **Bid Opening:** Bids shall be opened publicly in the presence of one or more witnesses at the time and place designated in the Invitation for Bids. The name of each bidder shall be recorded. The amount of each bid and such other relevant information as may be specified by regulation may be recorded; the record and each bid shall be open to public inspection.
5. **Bid Acceptance and Bid Evaluation:** Bids shall be unconditionally accepted without alteration or correction, except as authorized in these regulations. Bids shall be evaluated based on the requirements set forth in the Invitation for Bids, which may include criteria to determine acceptability such as inspection, testing, quality, workmanship, delivery, and suitability for a particular purpose. Those criteria that will affect the bid price and be considered in evaluation for award shall be objectively measurable where possible. The Invitation for Bids shall set forth the evaluation criteria to be used. No criteria may be used in evaluations that are not set forth in the Invitation for Bids.
6. **Correction or Withdrawal of Bids; Cancellation of Awards:** Correction or withdrawal of inadvertently erroneous bids before award, or cancellation of awards or contracts based on such bid mistakes shall be permitted in accordance with regulations promulgated by the Personal Services Contract Review Board. After bid opening, no changes in bid prices or other provisions of bids prejudicial to the interest of the State or fair competition shall be permitted. Except as otherwise provided by regulation, all decisions to permit the correction or withdrawal of bids, or to cancel awards or contracts based on bid mistakes shall be supported by a written determination made by the Agency Head with the approval of the Personal Service Contract Review Board. The written determination shall be maintained in the agency's procurement file.
7. **Award:** The contract shall be awarded with reasonable promptness by written notice to the lowest responsible bidder whose bid meets the requirements and criteria set forth in the Invitation for Bids.
8. **Multi-Step Sealed Bidding:** When it is considered impractical to initially prepare a purchase description to support an award based on price, an Invitation for Bid may be issued requesting the submission of un-priced offers to be followed by an Invitation for Bid limited to those bidders whose offers have been qualified under the criteria set forth in the first solicitation.

Request for Proposals (Competitive Sealed Proposals):

1. **Conditions for Use:** When, under regulations approved by the Personal Service Contract Review



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Board, the Agency Head determines that the use of competitive sealed bidding is either not practicable or not advantageous to the State, a contract may be entered into by competitive sealed proposals.

2. Request for Proposals: Proposals shall be solicited through a Request for Proposal. Adequate public notice of the Request for Proposals shall be given in the same manner as provided for Competitive Sealed Bidding.
3. Receipt of Proposals: Proposals shall be opened so as to avoid disclosure of contents to competing offerors during the process of negotiation. A Register of Proposals shall be prepared and shall be open for public inspection after contract award. The Register of Proposals shall indicate the name of all vendors submitting proposals.
4. Evaluation Factors: The Request for Proposals shall state the relative importance of price and other evaluation factors (i.e. Important, Very Important, or Critical).
5. Discussion with Responsible Offerors and Revisions to Proposals: As provided in the Request for Proposals and as set forth in PSCRB regulations, discussions may be conducted with responsible offerors who submit proposals determined to be reasonably susceptible of being selected for award for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements. Offerors shall be accorded fair and equal treatment with respect to any opportunity for discussion and revision of proposals, and such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by competing offerors.
6. Award: Award shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the State, taking into consideration price and the evaluation factors set forth in the Request for Proposals. No other factors or criteria shall be used in the evaluation.

To ensure compliance with the State Personnel Board's Personal Service Contract Procurement Regulations, Invitation for Bids and RFP originators must route their draft Invitation for Bids or RFP for review and comments to 1) Director of Human Resources (Contract Administration); 2) Chief Administrative Officer; 3) Originator's Program Director or Regional Administrator; and 4) Legal, prior to release for advertisement. Human Resources (Contract Administration) shall also participate in the scoring of Bids & Proposals submitted in response to such Invitations for Bids or proposals.

Employees preparing RFPs and review committees should refer to the Personal Service Contract Review Board's (PSCRB) Personal Service Contract Procurement Regulations.



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RFP Solicitations

1. Program directors shall solicit competitive contract proposals by advertising in a newspaper with daily general circulation and within an appropriate geographic area designated by the program director, for five (5) consecutive working days. The advertisement must include at least the following information:

- a. Notice that funds are available;
- b. Services to be supported by the funds;
- c. Deadline for submission of a proposal;
- d. Eligibility requirements; and
- e. Contact person or office, including telephone number and mailing address, to request the full proposal information kit.

2. Potential applicants must request proposal information kits, which shall contain the following items:

- a. Contract period;
- b. Amount of award(s) and/or funds available;
- c. Source of funds to be awarded; d. Applicable laws and regulations;
- e. Funding objectives and areas of special emphasis or interest;
- f. Recipient financial participation requirements where applicable, such as matching or cost sharing requirements;
- g. Proposal format, including deadline date and time for receipt of proposals;
- h. Criteria for review and evaluation and program priorities for funding; and
- i. Other materials or information the program director wishes to provide.

3. Applicants shall submit an original proposal and any additional copies required to the responsible MSDH program director, who will set the deadline for submission. MSDH will accept proposals received by the deadline date; late proposals will be returned to the applicant.

Proposal Review

1. A proposal may be determined as nonconforming if it cannot be properly evaluated or its deficiencies cannot be remedied before award, thereby ending the review process for that proposal. A "nonconforming proposal" is one that does not meet the requirements of the announcement to which it is responding because it falls under one or more of the following criteria:

- a. Proposal submitted by an ineligible contractor;
- b. Proposal omitted required material; or
- c. Proposal omitted any required document.



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2. An applicant may withdraw its proposal(s), in writing, at any time. Proposals will be returned at the discretion of the MSDH program director.

A. committee will review competitive proposals based on criteria specified in the information kit or announcement guidelines. Decisions will be based on:

- a. Recommendations resulting from the review process;
- b. Stated programmatic priorities;
- c. Availability of funds; and
- d. Any other available information.

4. The review process shall be completed a maximum of thirty (30) days after the deadline date for receipt of proposals.

Notification of Non-Selected Proposals

The program director shall provide written notice to applicants whose proposals will not be funded. The notice shall state the reason(s) the proposal was not selected for funding, the name of an official to contact for additional information, and that all inquiries regarding proposals not selected must be made in writing.

Notification of Selected Proposals

1. The program director will provide a notice of award to applicants who are approved for funding. The notice will indicate the following items:
 - a. Notice that funding has been approved;
 - b. The total or maximum amount of funding to be awarded;
 - c. The contract period; and
 - d. Notice that a formal contract will be forthcoming.
2. Any action resulting in a change in the amount of funds awarded or a change in the duration of support may be reflected in a revised notice of award. A copy of the notice of award will be forwarded to the appropriate Office Director or Regional Administrator and Finance and Accounts. A completed contract may be used in lieu of a notice of award.

Contract Preparation and Review

Following an award decision, the responsible program director will prepare a contract between MSDH and the contractor. Contracts must be reviewed and signed prior to the beginning date of the award



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period. MSDH will not forward funds to the contractor and no services may begin until a contract has been fully reviewed and executed.

The responsible agency administrator may interview a potential contractor, negotiate terms of the contract, initiate the agency’s internal review process, and secure all signatures. However, the contractor may not begin work and no funds will be paid until the contract has been fully approved. A completed IRS W-9 form must be attached before a contract can be processed or approved. The terms of the contract will be binding on the contractor until such time as they are modified by a revised contract or the contract is terminated.

Contract Review

Designated MSDH staff will review every agency contract. Each reviewer must ensure that all needed corrections are made before approval. Upon approval, the electronic application will forward the contract to the next person indicated in the approval queue.

Office Director or Regional Administrator

Ensures that the contract is in compliance with office policies, goals, and objectives. Further ensures that the contract:

- Follows the standard agency contract format;
- Includes all required attachments, properly completed.

Finance & Accounts Staff

Conduct a technical review to ensure financial accuracy and appropriateness.

Human Resources Director

Ensures that the determination of Independent Contractor or Contract Worker is appropriate and that the contract is on the correct contract agreement form. Ensures that the appropriate classification and hourly rate is used for any contractual staff positions. Human Resources office staff will review the contract for completeness and ensure that all required documents are attached. For contractors receiving benefits from the Public Employee’s Retirement System, the contract will be reviewed to ensure compliance with retirement system requirements (PERS Form 4B).

Any modification to a contract must be in writing, following the same procedures.

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Payments to Contractors

Contractors will request payment at intervals specified by the contract, such as monthly or quarterly, through a letter or Payment Request (Form 13). The request must detail what funds have been spent, with documentation attached (copies of payroll, invoices, vouchers, warrants). The contractor shall submit the request to the responsible program director, who will forward it to Finance and Accounts. The program director will authorize payment based on the contractor's progress in performance of the contract and closeout of the contract, when applicable.

MSDH will consider requests to carry over unexpended funds from one contract year to the next on an individual basis. MSDH will not pay bills or requests for payment submitted on or after forty-five (45) days beyond the contract's expiration date. It is the contractor's responsibility to ensure that all bills and requests for payment are submitted in a timely manner. The contractor must maintain accurate accounting and administrative records, indicating proper classification of expenditures.

Project or Budget Changes

The contractor or the MSDH must request in writing any modification to an existing contract, and the modified contract must be routed following the same procedure as the original contract, See Section 5.3 of this manual. All requests must bear the signature of an authorized official of the business office of the contractor organization and the Project Director, Office Director, and the Chief Administrative Officer.

Contract revisions are not authorized until the review process is complete and all appropriate parties have signed the revised contract. Examples of changes which require a contract modification include, but are not limited to, the following:

1. Changes in the scope of activities, direction, type of service delivery, or other areas that constitute a significant change from the objectives or purposes of the approved project.
2. Changes in the effective dates of a contract.
3. A significant change in responsibilities of the approved project director or any other persons named and expressly identified as key project personnel by the MSDH and/or the contractor. The contractor should notify the program director as soon as such information is known, but no later than two (2) weeks before the expected date of departure or change in participation level.
4. Transferring to a third party by contracting, subcontracting, or other means, the performance of a substantive portion or component of the contract work or services.
5. Where the need for patient care in the project has not previously been approved by the MSDH.



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6. Undertaking any activities disapproved or restricted by the contract, including restrictions imposed by standard contract provisions, such as cost principles, federal regulations, state statutes, or others.
7. Re-budgeting between approved budget categories to meet unanticipated requirements or to accomplish certain or specific project changes.
8. Undertaking any expenditure disapproved or restricted as a condition of the contract.
9. Making changes in established indirect cost rates.

Compliance with State Statutes and Requirements

Section 31-7-13 of the Mississippi Code of 1972, Annotated, sets forth the requirements that all state agencies must follow when purchasing commodities and other items. State purchasing statutes also apply to any contractor, sub-grantee, or any other relationship funded through the MSDH. For further information on these requirements, contact Finance and Accounts.

In addition, the agency must abide by state statutes and State Personnel Board requirements when entering into contracts for personal services. Contact Finance and Accounts or Human Resources for details of these requirements.

Contracts Monitoring

The program director or other MSDH staff responsible for administering the contract must have a plan for routine program monitoring. The monitoring plan must be submitted for review with the original contract, and monitoring reports must be submitted on a regular basis (monthly, quarterly, annually) with the contract payments. Any irregularities noted during the monitoring process should be addressed. Policy Evaluation, Legal, and Internal Audit staff may be called upon to provide consultation.

All entities contracting with the MSDH must maintain acceptable audits. The MSDH reserves the right to terminate any contract should the contracting organization incur an unacceptable audit

Contract Workers

These policies and procedures apply to any contract whereby MSDH enters into formal agreement for a contract worker. Administrators with questions regarding the type of contract to be used and/or the proper procedures to be followed may contact Human Resources.

Criteria to Determine Need

The following criteria will be utilized to determine whether or not to contract:



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1. Unmet service need
2. Workload of existing staff
3. Pertinent factors from regional personnel, program directors, and support units

The MSDH will not execute a contract if the need can be met by filling an existing vacant, authorized position in the agency.

Contract Justification

Administrators must attach a justification of need for a contract worker to each contract document. The required justification is a part of the Contract Worker agreement on the agency Intranet site and includes the following information:

Assessment of current personnel resources, including current position vacancies

1. Detailed description of contractual services to be performed
2. Qualifications that make contractor the best suited to perform task
3. Consequence of contract being disapproved

Contractor Qualifications

Contract Worker candidates must meet, at least, the published minimum qualifications (see State Personnel Board class specifications at www.mspb.ms.gov). Programs with position titles and functions that are not covered by the SPB must refer to its own published position qualifications. The following requirements must be met prior to hiring a Contract Worker:

1. Contract Workers must complete a MSDH Personal Services Contract Application (Form 161). *This application is available on the agency intranet under Forms.*
2. Contract Worker applications must be certified by the hiring organization, attesting that it has exercised its due diligence in determining that the candidate selected meets all of the minimum requirements for the position for which the candidate's personal services are being contracted. The certification language is located at the top of the Personal Services Contract Application (Form 161). The Office Director's or Regional Administrator's signature will be required to certify the application.
3. Contract Worker agreements submitted without a properly completed and certified application will be returned as incomplete.
4. Falsification of the application will be grounds for immediate termination.

Terms of the Contract

The appropriate MSDH administrator and the contractor will discuss the following terms:



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1. Qualifications of contractor
2. Contract period
3. Services to be provided
4. Compensation for services rendered
5. Location and schedule for services to be provided and required reports
6. Other information as necessary

Prohibited Contractual Relationships

The contractor shall not be an employee of the Mississippi State Department of Health. Likewise, the contractor shall not subcontract with any MSDH employees.

The contractor shall not pay any department employee additional compensation, stipend, or honorarium for any work done or presentations made outside of the agency if such work or presentation constitutes the employee's usual duties or is a service the agency would normally provide to the public.

Notification for Decline of Services

The MSDH administrator initiating discussion of a contract must notify the contractor in writing within ten (10) working days following a decision not to utilize the contractor's services. The notice will state the reason(s) the services of the contractor will not be utilized and the name of an official to contact for additional information.

Notification of Contract Approval

The responsible MSDH administrator must notify the appropriate contractor in writing within ten (10) working days of a decision to use the contractor's services. A fully executed contract may serve as the written notification.

Contract Routing Procedures

Contracts must be signed prior to the beginning date of the contract period or implementation date. The responsible agency administrator may interview a potential contractor, negotiate terms of the contract, initiate the agency's internal review process, and secure all signatures. However, the contractor may not begin work and no funds will be paid until the contract has been fully approved. A completed IRS W-9 form must be attached before a contract can be processed or approved. The terms of the contract will be binding on the contractor until such time as they are modified by a revised contract or the contract is terminated.



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Contract Review

Designated MSDH staff will review every agency contract. Each reviewer must ensure that all needed corrections are made before approval. Upon approval, the electronic application will forward the contract to the next person indicated in the approval queue.

Office Director or Regional Administrator

Ensures that the contract is in compliance with office policies, goals, and objectives. Further ensures that the contract:

- Follows the standard agency contract format;
- Includes all required attachments, properly completed.

Finance & Accounts Staff

Conduct a technical review to ensure financial accuracy and appropriateness.

Human Resources Director

Ensures that the determination of Independent Contractor or Contract Worker is appropriate and that the contract is on the correct contract agreement form. Ensures that the appropriate classification and hourly rate is used for any contractual staff positions. Human Resources office staff will review the contract for completeness and ensure that all required documents are attached. For contractors receiving benefits from the Public Employee's Retirement System, the contract will be reviewed to ensure compliance with retirement system requirements (PERS Form 4B).

After all approval signatures have been obtained, the contract will be processed in the Statewide Payroll and Human Resource System (SPAHRs) and transmitted for approval. Human Resources will update the MSDH contract tracking system to reflect the approval date.

Any modification to a contract must be in writing, following the same procedures.

Breach of Contract

In the event of breach of contract, MSDH may exercise any of its legal options.

Contract Revisions

Any action resulting from a change in the amount of compensation, duration of the time period, or other contract provisions must be reflected in a modified contract.



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Contract Terminations

The responsible agency administrator must notify the contractor in writing fifteen (15) calendar days prior to termination of the contract. The Contract Analyst is to be immediately notified in writing of any terminations, resignations, or expirations. The notification should state the contractor’s name, the reason for the action, the effective date, and any other pertinent information.

Temporary Staff Contract Administration

Requests for contractual personnel available through temporary staff providers should be submitted using Form 101, Request for Temporary Services, to Human Resources fifteen (15) calendar days prior to the proposed effective date.

The Human Resources office will notify the responsible agency administrator upon approval or disapproval of the request.



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5.3 Sub-grants

For contracts, sub-grants, and MOUs the term **“Implementation Date”** refers to the date that the contract, sub-grant, and MOU begins.

For uniform procedures for administering and monitoring agreements to sub-grantees, refer to the Sub-grantee Manual found on the agency intranet.

Sub-grant Preparation and Review

Following an award decision, the responsible program director will prepare a sub-grant agreement between MSDH and the sub-grantee. All sub-grants must be routed through the internal review process described below, including uploading a copy of a final signed document to the electronic document storage application. Sub-grants must be reviewed and signed prior to the beginning date of the award period. MSDH will not forward funds to the sub-grantee and no services may begin until a contract has been fully reviewed and executed.

The sub-grantee must maintain accurate accounting and administrative records, indicating proper classification of expenditures as defined in the MSDH Sub-Grantee manual.

All sub-grants will be awarded and monitored in compliance with the requirements of the MSDH Sub-grantee Manual, including submission of the MSDH Internal Audit Information Form 120, later than 90 calendar days after the end of the sub-grantee’s fiscal year. A copy of this manual should be furnished to all sub-grantees at the time of award. MSDH Sub-grantee Manual is available on the MSDH website.

Determination of Document Type

Before developing any sub-grant agreement, staff should complete the MSDH Contractor/Sub-grantee Determination Worksheet (Form 593), which is located on the agency’s intranet site. This completed worksheet must be included as part of documentation for each sub-grant. If the worksheet indicates that an agreement is a sub-grant, use the Sub Grant Agreement (Form 607) located on the agency’s Intranet site.

Preparation of Sub-grants

Documents should be saved to a hard drive with completed information only for archival purposes. **DO NOT save blank copies of the documents from the intranet to a hard drive and continue to**



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use those documents for future sub-grants, to assure the correct document revision is used. If the most current revision of the documents is not used, sub-grants will be returned to the originator for resubmission on the most current document revision.

All sub-grants must include the following components:

1. Agreement between department and sub-grantee
2. Proposed Budget Justification/Narrative
3. Scope of Work
4. Form 115: Ensure that the document has been reviewed to conform to the Health in All Policies strategic plan goals and the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare by completing the HiAP-CLAS Internal Policy Assessment.

Other components may include the following, if needed:

1. Additional terms of the agreement
2. IRS Form W-9
3. Applicable Assurances

Do not change or delete any part of the agreement's wording. If there is a need for any change, consult with the Legal Division about including changes.

Ensure that sub-grantees complete all sections of the Conflicts of Interest page, disclosing board members, any relationship of board members to MSDH staff, and other current contracts or sub-grants with MSDH. It is MSDH policy not to contract or enter into sub-grant agreements with staff, their spouses, their children, their parents, or any organization in which the staff member has a material interest (see Conflicts of Interest).

Initiating the Review Process

Thirty days are required for the review process. Initiating the review process, the program director will prepare all appropriate documents for review and submission. If the sub-grantee is new or has implemented a name or address change, include a completed IRS Form W-9, located on the agency's intranet.

Sub-grant Review

Designated MSDH staff will review every agency sub-grant. To initiate the review process, the program director shall:



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- ✓ Set up a document file by entering the appropriate information into the electronic document routing and storage application. For instructions on entering information into the application refer to the instruction documents located at Intranet/Tools/Technical Support.
- ✓ Upload all related documents into the document file and submit for approval, including the MSDH Contractor/Grantee Determination Worksheet.

Each reviewer must ensure that all necessary corrections are made before electronically approving the document. Upon approval, the application will forward the sub-grant agreement to the next person in the pre-determined approval queue.

Program Director/Originator – Ensures that the sub-grant follows agency policy and includes all required documents, properly completed.

Office Director or Regional Administrator – Ensures that the sub-grant is in compliance with office policies, goals, and objectives. Further ensure that the sub-grant includes all required documents, properly completed.

Policy Evaluation – Ensures that the sub-grant complies with agency policies, procedures, goals, and objectives. Also ensure that the sub-grant documents are properly completed.

HIPAA Officer or designee

Ensures that all agreements and contracts are HIPAA compliant.

Finance & Accounts – Conduct a technical review to ensure financial accuracy and appropriateness of the budget. Ensure that the proposal includes an acceptable auditing procedure of the sub-grantee.

Human Resources Director – Ensures that the appropriate classification and hourly rate are used for any contractual staff or agency positions.

Director of Health Informatics – Ensures that all proposed expenditures related to information technology and telephones are appropriate.

Legal – Ensures appropriate form and legality of each sub-grant.

Director of Health Administration/Chief Administrative Officer – Reviews the sub-grant for overall appropriateness.

State Health Officer – Upon approval, the application will sub-grant agreements will be sent to Policy Evaluation who will forward approved document to the originator.



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Procedures Following Review and Signatures

When all needed corrections have been made and all reviewers have been approved, the Program Director will send two original contract documents to the contractor for signature. Returned contractor signed documents will then be signed by the Program Director and sent to the Office Director and Chief Administrative Officer for signatures (Office Director signature is optional.) After the agreement is signed by the above referenced parties, the program director will submit one of the original signed contract(s) back to the sub-grantee and send the second original document to Finance and Accounts **after uploading a copy to the electronic storage application.**

Sub-grants must be signed prior to the beginning date of the award period. MSDH will not forward funds to the sub-grantee until the agreement has been fully executed. The terms will be binding until such time as they are revised by an appropriately executed modification, the agreement period ends, or the agreement is terminated.

Project or Budget Changes

The sub-grantee or the MSDH must request in writing any modification to an existing agreement, and the modification must be routed following the same procedure as the original agreement. All requests must bear the signature of an authorized official of the business office of the sub-grantee and the project director.

Sub-grant revisions are not authorized until the review process is complete and all appropriate parties have signed the modification. Examples of changes which require a modification include, but are not limited to, the following:

1. Changes in the scope of activities, direction, type of service delivery, or other areas that constitute a significant change from the objectives or purposes of the approved project.
2. Changes in the effective dates.
3. A significant change in responsibilities of the approved project director or any other persons named and expressly identified as key project personnel by the MSDH and/or the sub-grantee. The sub-grantee should notify the program director as soon as such information is known, but no later than two (2) weeks before the expected date of departure or change in participation level.
4. Transferring to a third party by contracting, subcontracting, or other means, the performance of a substantive portion or component of the sub-grant scope of work or services.
5. Where the need for patient care in the project has not previously been approved by the MSDH.



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6. Undertaking any activities disapproved or restricted by the sub-grant, including restrictions imposed by standard provisions, such as cost principles, federal regulations, state statutes, or others.
7. Re-budgeting between approved budget categories to meet unanticipated requirements or to accomplish certain or specific project changes.
8. Undertaking any expenditure disapproved or restricted as a condition of the agreement. Making changes in established indirect cost rates.

Sub-grant Monitoring

The program director or other MSDH staff responsible for administering the sub-grant must have a plan for routine program monitoring. The monitoring plan must be submitted for review with the original agreement, and monitoring reports must be submitted on a regular basis (monthly, quarterly, annually) with the sub-grant payments. Any problems noted during the monitoring process should be addressed. Policy Evaluation, Legal, and Internal Audit staff may be called upon to provide consultation. All entities receiving funds from the MSDH must maintain acceptable audits. The MSDH reserves the right to terminate any sub-grant should the sub-grantee incur an unacceptable audit.

5.4 Grants, Cooperative Agreements, Memorandum of Understanding, and Other Similar Documents

For contracts, sub-grants, and MOUs, the term “Implementation Date” refers to the date that the contract, sub-grant, and MOU begins.

For grants, the term “Implementation Date” refers to the due date given by the funding entity.

Preparation of Grant Applications

For grant opportunities, program directors or other appropriate staff must prepare a copy of any Request for Proposals (RFP) or Program Announcement (PA) for which an application will be submitted as soon as the RFP or PA is received. These documents and a completed Pre-application Grant Review Form (Form 1001) must be submitted to the Office of Policy Evaluation for Grant Committee review. The Grant Committee will convene either virtually or physically as needed. The committee members will include but are not limited to:

- DH-Office Director of the requesting program
- Office Director of the requesting program
- Policy Evaluation staff assigned to the requesting program
- Chief Financial Officer
- Human Resources Director
- Director of Health Informatics



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Chief Administrative Officer
State Health Officer

This group will review grant applications as they are received and before any substantial work has been expended to assure that alignment with the Strategic Plan is maintained.

1. Director of the Office of Health Informatics will ensure appropriateness of objectives and budget line items related to information technology and telephone systems.
2. Director of Human Resources will ensure the appropriate classification of all positions for which funding is requested in a grant application, including proposed new positions and existing positions.
3. Director of the Office of Health Administration will facilitate the development of the budget for the grant application.
4. Policy Evaluation staff will ensure that the application and required activities complies with agency policies, procedures, goals, and objectives; also will ensure that the application and all related documents are properly completed.

Initiating the Review Process

Thirty days are recommended for the review process, beginning with approval by the Grant Review Committee. To initiate the review process, the program director will prepare the Pre- Application Grant Review and forward it and the program announcement or request for proposal to the Office Director for approval. After approval, the Office Director shall forward these documents to the Office of Policy Evaluation, where appropriate staff will place the item on the agenda for the next Grant Review Committee meeting. Policy Evaluation analysts will monitor and facilitate the approval process, to include ensuring that deadlines can be kept so the program has sufficient time to write and submit the grant. After the Grant Review Committee makes the determination of whether funding should be pursued, the Chief Administrative Officer and State Health Officer shall sign the Pre- Application Grant Review document and return it to the appropriate policy analyst. The designated analyst will set up a grant file in the electronic document routing and storage application and return the signed document to the originator so the process can continue.

Application Review

Designated MSDH staff will review every grant application or cooperative agreement. Grant documents will be uploaded into the pre-established file containing the Pre Application Review document in the electronic routing application and submit for approval.



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Each reviewer must ensure that all necessary corrections noted are made before he/she approves the document. Upon correction (if needed) and approval, the application forwards the documents to the next person indicated in the pre-populated approval queue.

Program Director/Originator – by approving the document ensures that the application:

1. is written in a clear, concise, and organized manner;
2. is free of grammatical, statistical, and financial errors;
3. includes all necessary forms; and
4. meets the requirements of the RFP or PA.

The Program Director will ensure the Grant Review Committee has approved the application.

Office Director or Regional Administrator – by approving the document, ensures that the application is in compliance with overall office policies, goals, and objectives and further ensures that the application:

1. is written in a clear, concise, and organized manner;
2. is free of grammatical, statistical, and financial errors;
3. includes all necessary forms;
4. meets the requirements of the RFP or PA; and
5. follows agency policy regarding grant application development and routing.

Director, Office of Health Informatics or designee – if applicable, by approving the document assures that he is in agreement with the elements of the grant application related to information technology and telephone systems.

Chief Financial Officer or designee – by approving the document ensures the financial accuracy and appropriateness of the proposed budget. Any budget errors or concerns should be addressed and corrected prior to approval by the Chief Financial Officer.

Director of Human Resources or designee - by approving the document, ensures that all positions proposed in the application are necessary and appropriately classified, and that the salary line item of the budget is correct. The review shall include all positions funded by the grant application, both permanent



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and time-limited, and both new and existing positions.

Policy Evaluation – by approving the document, ensures that the application meets the following criteria:

1. compliance and consistency with agency policies, procedures, goals, and objectives;
2. compliance and consistency with applicable federal and/or state laws, rules, and regulations;
3. accuracy and appropriateness of the budget and justification;
4. compliance and consistency with application guidelines from the grantor entity;
5. compliance and consistency with the Mississippi State Health Plan;
6. written in a clear, concise, and organized manner and free of grammatical, mathematical, and statistical errors; and,
7. inclusion of all necessary forms, properly completed.

Director, Office of Health Administration/Chief Administrative Officer – reviews grant application and approves the application documents prior to the State Health Officer.

State Health Officer – approves the documents, cover letters, forms, and application. The document owner is notified by the electronic application by email when all approvers have responded.

Procedures Following Review

The program director will ensure that the funding agency receives the application by the established deadline.

Procedures Following Notification by Funding Agency

The program director shall:

1. Provide copies of Notice of Award Letter or notice that the proposal was not funded to the Office of Health Administration. and to the Office of Policy Evaluation by uploading the notice into the electronic document storage application and completing the date for the assigned action in the system.
2. Notify these same offices prior to any conference calls or other communication involving negotiations or final settlement of the proposal terms.
3. Assure that any revisions that require approval of the funding agency are approved through the MSDH review and approval process.



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4. Provide a copy of any revised budgets or terms of a proposal to Finance and Administration and Policy Evaluation upon final approval by the funding agency.

Revisions

All revisions to the terms of a grant, cooperative agreement, or similar document require the same review process and approval of the State Health Officer or designee.

Progress Reports

All progress reports submitted to the funding agency – quarterly, semi-annual, or annual – require the same review process and approval of the State Health Officer or designee.

Endorsements

The State Health Officer or designee has sole authority for providing endorsements in the name of the agency. When another organization requests an endorsement from the MSDH for a grant proposal, the director of the organization should submit the following to Policy Evaluation:

- ✓ the request,
- ✓ a copy of the proposal, and
- ✓ a draft letter of support.

Policy Evaluation will review the request and forward it to the State Health Officer with any applicable recommendations. Upon approval or disapproval, the State Health Officer will return documents to Policy Evaluation for distribution to the appropriate office director.

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Memorandum of Understanding

A memorandum of understanding (MOU) is a legal document that outlines the terms and details of an agreement between parties, including each parties' requirements and responsibilities. No party to an MOU should receive reimbursement or compensation for services rendered, nor should any party be expected to pay for any services rendered. If financial compensation is involved in an agreement, then an MSDH contract document must be used.

For information or guidance in developing a memorandum of understanding, contact the MSDH Legal Division.

All memoranda of understanding must be routed through the same internal review process as sub- grants found in Section 5.3 of this manual, including completion of Form 115, HiAP-CLAS Internal Policy Assessment.



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6.1 Policies and Procedures

The Mississippi Administrative Procedures Law (hereinafter referred to as “Act”) outlines the state procedures agencies must follow prior to the adoption, amendment or repeal of an agency rule or regulation (as defined in the Act (Section 25-43-1.102 (i))), or the issuance of an order or declaratory opinion under the Act. MSDH has rules and regulations governing the interpretation of the Act and this section are meant to outline internal policy of the MSDH in regards to the Act.

6.2 Adoption of New Rules and Regulations or Amendment to Existing Rules and Regulations

All forms concerning this Act will be maintained in an electronic form by Legal Counsel and will be available through the agency’s intranet.

Notice of Proposed Rule Adoption

1. Once a rule or regulation is drafted, the draft must be reviewed and approved internally in accordance with agency policy by agency personnel. Internal review shall be initiated at the program level and shall include a consideration of the requirement of an economic impact statement (i.e., a determination as to whether or not the new or revised rule/regulation will result in an economic impact of less than or more than \$100,000 on the affected parties).
2. If an advisory council, committee, or review board of non-agency personnel is involved in the review of the draft rule or regulation, the program director shall file with Legal Counsel a list of names and addresses of those participants.
3. The draft language for the rule or regulation and the economic impact statement, if required, shall then be further reviewed and approved by appropriate agency personnel, the agency’s legal staff, the appropriate committee of the Board (if applicable), and finally by the State Health Officer or his/her designee.
4. After proper approval is obtained, the program director shall complete a Notice of Proposed Rule Adoption electronic form (SOS FORM APA 001) and forward the completed form and the rule or regulation to Legal Counsel. Completion of this form requires the program director to schedule an oral proceeding for public comment, and to make a final determination as to whether or not an economic impact statement is required for the proposed rule or regulation. If it is determined that an economic impact statement is required for the rule or regulation, the program director will be responsible for preparing the economic impact statement and the form Concise Summary of Economic Impact Statement (SOS FORM APA 004).
5. The Notice of Proposed Rule Adoption form will be forwarded to Legal Counsel for filing with the Secretary of State, along with a hard copy of the revised regulations and an electronic copy in WORD and PDF format. Legal Counsel is responsible for maintaining the agency’s Interested Parties List and for sending notices to such persons. The program director shall be responsible for mailing the notice to any person on his or



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her subject-specific Interested Parties List.

6. Prior to any rule or regulation being presented to the Board for final adoption, an oral proceeding must be held on the rule or regulation. This oral proceeding shall be conducted by the office director or his or her designee. This oral proceeding shall be open to the public and if any record, memorandum, or other recording is made of the oral proceeding, the official copy shall be filed with Legal Counsel. The program director shall be responsible for obtaining space necessary to hold the oral proceeding and for contacting Communications to place the hearing date on the Agency's calendar.

Final Adoption

1. If there are no substantial changes to the proposed rule following the oral hearing, the program director shall request that the proposed rule be placed on the agenda for final adoption at the next Board of Health meeting. (If substantial changes are made to the proposed rule as a result of comments received during the oral proceeding, the program director must re-submit the Notice of Proposed Rule Adoption to Legal Counsel to be filed with the Secretary of State's Office and re-schedule another oral proceeding.)
2. At the next Board meeting, the program director shall present a summary of any written or oral submissions received regarding the proposed rule or regulation to the Board, along with the economic impact statement, if required. If the Board votes to adopt the proposed rule, a Notice of Rule Adoption – Final Rule electronic form (SOS FORM APA 002) shall be prepared and filed with Legal Counsel. Legal Counsel will file the Final Adoption form with the Secretary of State. If the Board does not vote to adopt the proposed rule, a Notice of Withdrawal of Proposed Rule (SOS FORM APA 005) shall be prepared and filed with Legal Counsel.

6.3 Review

At least every five years, the program director is responsible for reviewing all rules and regulations to determine whether any rule should be repealed, amended or a new rule adopted. The program director must appear at a Board meeting at least every five years to confirm compliance with this review requirement, and documentation of this appearance must be included in the minutes of the Board.

Issuance of Official Orders

1. A copy of any official order of MSDH as defined by Miss. Code Section 25-43- 1.102(f) shall be forwarded to Legal Counsel.
2. Legal Counsel shall be responsible for maintaining all official orders and shall maintain an index of orders by name and subject.
3. Any request for a copy of an official order of MSDH shall be forwarded to Legal Counsel.
4. Any order that contains protected health information or other confidential information that is



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protected from disclosure pursuant to state or federal laws or regulations shall be forwarded to Legal Counsel with such information redacted.

6.4 Issuance of Declaratory Opinions

1. All requests for declaratory opinions shall be immediately coordinated with the agency's legal department and the office director in accordance with MSDH rules and regulations regarding issuance of declaratory opinions. Any issuance of a declaratory opinion or response to a request for a declaratory opinion shall be maintained by the office director and an official copy forwarded to Legal Counsel.
2. Legal Counsel shall be responsible for maintaining all official declaratory opinions and shall maintain an index of them by name and subject.

6.5 Maintenance of Rule-Making Docket and Rule-Making Record

1. Legal Counsel shall be responsible for maintaining the MSDH rule-making docket and rule-making record as required by Mississippi Code Sections 25-43-3.103 and 25-43-3.110, respectively.
2. Any request to review the MSDH rule-making docket or rule-making record shall be forwarded to Legal Counsel.
3. Certification of the rule-making record shall be made solely by authorized personnel in Legal Counsel.

Temporary Rule-Making

1. No temporary rule or regulation may be adopted without approval of the State Health Officer or his/her designee.
2. When a program director, with the approval of the office director, seeks to have the State Health Officer consider the adoption of a temporary rule or regulation, the office director must first consult with Legal Counsel and conclude that the rule or regulation meets the requirements of Mississippi Code Section 25-43-3.108 before requesting the approval of the State Health Officer.
3. Once the State Health Officer approves the adoption of the temporary rule or regulation, the program director must complete a Notice of Rule Adoption – Temporary Rule electronic form (SOS FORM APA 003) and forward it, with a hard copy of the rule and an electronic copy in WORD and PDF format, to Legal Counsel for filing with the Secretary of State.



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Introduction

The Office of Communications is the primary channel for informing the public through mass media communications. This includes all public health messages and public health campaign material distributed to the public, the media, or any material that contains the copyrighted Mississippi State Department of Health (MSDH) logo.

The Agency speaks – through the Office of Communications – with a unified voice and uses the Centers for Disease Control and Prevention (CDC) Best Practices and an integrated and scientific approach to initiating, developing and producing communications materials. It is the clearinghouse for MSDH staff and the mass media on correctness and consistency of information representing the Agency and its messages.

7.1 Office Roles

The Director of the Office of Communications serves as the agency’s Public Information Officer (PIO). The PIO is the first point of contact for the agency regarding media relations. The PIO speaks with the public on behalf of the agency, designates alternate and subsidiary PIOs, assigns roles and responsibilities for the Communications staff, establishes the agency communications policy, and is responsible for ongoing relations with the news media, partners and stakeholders.

The PIO holds primary responsibility for designing effective news and information communications, including news releases, interviews and media materials. The PIO oversees all public health communications produced by or on behalf of the agency, including health promotion and health information campaigns, and ensures that they meet high standards of quality, align with public health needs, and demonstrate quantifiable effectiveness.

The MSDH spokesperson (the State Health Officer or his/her designee) is the chief person responsible for communicating health information to the public.

The MSDH Director of Communications will be the Lead PIO unless otherwise directed. In the absence of the Director of Communications, the Division Director of Emergency Preparedness Communications would serve as Lead PIO.

Other responsibilities of Office of Communications staff members include but are not limited to:

- Media relations/public information: (Division Director of Emergency Preparedness Communications, SPO IV, SPO III, or Senior Business Systems Analyst) responsible for either developing press releases, amending pre-prepared templates, and other communication materials, proofing the materials, and coordinating their approval and release to the proper audience. These staff members also work with the Agency’s program areas to develop public health campaigns.



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- Graphic Arts: (the Graphic Arts team) responsible for creating campaign materials and ensuring the Agency’s graphic arts standards. This is in conjunction with the Director of Communications or the Lead PIO.
- Website and Social media: (the Senior Business Systems Analyst or the Business Systems Analyst II) responsible for keeping the website and social media accounts continually updated with the latest information and messages. The Lead PIO should work in conjunction with this team to ensure consistency of message.
- Additional media monitoring, answering phones or distributing material: Emergency Public Information Officers (E-PIO) will assist with these efforts under the leadership of the Director of Communications, Lead PIO and/or the Division Director of Emergency Preparedness Communications. These are individuals that do not work in the Office of Communications but are asked to help transfer information in an emergency.

7.2 Mass Media Relations

Policy Statement and Purpose

The Office of Communications is the authorized channel for release of official information about MSDH including – but not limited to – its programs, services and related public health issues. The Office is the liaison between the Agency and the media. The Office works with all media including local, state and national commercial press (print, electronic and social media.)

The Agency speaks with a unified voice and the Office of Communications is the clearinghouse for this type of activity. This is to ensure the latest and most accurate up-to-date information is released. All media calls should be directed to the Office of Communications so that they may be properly logged in, researched and assigned to the appropriate spokesperson. Media output and response are monitored daily and tabulated monthly. This is done to ensure our messages are going out to the public, ascertain geographical areas reached, and to assess the saturation level.

With the assistance of program area staff, clear, consistent and effective core messages are created and distributed to the public. The Office strives to develop coordinated and consistent public health messages (brand messages) across program areas with overlapping behaviors, functions and goals. These messages are created based on risk communications principals recognized by the CDC – formulated to be easily understood by the user and appropriately stated for the vehicle of distribution.

The Office of Communications coordinates mass media relations and provides interview training sessions/skills (including message development) to MSDH staff and designated spokesperson(s) prior to media presentations or interviews. Agency spokespeople are selected by the State Health Officer and the Director of Communications with input from senior leadership. These spokespeople are



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selected based on: job classification level; level of topic expertise; communications skill level; and prior media/messaging training.

All mass media activities must include the Office of Communications prior to release of information.

At no time should any media activity – with regard to the Agency and its programs – be generated without prior knowledge and approval of the Office of Communications. This includes – but is not limited to – news conferences, news interviews, public service announcements, photo opportunities, advertisements, public affairs programs, radio or television talk shows, letters to the editor, guest editorials or commentary, posts on social media, blogs, Internet sites, newsgroups, chat rooms, Internet forums, etc.

If media is present when an MSDH employee makes a presentation, the employee should notify the Office of Communications Media/Campaign Representatives.

Whenever possible, the Office strives to release information to appropriate MSDH Office Directors, District Health Officers and District Administrators (and others including government agencies and stakeholders) before releasing information to the media.

Process and Procedures

- If an MSDH staff person, contract worker or other representative of the Agency is directly contacted by a reporter and he/she has not received specific authorization to speak to the media on the stipulated subject matter, the contacted person should not give out any information, no matter how insignificant it may seem, until approval is received to do so.
- Ask the reporter what information he or she wants, which news organization (i.e. newspaper, magazine, radio or television station or web publication, etc.) they represent, what their deadline is and how to contact them by phone and email. Then immediately advise the Office of Communications. Or, you may simply refer the reporter or media entity to the Office of Communications.
- The Communications Director or a Media/Campaign Representative (within the Office) will call the reporter back and proceed appropriately to answer all media inquiries or direct the reporter to the appropriate spokesperson.
- To maintain credibility and positive relationships, information needed from program areas for media requests must be responded to in a timely manner as most reporters are on deadline. The Office of Communications is the only office to solicit the media or otherwise send information to them. The only exception is when template press releases are produced by the Office of Communications with specific direction to distribute to the local media. A complete electronic media database is housed in the Office of Communications and is updated daily as information or contacts change. In the event of power loss, a printed phone directory is also available.
- All press releases (including information and messages) are created in the Office of Communications with the partnership of the appropriate program area or office.



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- The Office of Communications will write the press release or messages (in the proper marketing and media style) and obtain necessary Agency approval. Once this takes place, the Office will distribute the information to the media.
- News releases and messages are also distributed to partner organizations and agencies, including community members such as the Board of Health, for redistribution.

Initiating Media Coverage

- A meeting will be set up to discuss core messages, audience, deadlines, spokesperson and best vehicle of distribution.
- Agency spokespersons will be designated by the State Health Officer, the Director of Communications, and with input from senior leadership based on knowledge, training and ability to communicate message.
- If a representative of the media is present at a public meeting where an MSDH employee is giving a report or responding to questions in his/her capacity as an employee of the MSDH, the employee is to notify the Communications Director or his or her media staff via email or phone call and provide details as soon as possible.
- Any effort made by an MSDH employee to contact the media to generate or respond to media coverage as a representative of the Agency must be cleared first through the Communications Director or his/her media staff. This is the case even if media requests occur outside normal business hours.
- Such communication includes, but is not limited to, news releases, media advisories, news briefings, news interviews, news conferences, public service announcements, photo opportunities, advertisements, public affairs programs,
- Radio or television talk shows, letters to the editor, guest editorials or commentary, requests for editorial support, or posts on blogs, Internet sites, newsgroups, chat rooms, wikis, Internet forums, and social media.

At no time is it appropriate for any MSDH employee to speak to a member of the media in a manner considered to be “off the record” or “not for attribution.”

Media are not allowed to enter county health departments to interview, take pictures or shoot video during working hours. This is for the privacy and protection of MSDH patients and clients.

7.3 Joint Messaging

When health news or information is specialized or urgent, we draw upon partner organizations and community partners to help disseminate messages more widely, or to specific audiences.



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- When messaging is being planned, appropriate partners are identified. These may be community health educators or community members of health promotion coalitions, or statewide agencies/organizations such as the state Department of Education, the Mississippi Emergency Management Agency, or the Mississippi Public Health Association.
- The Office of Communications will design the health content of all messages, and plan suitable wording, additional materials, and methods of delivery with the cooperation of partner PIOs.
- When messages are released jointly, they are done so on an agreed-upon schedule for best effectiveness. Partners should report their messaging outcomes (reach, response, coverage) whenever possible to the Office of Communications so that overall messaging effectiveness can be evaluated.

7.4 Communication of Enforcement Activities to Other Agencies / Organizations

Most enforcement actions performed by the Agency do not require interagency notification. Consequently, notification of other agencies is done on a case-by-case basis dependent on violations and the enforcement action prescribed. Nevertheless, in certain cases the occurrence of a violation only requires notification to another agency even when no enforcement action is necessary.

In certain instances, the required notifications are codified in federal or state law, federal or state regulation, agency policy, or agency agreements. Accordingly, for those incidents, staff should first follow the law, regulation, policy, or agreement and make other relevant agency notifications based on the violation or enforcement action taken. Additionally, other units of our Agency or other agency that may be impacted by the violation or enforcement action should be notified.

Below is a list of agencies and organizations along with the types of violations and enforcement issues that may result in notification by units of the Office of Health Protection. The agencies listed include local, state, and federal entities.



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Environmental Health Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
Public Service Commission	Certification of viability for new community and non-transient, non-community public water supplies
Mississippi Department of Environmental Quality	Well permits for newly constructed public water wells Ground or surface water contamination
Mississippi State Board of Registration	Issues related to Professional Engineers submitting public water or wastewater plans and specifications
Mississippi Emergency Management Agency	Boil water notices
Mississippi Department of Agriculture	Regulatory violations in grocery stores
Mississippi Department of Marine Resources	Regulatory violations involved in selling and serving molluscan shellfish
Mississippi Department of Wildlife, Fisheries, and Parks	Regulatory violations involved in selling paddlefish as roe Foodborne illness outbreaks and investigations involving freshwater fish
U.S. Food and Drug Administration	Any foodborne illness outbreak and investigation
Mississippi Department of Corrections Mississippi Attorney General's Office	Sanitation violations impacting state prisoners



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Health Facility Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
Mississippi Board of Nursing Home Administrators	Reports of substandard quality of care survey findings in a licensed nursing home
Mississippi Attorney General’s Office Mississippi Division of Medicaid Fraud Control Unit Mississippi Department of Human Services	Reports of alleged abuse, neglect, exploitation, and/or misappropriation of resident property in a licensed health care facility or provider
Mississippi Division of Medicaid U.S. Centers for Medicare and Medicaid Services	Licensure infractions and/or revocations of a licensed health care facility or provider
U.S. Health Resources and Services Administration (National Practitioner Data Bank)	Adverse actions regarding the certification of Mississippi Certified Nurse Assistant
Local Law Enforcement	Adverse actions regarding the certification of Mississippi Certified Nurse Assistant that involves the theft of resident funds or property



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Child Care Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
Mississippi Department of Human Services Local Law Enforcement	Complaints of suspected child abuse and/or neglect in a licensed or unlicensed child care facility
Mississippi Department of Human Services Mississippi Attorney General’s Office Local Law Enforcement	Complaints of suspected child abuse and/or neglect in a registered or unregistered child residential home

Professional Licensure Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
U.S. Health Resources and Services Administration (National Practitioner Data Bank)	Adverse actions regarding the certification of any health related discipline registered, certified, or licensed by Professional Licensure
National Board for Certification of Occupational Therapy	Disciplinary actions regarding Occupational Therapists or Occupational Therapist Assistants
Board of Certification, Inc.	Disciplinary actions regarding Athletic Trainers
American Speech-Language-Hearing Association	Disciplinary actions regarding Speech Language Pathologist or Audiologists
National Board of Respiratory Care	Disciplinary actions regarding Respiratory Therapists



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Radiological Health Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
U.S. Food and Drug Administration	Level 1, 2, and repeated Level 3 X-ray non-compliance
Conference of Radiation Control Program Directors	Misadministration or reportable event with Linear Accelerator
U.S. Nuclear Regulatory Commission	Radioactive material events or incidents
U.S. Department of Energy	Issues with Salmon Test Site testing results

EMS Enforcement Actions – Potential Interagency Notifications

Agency	Potential Types of Enforcement
U.S. Health Resources and Services Administration (National Practitioner Data Bank)	Adverse actions regarding the certification of Mississippi certified Emergency Medical Technicians
National Registry of Emergency Medical Technicians	Adverse actions regarding the certification of Mississippi certified Emergency Medical Technicians

7.5 Photographic Releases

Policy Statement and Purpose

The Office of Communications regularly uses photographic and electronic images of employees, events, ceremonies, meetings and other activities to advance the mission of our Agency and to communicate with our stakeholders. These images can and do appear on our website, social media and in our employee newsletter *HealthBeat*. They may also appear on our marketing materials such as brochures, flyers and emails.

Process and Procedures

- A Photographic Release must be obtained if the subject is not an MSDH employee.
- The Photographic Release can be found on the Intranet (under “forms” and then “communications”).



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- If the subject is a minor under the age of 18, a Photographic Release must be signed by the minor’s parent/or guardian and secured before any photograph or video can be taken.
- All Photographic Releases should be sent (fax or email) to the Office of Communications.

7.6 Emergency Public Information Officers (E-PIO’s)

These are individuals that do not work in the Office of Communications but are asked to help transfer information in an emergency.

Policy Statement and Purpose

The Emergency Public Information Officer (E-PIO) is an important link in the public health emergency chain. The way these duties are carried out can assist in preventing inaccurate, fear driven, and rumor created information from mass distribution. E-PIOs (two per county) are chosen by the District Administrator or District Health Officer. The list is re-examined annually, and training is provided periodically as needed. These persons do not normally have front line duties during a public health emergency. The E-PIOs will assist the Office of Communications with dissemination of information to the media and work in the field as the “eyes and ears” of the office. Their role is to keep the Office of Communications informed and give out information as it is sent to them from the Office of Communications. The role of the E-PIO is very important but limited.

Process and Procedures

- All E-PIO’s must receive training by the Office of Communications.
- All E-PIOs are activated by the Communications Director or a member of his/her staff.
- The E-PIO will be notified by telephone and travel orders will be issued by the Public Health Command Center.
- Once the E-PIO arrives at the destination, he or she checks in with the Office of Communications to establish avenues of communication.
- After checking in with Incident Commander/Logistics lead and Office of Communications, locate an area where you can work and store communication materials for distribution.
- Confirm that equipment for communication is available and working.

Report the phone and fax numbers to the Office of Communications and test email for transmission.

A laptop should be on site.

If no laptop is available, notify the Office of Communications.

Your job is to distribute the written releases and information received from the Office of Communications.



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- Do not comment or make assumptions or judgments of any kind. Respond to all questions and requests for information by reading or handing out written, approved releases only or refer the media to the Office of Communications.
- When written information arrives, print/copy as needed and have it ready to distribute.
- Deliver written press information by phone and/or by handing out to media. Give a copy to the Incident Commander.
- Distribute fact sheets and other printed material received from the Office of Communications.
- Provide approved, written information as received in a timely manner.
- Make sure to check time on printed media releases so that the most current information is given out.
- Keep information (sent from Office of Communications) in order on a clipboard with the newest information on top.
- Requests for media interviews should be referred to the Office of Communications for coordination and be set up with the on-site spokesperson.

Providing Feedback Information

Listen carefully and record media questions and concerns on *Emergency PIO*

On-Site Reporting Form.

- Check/Work with Incident Commander or designee to update number of individuals reporting to dispensing site if appropriate.
- Keep all information updated. Send On-Site Reporting Form as instructed, and always at the end of the shift.
- Check inventory of any communication materials for distribution on a regular basis.

When supplies are getting low, request additional materials from the Office of Communications.

The role of the E-PIO is to:

Receive information and communications from the Office of Communications. Distribute the approved, written communication to the press and/or public by handing out the release or by reading it out loud.

Provide feedback to the Office of Communications regarding media response, concerns/rumors, communication materials inventory, and dispensing site information on the Emergency PIO On-Site Reporting Form (sent to the E-PIO by the Office of Communications).



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- An E-PIO **does not create:**
 - Press releases
 - Advisories
 - Alerts
 - Fact sheets
 - Any material released to the media or public
- The E-PIO **does not:**
 - Give interviews (but can read press releases or any other approved information).
 - Confirm or deny information not in approved, written form.
 - Address the media in any way except through approved, written material sent by the Office of Communications Director or his or her appointee.

This applies even if you have information from other sources that you are sure is correct.

7.7 Public Health Campaigns/Marketing Communications

Policy Statement and Purpose

With the partnership and often initiation of the Agency's various program areas, the Office of Communications develops and manages campaigns that promote and protect the health of all Mississippians, including traditional printed and visual materials, media opportunities, and social media opportunities, designed to inform and educate the media, stakeholders and the general public. The goal is to ensure cohesive messaging and the highest quality design standards (layout and graphic design).

Materials should contain clear, concise and correct information – aimed at the proper/intended audience – and utilize the appropriate communications messages and graphics that resonate with the targeted audience. If intended, the materials or campaign should prompt the targeted audience to take action or make behavior changes. The most strategic marketing style combined with the most up-to-date layout and graphics standards maintain the integrity of the Agency.

Best practices and evidence-based strategies will be applied whenever possible, including using focus groups if funds are available.

When writing grants and contracts that include marketing and communications work or campaigns, it is necessary to include the Office of Communications in the initial planning stages. This ensures the program area requests proper funding to adequately complete the designated public health campaign or project. Pre-planning – whenever possible – allows the Office of Communications to determine whether an outside advertising agency will be needed and how funding authority will be impacted (Master Contract).



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The Office of Communications utilizes a Master Contract with a local advertising agency to complete various communications projects.

All advertising containing the name of the Agency or the image of the logo – except employee recruitment and program-specific legal advertisements – must be coordinated with and approved by the Office of Communications (more in Logo Section). This ensures the integrity of the Agency, the proper uses of messaging and image, and the professionalism of the final product.

Public Health Campaign Principles

The creation, design and implementation of public health messaging campaigns should be:

Targeted: Campaigns begin with the determination of an appropriate target audience, based on evidence of a prevailing disease or morbidity, the need for establishing preventive behaviors, or the identification of a broad health inequity in a group. This also includes the consideration of at-risk groups and special populations.

Participatory: As much as possible, the design and planning of health messages, materials, means of delivery and supporting processes (such as hotlines, support groups, education centers, or follow-up contact) should be made with the active consultation and participation of representative members of the target audience and community, and with consideration their social and lived environments. Focus groups, surveys, site visits, and community meetings are all examples of such planning tools. Participation is not limited to the planning phase of a campaign but should extend to reviewing and revising the final products, and even implementation, whereby audience members become advocates for a message on our behalf.

Collaborative: In addition to the target audience, stakeholders should be engaged participants in planning and design whenever necessary. Early and ongoing involvement of partner organizations through the implementation phase is essential for a broad knowledge base, diversified message delivery, and extended campaign reach.

Culturally competent: The content, style, appearance and language of message materials must take into account the specific character of the target audience, including cultural and ethnic considerations, language restrictions, literacy, and social setting.

Environmental: Campaigns should address not only the individual, but elements of their environment which contribute to messaging or affect their behavior. Environmental elements may be policies,

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social or civic organizations, schools, the built environment (roadways, transportation, parks, sidewalks, restaurants) or religious institutions.

Horizontal: Messaging and interventions should be made in the widest variety of relevant media and manners so as to afford the greatest access to messages and participation in intervention.

Complementary messaging (digital, print, broadcast), environmental targeting and advocacy/recruitment help accomplish thorough and successful audience reach.

Vertical: Just as important as initial audience reach is ongoing audience contact. Campaigns should be designed to connect audience members with a durable source of continuing and responsive messaging and follow-up. Examples are registering for a clinical visit, subscribing to a topical newsletter, joining a support group, following a Facebook page, or subscribing to periodic text messages appropriate to the stage of pregnancy or childhood (Text2Baby).

Evidence-Based: The communication strategy and materials should be designed based on prior evidence of effectiveness in similar circumstances; or on a sound hypothesis drawn from analogous campaigns; or on recognized theories of behavior change that are applicable to the target audience. Data/statistics should be used in the development of health promotion materials and activities whenever possible.

Process and Procedures

(For all Public Health Campaigns, Ads, Grants and Contracts that include communications and marketing activities)

- A signed Work Request (located on Intranet under “forms” and then “communications”) should be submitted to the Office of Communications outlining the goals, objectives, resources available, and timeline for project implementation.
- The work request must be signed and approved by the Office Director – of the program area – and the Office Director’s supervisor. This is to ensure that everyone responsible for the program area is notified and in agreement of the project.
- Submit the completed and signed work request to the Office of Communications.
- Once the Work Request is received, it will be stamped in and sent to the appropriate Communications Media/Campaign Representative.
- The Office of Communications Media/Campaign Representative will assemble all relevant partners to meet and discuss the project including the core messages, the vehicle(s) of distribution and delivery, as well as the coordination of communications and marketing activities necessary to complete the campaign or project.
- At the campaign meeting the Work Request will be discussed and a plan outlined that includes work to be completed, budget and project deadline. It is at this meeting that all relevant campaign details should be discussed.
- The Office of Communications Media/Campaign Representative and the Communications Director will then sign off on the Work Request and conference notes will be sent to the



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program area for review. All relevant parties, including the Office Director, must respond by reply email that he or she approves all the final details agreed upon at the meeting. This is important because these conference notes are the agreed upon deliverables and details of the campaign.

- Once the conference notes are approved, the new campaign is added to the Communications/Graphic Arts Job Master.
- Each week, all program areas currently working on a campaign will receive weekly updates tracking progress. Office Directors and their Supervisors will receive these updates as well.
- All copy (this is text, language and content provided by the program area that is to be inserted into a communications/marketing piece) must be electronically submitted in a Word document and a hard copy must be printed and submitted with the Office Director and his or her Supervisor's signature.
- This is the time for you to review all copy and content. In other words, the time for you to review copy is prior to submitting it to the Office of Communications.
- Once work begins (including layout, design and graphic work) any changes in already approved text will delay the project.
- The Office of Communications maintains the appropriate records, works with printers and act as the liaison with vendors needing the Agency logo.
- The Office of Communications will supply the specs for printing and obtain quotes; it is the responsibility of the program area/office to submit a Purchase Request and obtain a Purchase Order.
- Artwork won't be sent to vendors for printing or production until the Office of Communications receives the Purchase Order.
- Each Requester will secure the publication catalog or inventory control number for items to be stored in Central Supply.
- As campaign and project pieces are completed by Graphic Arts, the Campaign Manager will review said pieces and alert the program area for its review.
- Minor design adjustments can be made at this time, but any major changes that veer from the initial meeting and agreed-upon conference notes will delay the project.

Production, whether in-house or through external vendors, must be coordinated with the Office of Communications, which will work with the Requester to achieve the highest quality of writing and editing, photography and/or artwork, design, typography, approvals and final production.

If external professional services will be needed for communications and marketing work, the Office of Communications develops and manages the contract for those services including obtaining bids according to state regulations and the contract review process. The Office of Communications will use the Master Contract Vendor first for external work if the project is appropriate and funding authority is available.

In the event that the Master Contract is not used, the Office of Communications prepares the Request For Proposals (RFP) if necessary, as well as the communications deliverables for the contract. The Office of Communications works with the Program/Office Director in reviewing



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proposals and selecting a qualified candidate, company or agency. The Office of Communications is the contact and final approval authority for contractors engaged to provide communications/marketing/public awareness services and materials.

- The Office of Communications will ensure all stipulated work has been completed and all deliverables have been met before payment is made to vendor(s).

7.8 Contract, Grants and Requests for Proposals (RFP)

Policy Statement and Purpose

MSDH employees will consult the Office of Communications regarding all requests for proposals (RFPs), request for grant proposals (RFGPs), and contracts that involve any marketing or communications activity including advertising campaigns to promote public health programs or initiatives. This includes but is not limited to collaterals (e.g. posters, brochures, flyers, newsletters, etc.) scripts for videos and public service announcements, billboards, and conference or event materials.

This applies to situations where the Mississippi State Department of Health logo will be used or if the MSDH is using federal or state funds for the project and accompanying materials.

Process and Procedures

- The program area should fill out a Work Request (found on the Intranet under “forms” and then “communications”).
- Once necessary signatures are obtained, forward the Work Request to the Office of Communications.
- The appropriate Communications Campaign Manager will contact the program area to set up a meeting to discuss and consider the communications aspect of the project and whether it can be accomplished in-house or whether the project should be completed by an outside vendor.
- If an outside vendor is used for a communications project, the Office of Communications will write the RFP and follow State Personnel Board policies, procedures and regulations. If the communications activities are part of a contract, the Office of Communications will write the deliverables and approve the vendor designated for the project (based on résumé, portfolio and prior marketing and communications experience).



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7.9 Vendor Promotion

The MSDH does not participate in any promotion of vendors used by the agency for various services – such as product or service endorsements – in a press release, professional article or any other form of mass and social media.

7.10 Promotional Items

Policy Statement and Purpose

When appropriate, promotional items can be used as another vehicle to reach audiences with a public health message. There should be a direct correlation between the promotional item, the campaign and the target audience.

At this time, MSDH is following the Health and Human Services (HHS)/CDC guidance below for the authorization and purchase of promotional items, with both state and federal funds.

HHS/CDC Guidance for Authorization to Purchase Promotional Items

This policy is effective immediately and applies to all funds authorized or appropriated by Congress.

Promotional items include, but are not limited to: plaques, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags that are sometimes provided to visitors, employees, grantees, or conference attendees. In general, items or tokens to be given to individuals are considered personal gifts for which appropriated funds may not be expended.

It is the policy of the Department of Health and Human Services and CDC/ATSDR that appropriated funds shall not be used to purchase promotional items unless they are a necessary expense to support the agency mission

In making the decision to authorize appropriated funds to purchase giveaways and promotional items, CDC must consider the following questions:

- What is the item, and what evidence is there that the use of this item is an effective way to disseminate this information?
- What is the public health message being disseminated by the purchase and distribution of the item?
- What is the direct connection between purchasing the promotional item and accomplishment of the program mission?
- What is the target audience for the items and in what venues will the item be distributed?
How was the requested number of items determined?



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- What is the estimated unit amount and total cost of the items?

Any request for the use of awarded appropriated funds for promotional items should be submitted to the awardees' CDC project officer. It is anticipated that approval of such requests will be rare. Should permission be granted, attached such confirmation to the Work Request.

In the event the HHS/CDC Policy is no longer in place the authorization and purchase of promotional items will be at the discretion of the Office Director and his or her Supervisor.

Process and Procedures

- A Work Request with the words: "promotional item needing logo or message" is required for promotional items. The Work Request should have the signature of the Office Director and his or her Supervisor.
- The Office of Communications will obtain quotes for the item(s).
- The Office of Communications will set up the artwork in a vector file and forward it to the vendor.
- The Office of Communications will review the product proof before moving the item to production.
- Once the product proof is approved, the items will be produced and directly delivered to the program area.

7.11 Straight Reprints

Policy Statement and Purpose

MSDH-produced materials already in existence and containing the MSDH logo require a Work Request because the original artwork must be submitted to the printer in a specific format and a date must be placed on the latest reprint.

Process and Procedures

- A Work Request should be filled out (found on the Intranet under "forms" and "communications") with only the word "Reprint" written on it, the necessary signatures, with an example of the marketing piece to be printed.

The Office Director and his or her Supervisor must sign and date the hard copy submitted for reprint.

The Office of Communications will obtain quotes for printing.

The program area is responsible for filling out the Purchase Request and obtaining the Purchase Order.

Once the Office of Communications receives the Purchase Order, the files will be sent to the printer.

The program area is responsible for securing space at Central Supply prior to reordering.



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7.12 Non-MSDH Produced Brochures and Other Materials Already in Existence

All materials (such as brochures, flyers, infographics, etc.) used by the Mississippi State Department of Health must be created and produced by the Office of Communications and feature the agency logo. This policy is necessary for branding of the agency and to ensure all materials MSDH staff publicly distribute goes through the approval process, speaks on behalf of our mission, and meets our graphic standards.

Created pieces from the CDC, USDA, EPA and other federal agencies may be considered if they meet MSDH graphic standards and a MSDH logo can be affixed. Just as with all other publicly distributed materials, the material must be approved by the program area, supervisor, department head and the Office of Communications. Materials designed by outside organizations (such as March of Dimes, the Alzheimer’s Association etc.) may be considered on a case-by-case basis applying the same approval, thereby ensuring the materials meet agency graphic standards.

Program areas, supervisors and senior staff members are responsible for following all purchasing requirements and regulations.

Process and Procedures

Brochures and other printed materials already in existence need only the approval of the Office Director and his or her Supervisor if:

- The piece or item is produced by the CDC, HHS or other federal funding partner and does not contain the MSDH logo;
- It is produced by Channing Bete, Journeyworks, Quick Series, or other approved publisher of public health material (decided by the Program Office Director and his or her supervisor), and doesn’t contain the MSDH logo; and
- These pre-produced items should be the most recently produced, updated and accurate brochures available.
- The program area, the Office Director and his or her supervisor are responsible for following all purchasing requirements and regulations.

7.13 Use of Agency Logo

Policy Statement and Purpose

The purpose of the MSDH logo policy is to provide guidelines for use, appearance and graphic standards for the MSDH logo and accompanying identifier.

The MSDH logo is copyrighted and the property of the MSDH. It may not be used or replicated without permission from the Office of Communications. Also, the logo may not be replicated from the website, social media or any other electronic format.

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The logo readily identifies our Agency and the services we provide. A high-quality visual presentation helps support our mission and strategic plan and helps maintain the integrity of the Agency. It is important that the MSDH logo always be used according to these guidelines.

Process and Procedures

The MSDH Logo can be affixed only by the Office of Communications to products in accordance with the guidelines noted in this section.

The MSDH Logo can be used on brochures, technical papers/specifications, presentation materials, training materials, signage, certificates, exhibits, paid advertising, specialty advertising products, apparel, and business stationery (letters, envelopes and business cards) as directed and approved by the Office of Communications.

- The MSDH Logo can also be used to promote MSDH events or on materials with collaborating agencies.
- The logo is made up of two elements: the logo (faces) and the logotype. The logo is registered and copyrighted. These two parts are to be used together at all times unless otherwise specified. The MSDH Logo may be reproduced only in the versions shown in these guidelines and may not be altered in any way.



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The MSDH Logo should have a bounding box or “clear space” (.25 inches) around it to separate it from surrounding elements. Below is a space rule that should be followed in all applications.



The logo has been created as a two-color logo. The colors were chosen using the Pantone Matching System (PMS) The colors should not be altered or substituted in any way.



Blue PMS 295



Gold PMS 124

When color is not available, use the single color version of black on white or the reversed with white on black.

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The smallest size the MSDH logo can be applied is shown below. If your program area desires or needs to use an even smaller application of the logo, please confer with the Office of Communications.



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- Whenever possible the MSDH logo should be used on white or neutral backgrounds except for those applications that require a background color. Heavy patterned, textured or busy backgrounds should be avoided in order for the logo to stand out clearly.
- The MSDH logo may be used in conjunction with other agencies, partnerships or identities with the approval of the program area Office Director and his or her Supervisor and the Communications Director. When used in multiple applications such as co-sponsored external events, the size and strength of the MSDH logo must be equal to other identifiers.
- The Mississippi State Department of Health logo is only released to other partners in very specific circumstances (such as placing the logo on a TV commercial,
- PSA/commercial etc.). In most cases, the partnering agency will send the document to the MSDH Office of Communications and Communications will place the logo on said piece. This



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protects our identity, image and credibility.

- Each program, office or district subunit is authorized to represent its respective entity with distinction and clarity. If requested, the program name will appear under the gold line. It will not contain the words: office, bureau, division etc. This is due to spatial issues with respect to the logo and conformity. The faces and the “Mississippi State Department of Health” will appear with the gold line and then the Office, Program or District would appear below the gold line.

See examples:



- The logo may not be altered in any way.
- Any request for use of the MSDH logo for outside use on a product, document, website and social media must come through the Office of Communications (as stated above).

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7.14 Graphic Standards for Reports

Policy Statement and Purpose

The purpose of the Graphic Standards is to ensure all written and verbal communications reinforce and strengthen the Mississippi State Department of Health's identity and image.

The graphic standards will ensure visual consistency throughout the Agency.

Process and Procedures

- A Work Request should be filled out (can be found on the Intranet under "forms" and then "Communications").
- The Work Request must contain the necessary signatures including the signature of the Office Director and the Office Director's Supervisor on a printed copy of the Report.
- Report Standards include:

Layout: Begin by setting-up pages on letter size (8.5" x 11") paper margin should be 1/2" to 1" around.

Color: Inside pages will be limited to two colors. *Example:* black and one other color, or blue & gold

The cover will be developed in Office of Communications using one color.

Alignment: Align or justify to the left. Do not use right justification. Justification sometimes puts excess space between letters of a word.

Fonts: Use one font consistently, do not mix fonts. Mixing contrasting fonts is like wearing clashing colors.

Contrasting styles can subtract from efforts to communicate by diverting attention instead of capturing and retaining it.

The approved fonts are Times New Roman or Times Roman – both provide strong readability and make good use of space.

Use Arial or Helvetica for a clean sans-serif look. These fonts are the most effective when their use is kept short and simple.

Stay away from hard-to-read slanted or vertical type. Avoid excessive use of reverse type (white on black) background.

Type is measured by points. Make the body copy 10 or 12 points. Make headings over paragraphs from 14 to 18 points.

With titles and headings: Using all capital letters is not recommended. Instead, capitalize the first letter of each word (except prepositions). Readers recognize the shapes of words



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by nuances in the letters. “All caps” blurs those nuances, leaving the reader to decipher text by slowly stringing letters together.

Lists: When making lists, use bullets (not asterisks). Only use numbers when the lists are in order of importance or chronological order.

Dashes: Always use a long dash — instead of a combination of two hyphens.

Comma: Agency style uses the comma within a series, with no comma before the conjunctive (unless there are a group of words).

Numbers: Spell numbers with one numeral. Use numerals with numbers 10 and up.

Hyphens: Do not use hyphens with ragged margin copy or left-justified text.

Abbreviation: Rarely abbreviate. When you abbreviate, have a good reason. You almost always have space to spell words.

Address: Spell out words such as Post Office Box. Spell out MS as Mississippi.

Date: Spell out days and months of the year.

Phone Numbers: When listing phone numbers always include the area code followed by a hyphen. Hyphens flow better than parentheses. *Example:* 601-123-4567.

Titles: Don’t precede names with “Dr.” Instead, give the specific degree after the name. You can reduce clutter by leaving out periods.

Example: John Smith, MD, MPH

Photography: Use people in action. Avoid “grin and grip” poses. Remember that your photos must be correctly screened or reproduced with a dot pattern (high resolution).

Graphs & Maps: Set up graphs and maps using different percentages of screen. Once the report is printed the graphs will be different shades of color. Graphs & maps must be saved in a PDF format.

Proofing: The report should be proofed by at least two people, ensuring all information is accurate and spelled correctly. Your program will be responsible for spelling and accuracy.



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When the report is finished and ready for printing:

- Save as a PDF and store on CD, flash drive, thumb drive, etc.
- Print out the report (with the necessary signatures of the Office Director and the Office Director’s Supervisor) and bring/send a printed and electronic copy to the Office of Communications with the approved Work Request.
- The Office of Communications does not review or proof reports due to lack of program area knowledge and expertise of said material.

Report printing

- The Office of Communications will design the standard blue cover with the logo on the back cover and obtain quotes for printing.
- The program area is responsible for filling out the Purchase Request and tracking it through the Purchase Order process.
- Once the Purchase Order is received in Communications, the file (containing the document) and the Purchase Order will be given to the printer.
- Communications will notify the program area when the printed proof has been delivered.
- Once the copy has been proofed and reviewed by the program area, it is returned to the Office of Communications.
- There will be an additional charge levied by the printer for additional changes made by the program area unless the changes are due to the printer’s error.

7.15 Display Posters, Abstracts and Conference Exhibits

Policy Statement and Purpose

MSDH program areas often wish to display/exhibit information at various conferences throughout the country. These display posters often highlight ongoing studies, results of studies, and MSDH program area accomplishments. The purpose of these display posters is to inform audiences of MSDH work, achievements, studies and/or results.

Process and Procedures

The Office of Communications is tasked with aiding in the layout, design, appropriate graphic presentation, addition of the logo, and printing of the display poster.

Procedure for posters

(Allow 10 working days for completion of project)

Requestor completes communications Work Request (which can be found on the Intranet under “forms” and then “communications), obtains appropriate signatures on the Work Request and the State Health Officer’s signature on a printout of the poster display.

This is all completed prior to sending any documents to the Office of Communications.

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Requestor then sends the Work Request, the document (**which should be in an electronic format**)

Pictures and graphs should be placed in separate files as either JPG or TIFF.

- The Office of Communications does not proof or change copy (wording, content, etc.). The copy must come to Communications completely correct. The Office then ensures proper layout and graphic standards.
- Requestor will look over the layout and have an opportunity to comment. Changes can be made at this time.
- Finished layout will be sent to the program area along with the pink approval sheet to be signed by the Office Director and his or her Supervisor of the requesting program area.
- Printing will be completed after all signatures have been obtained.
- Program area will be billed per product cost.
- Requestor should allow 10 working days for completion of the project.

7.16 Proclamations

Policy Statement and Purpose

Proclamations are often requested by Program areas to recognize and promote social awareness of a particular health topic. At times, these proclamations are accompanied by a press release, or website/social media message, or mention in the employee newsletter *HealthBeat*.

Process and Procedures

- All proclamation requests should begin with a Work Request (found on the Intranet under “forms” and then “communications”) containing all the necessary signatures.
- Requestor should set up a meeting with his/her Communications Campaign Manager.
- The Campaign Manager will review (proof the content) or write it if necessary and then obtain final Office Director and his or her Supervisor’s approval.
The Office of Communications will then forward the finished proclamation to the Governor’s Office.

7.17 Newsletters

Policy Statement and Purpose

The Mississippi State Department of Health has one Agency newsletter. MSDH employees are the target audience for *HealthBeat*. The Agency newsletter is for the purpose of sharing Agency and employee news within the Agency.

Program areas wanting to communicate specifically with their own stakeholders should use a memo format rather than a newsletter. This is because any Agency newsletter would contain the logo and all graphic standards would need to be followed including proofing and review within the Office of Communications which is not staffed for this purpose. A memo does not include graphic arts or pictures. A picture may be sent with the memo as an attachment.

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Process and Procedures

- The Office of Communications serves as the editor and publisher of the newsletter.
- All MSDH employees are invited to submit Agency news and personal stories and photos.
- Employees can email or place a story and pictures in the mail to the Office of Communications or stop by the Office of Communications with your information and pictures.
- The publication is written and reviewed within the Office of Communications.
- Depending on funds, the *HealthBeat* is published monthly or bi-monthly.

7.18 Forms

Policy Statement and Purpose

The Office of Communications (Graphic Arts) works with the Office of Policy Evaluation in creating the Agency’s forms. Graphic Arts will create and or aid in the development and proper layout of a new form or a revised form.

Process and Procedures

- The Requester may submit a Form Request (Form 86) or create a draft file in the electronic document storage application.
- The Office of Policy and Evaluation reviews the request and when approved, forwards the request to the Office of Communications (Graphic Arts).
Graphic Arts will then notify the program area Requestor and begin layout and graphic design. Graphic Arts will send the form to the Requestor for Office Director Approval.
Once Graphic Arts receives Program/Office Director approval, the form is sent to Office of Policy and Evaluation Forms staff for final approval.
When Graphic Arts receives final approval, the program area will be contacted for further instruction such as but not limited to placing the form on the Website, the Intranet, or printing in-house or with an outside printer.
The above policy applies for forms to be placed on the Intranet as well.

7.19 Public Records Requests (Public Records Act)

Policy Statement and Purpose

The 1983 Mississippi Legislature passed the Public Records Act (the Act), §§ 25-61-1 through 25-61-17, Mississippi Code of 1972, Ann. The state statutes define “public records,” mandate public access, require written explanation of denials, declare certain records to be exempt from public access, allow fees to cover costs, and provide a penalty for wrongful denial of access to records.

MSDH practices an open records policy, offering full and responsible access to records not exempt from disclosure. The MSDH administrative process provides streamlined access to records which are clearly open for disclosure; legal scrutiny for records that might be open; and written denial (provided by Legal Counsel) and explanation for records that are not open to the public. The Act requires that records be made available for inspection, copying, or electronic/hard mail delivery within seven

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working days of the request.

Process and Procedures

The Office of Communications manages all public records requests. Any request for access to or copies of a public record can be faxed (601-576-7517) or a letter written and addressed to: Mississippi State Department of Health, Office of Communications, P. O. Box 1700, Jackson, MS 39215-1700.

The request must be placed on a Public Records Request Form that can be accessed on the Intranet (under “forms” and then “communications”). The Request Form can also be accessed on the MSDH website at: www.HealthyMS.com.

Once the Office of Communications receives the Public Records Request, it is logged in and a letter is sent to the Requestor confirming arrival and further action. Communications then forwards the request to the appropriate program area (a streamlined request) or to legal counsel for further action. Once the request is completed, Communications should receive the original form back so that the Public Records Request can be closed out.

If possible, records or documents will be supplied at little or no cost to the individual Requestor; however, the Agency may charge reasonable fees to cover costs (outlined on the form and on the MSDH website). The Agency will notify the Requester of the actual or estimated costs (fees) associated with the request. Agency staff will produce and deliver the requested records *only* after payment of the processing fee; payment should be by certified check or money order, payable to “Mississippi State Department of Health.”

The Office of Communications manages all Public Records Requests that come from the media where a Media Open Records Request Log is maintained. Communications works with the direct program area or Legal Counsel to fulfill the request. The Office of Communications will notify Media of any charge (which is the same charge levied for any other Requestor). The Office of Communications will receive the check and forward

it to the appropriate program area and deliver the material to the Media Requestor. The request is then logged complete with the date.

If legal staff determines that a Public Records Request is exempt or privileged under state or federal statutes, the legal staff will send a letter of denial and explanation to the Requestor. A copy of the letter of denial will also be sent to the Office of Communications.

Such denials will be kept on file for inspection for at least three years. Legal counsel may disapprove a request, for example, because the information was obtained from third parties that have not given their authorization for release, contains trade secrets, or contains confidential commercial or financial information.

An electronic tracking system is utilized to monitor the request and its timely delivery per statute.

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7.20 The MSDH Website

Policy Statement and Purpose

The website serves as an authoritative, up-to-date source of information and services associated with the Agency. Its goal is to be as comprehensive, current and useful as possible for those within and outside of the Agency.

The Department of Health Website Development Team assembles information, organized into a logical structure to assure user-friendliness, and delivers the information in an efficient and easy to navigate format for the public. Information provided is related to public health with the goal of providing the highest-quality educational or informational materials.

All website content is created, managed and published through the Office of Communications (Website Development Team) in consultation with the relevant Program area. The Office of Communications ensures that published material meets standards of copyright laws, clarity and correctness, and is effectively organized and presented for online reading. Site content, functionality and technology including graphic design are under the purview of the Web Development Team. All web postings conform to Office of Communications and Mississippi State Department of Health graphic standards and policies.

It is the responsibility of each Program area to frequently review its website pages to ensure they contain the most accurate and up-to-date information. To ensure regular reviews and to comply with House Bill 480, the Office of Communications will issue a monthly reminder to the Office Directors and their Supervisors, along with a monthly verbal reminder from the Communications Director at weekly Senior Staff meetings.

MSDH program information is submitted by each individual area with the permission and final approval of the Program area's Office Director and the Office Director's Supervisor.

This is an effort to again ensure accuracy and keep the Office Director and Supervisor apprised.

It is the responsibility of the Office Director and his or her Supervisor to ensure any updated or changed material is submitted to the Office of Communications within the timeframe stipulated by House Bill 480.

Process and Procedures

- A Work Request (found on the Intranet under "forms" and then "communications") must be filled out by any Program area wishing to update existing pages or create new pages.
- Once the necessary signatures are obtained (Office Director and Office Director's Supervisor), the Work Request should be sent to the Office of Communications. Also included should be

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the information to be revised or created initialed by the Office Director and his or her Supervisor.

- The Media/Campaign Representative may contact the Requestor to set up a meeting with the Web Development Team if necessary.
- The Website Development Team and the Campaign Manager will work with the Requestor to determine needs and finalize material to be included.
- The Media/Campaign Representative will work with the Website Development Team to track progress.
- The Website Development Team relies on the Requestor for information and materials to be published, but determines the final wording, layout and effective online presentation.
- Links to and articles from outside sources which are not recognized authorities, or which may contain unreliable information, will not be posted on the MSDH Agency website.
- All parties with an interest in the newly published material are notified when it becomes available on the MSDH Website. This includes the Media/Campaign Representative in the Office of Communications, the Director of Communications, the relevant Bureau or Division Director, and the appropriate Office Director and his or her Supervisor.
- Work in progress is regularly made available to the Requestor for preview and feedback. When work is completed, and receives final approvals, it is published to the MSDH Agency Website.
- In designated situations requiring frequent Program area updates such as Boil Water notices and Restaurant Inspections, the updates are left to the designated Program areas and their designated employees.

7.21 Intranet

Policy Statement and Purpose

The Intranet is an Agency-wide resource to support the work-related activities of all Department of Health employees. It is one of the Agency's primary methods for disseminating information and improving productivity for employee audiences. Employees are encouraged to access the Intranet for work-related information.

The Intranet serves as an information distribution and communication system for all employees of the MSDH. Work-related information that is of interest to a large employee audience can be distributed on the Intranet to share Agency-wide news, technical information, reference data, policies, forms, procedures, departmental information and employee activity information.

The Office of Communications determines the content, appearance and organization of the Intranet. All documents, forms or links that are useful to areas of the Agency, or that improve its productivity or management are welcome. All material will be posted in a timely manner and conform to MSDH and Office of Communications standards.

Work-related announcements of general interest may be requested through the Office of Communications via a Work Request form (found on the Intranet under "Forms" and then "Communications"). As the Intranet is primarily a productivity tool, announcements will be displayed so

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that they best deliver their message without interfering with the usual working of the site.

Process and Procedures

- The Intranet is maintained by the Communications Website Development Team.
- A Work Request (found on the Intranet under “Forms” and then “Communications”) should be filled out with the necessary signatures and then forwarded, mailed, or delivered to the Office of Communications.
- Requests for changes to material already in existence on the MSDH Intranet will need a Work Request signed by the Office Director and his or her Supervisor. Same process as above.
- When the request for changes is completed, notification will be made to the Requestor and the Office Director and his or her Supervisor.

7.22 Social Media

Policy Statement and Purpose

Because online postings have the potential for conflicting with the interests of the Mississippi State Department of Health and its many clients, patients and stakeholders, the MSDH has adopted this social media policy. As used in this policy, “*social media*” refers to blogs, chat rooms, online bulletin boards, forums, social networking sites (such as Twitter, Facebook, LinkedIn, YouTube, and MySpace, among others), and agency-created smartphone applications or email. The Mississippi State Department of Health will utilize social networks as appropriate. Social networking sites are used to provide news and education and build relationships with individuals and organizations that may not respond to traditional media or to supplement traditional media efforts.

Social media can often be an effective tool for creating behavior change. Participation in Facebook and other social media tools are intended to be part of a larger integrated health communications program, campaign or project developed with the Program Area and under the leadership of the Office of Communications.

As with traditional media, the agency will use social media to speak with a unified voice, and the Office of Communications is the clearing house for this type of activity.

Social media presents an image of our Agency and brand and should achieve Agency objectives. Each social media network has its own use and the appropriate vehicle should be targeted to the desired audience and the designated cause. The image presented in social media should therefore be just as well thought out as the image presented in any other Agency marketing activity and meet the same standards of accuracy and timeliness.

According to the Centers for Disease Control and Prevention (CDC), effective communication is best achieved by a single permanent social media site conveying a broad range of messages. In rare circumstances, when communication goals require it, social media sites for specialized purposes/events maybe created with the approval and guidance of the Office of Communications.

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MSDH social media sites are monitored regularly and prompt corrective action shall be taken when an issue arises that places or has potential to place the Agency at risk.

The Office of Communications designees will monitor the content on each of the Agency pages to ensure that accurate information and a consistent message is being conveyed and that the site adheres to the MSDH Social Media Policy. The Office of Communications reserves the right to direct staff to modify social media content based on best practices and business norms.

Employee use for official agency interests: The use of social media at work is a privilege that comes with responsibilities. An employee’s use of MSDH social media is for the express purpose of communicating the agency’s broad interests or specific programmatic and policy interests solely as authorized by the Board of Health, the State Health Officer and as directed by authorized supervisory staff.

Employee use for professional interests: Professional use implies that an employee’s use of social media is for the purpose of furthering their specific job responsibilities or professional duties through an externally focused site. Reasonable use in this manner is allowable pursuant to the Mississippi State Department of Health’s official network access and technology use policies.

Employee use for personal interests: Accessing MSDH social media for personal interests has nothing to do with an employee’s job duties for MSDH, and such utilization is not permitted.

Employees are cautioned that any personal use of social media outside the agency setting should not cast the agency or its staff in an unprofessional light. Personal websites on subjects that are governed by the Board of Health/MSDH are not allowed (e.g., licensure and regulation of entities, medical/radiological technology, chemicals, food, water and other materials; public health policy, public health laboratory testing, etc.)

Employees are reminded that smart phone activity – other than incidental use – during scheduled work time is prohibited. Social media use must not interfere with the optimum performance of assigned job duties.

The use of any social media to illegally harass or discriminate against MSDH employees, patients, clients, vendors, partners or guests or to share protected patient or employee information or other confidential agency information shall be deemed a violation of this and possibly other agency policies.

Employees may be subject to discipline up to and including termination for violation of this policy.

The Office of Communications will evaluate all requests for the creation and usage of agency social media accounts and verify expertise of staff being authorized to use agency social media tools.

The Office of Communications will be responsible for maintaining a list of all agency social networking sites in use, the names of all employee administrators of these accounts, as well as the associated user identifications and passwords currently active.



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Employees should follow regulations and policies pursuant to the MSDH’s official network access and technology use policies.

By identifying yourself as an employee of MSDH, you are creating potential perceptions in the eyes of legislative stakeholders, clients, patients, business partners and the general public about your expertise and about the agency. Employees need to be sure that all content associated with MSDH is consistent with your work and with the agency’s mission, values and professional standards.

The agency has an expectation of high ethical standards for its employees. The following *Ethical Social Media Code of Conduct* should be followed by all employees utilizing social media as part of their assigned job duties:

- Patient, client and employee protection and respect are paramount.
- We will use every effort to keep our postings factual and accurate.
- We will comply with copyright laws and cite or reference sources accurately.
- We will provide links to credible sources of information to support our interactions, when possible.
- We will publicly correct any information we have communicated that is later found to be in error.
- We are honest about our relationship, opinions and identity.

Users and visitors to MSDH social media sites shall be notified that the intended purpose of the site is to serve as a mechanism for communication between the Mississippi State Department of Health and members of the public. Social media site articles and comments containing any of the following forms of content shall not be allowed:

- Comments not topically related to the particular social medium article being commented upon
- Comments in support of or opposition to political campaigns, proposed legislation, or ballot measures
- Profane language or content
- Content that promotes, fosters, or perpetuates discrimination on the basis of race, creed, color, age, religion, gender, marital status, status with regard to public assistance, national origin, physical or mental disability or any other class protected by state or federal law
- Inappropriate sexual content or links to inappropriate sexual content;
- Solicitations of commerce
- Conduct or encouragement of illegal activity
- Information that may tend to compromise the safety or security of the public or public systems

The agency encourages employees to use social media within the parameters of the above policy and in a way that does not produce adverse consequences for the agency, employees, patients, clients, business partners or the general public.

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Where no state or agency policy or guideline exists, employees are expected to use their professional judgment and take the most prudent action possible. If you are uncertain about the appropriateness of a social media posting, check with your manager or supervisor beforehand.

All agency policies that regulate off-duty conduct apply to off-duty social media activity including, but not limited to, policies related to illegal harassment, employee conduct, protecting confidential patient and/or proprietary information.

Employees may not use agency equipment or facilities for non-work-related social media activities without permission. Social media activities should not interfere with employees' duties at work. The agency monitors its network facilities to ensure compliance with this restriction.

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7.23 Non MSDH Social Media

You are personally liable for all communications and information you publish online. The MSDH may become liable for your online activity that uses state owned assets, an agency email address or an email address that can be traced back to the agency's domain, which is generally any email address affiliated with the MSDH. Using your name and an agency's email address may imply that you are acting on the Agency's behalf. Because social media and networking activities are public, your MSDH email address and all

MSDH assets should only be used to perform official agency related business, which may include professional networking but does not include personal social networking.

Outside of the workplace, you have the right to participate in social media and networks using your personal email address. However, information and communications that you publish on personal online sites should never be attributed to the MSDH or appear to be endorsed by, or to have been originated from the MSDH.

If you should choose to disclose your affiliation with the MSDH in an online communication, then you must treat all communications associated with the disclosure as professional communications governed by this and other agency policies.

Process and Procedures

- Social media postings are determined on a case-by-case basis by the Office of Communications as are all other elements of a Communications campaign. This can be accomplished with a Work Request if part of a campaign or simply as a suggestion by an Office Director or his/her supervisor.
- Objectives should be clearly defined. Social media posts can highlight content, spark action, and encourage awareness of an issue.
- Information is cleared for accuracy through the proper Agency resources.
- See process for Public Health Campaigns.
- The Office of Communications oversees and maintains all Agency social media sites (again just as with traditional media).
- Social Media posts should be short, simple and easy to read in conformity with accepted social media styles and standards.
- Appropriate pictures, songs, lyrics, video and content of pages will be made at the discretion of the Program Area Office Director, his or her Supervisor, and the Office of Communications.



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8.1 Confidential Information, Personal Identifiable Information and Protected Health Information

Confidential information, personal identifiable information (PII), and protected health information (PHI), whether in print or electronic format, must be stored in a manner inaccessible to unauthorized individuals. PII, confidential information, and PHI must not be downloaded, copied or printed indiscriminately, or left unattended and open to compromise. PII, confidential information, and PHI that is downloaded for educational purposes must be de-identified before use. Prudent judgment is essential when any PHI is being used for disclosure.

NOTE: Unauthorized or improper disclosure, modification, or destruction of Protected Health Information could violate state and federal laws and result in civil and criminal penalties.

8.2 Confidential Information/Personal Identifiable Information

Confidential information represents very important and highly sensitive material that is not classified as PHI. This information is private or otherwise sensitive in nature and must be restricted to those with a legitimate need for access. Confidential information is often referred to as personal identifiable information. Examples of confidential information may include: personal information, key financial information, proprietary information of commercial research sponsors, system access passwords, Social Security numbers, and information file encryption keys.

The unauthorized disclosure of confidential information to individuals without a need for access is against laws and regulations. Decisions regarding the provision of access to this information must always be cleared through the information's owner.

8.3 Protected Health Information

PHI is information, regardless of format, that:

- is created or received by a healthcare provider, health plan, or health clearinghouse;
- relates to past, present, and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
- includes demographic data which permits identification of the individual or could reasonably be used to identify the individual.



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Identifiers:

Names	Ages over 89
Postal Address	Device Identifiers and Serial Number
Telephone Number	Vehicle Identifiers and Serial Number
Fax Number	Biometric Identifiers (Finger/Voice Prints)
Email Address	Full Face Photos and Other Comparable Images
Internet Protocol (IP) Address	Account Numbers and Medical Records Numbers
Social Security Number	Certificate/License Numbers
Web Universal Resource Locators (URLs)	Any Other Unique Identifying Numbers, Codes, or Characteristics

Email

Protected Health Information or Personal Identifiable Information must not be electronically transmitted through emails, as MSDH agency security risks and vulnerabilities for breach of confidential PHI through email use have been identified. PHI data is not allowed via any remote access or method. All PHI data must be de-identified before being considered portable. The transmission or receipt of PHI must be encrypted and meet IT transmission and security policies to be transmitted in any remote method such as email or information exchanged with business associates.

Restricted Email Use

- 1) Limited, as of the date of this policy, to tuberculosis (TB) cases, suspects, or contacts who have an individually established TB electronic record system (ERS).
- 2) Minimal information allowed in an email related to TB is:
 - a. County/Clinic
 - b. PIMS-assigned patient identification number and first three (3) alphabetic characters of patient’s last name (to obtain patient demographics from PIMS and then access TB ERS)
 - c. A general statement in regard to laboratory results or medications
- 3) Email is not intended for use when critical lab values or critical signs and symptoms are present.
- 4) No patient care processes should be included in an email.
- 5) No medical orders may be given by email. Medical orders are to be given only by fax, verbally with timely follow-up signature, or directly written in a chart. Refer to the Public Health Nursing Manual of Practice, Documentation/Recordkeeping Standards.
- 6) An email must not be incorporated into a medical record.



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This procedure allows for the physician, nurse practitioner, or public health nurse, upon receipt of email, to be alerted to access the TB ERS for specific information and follow-up as indicated for laboratory results or other assessments, interventions, or medical and nursing documentation.

Telefacsimile (Fax)

Routine transmission of Protected Health Information or Personal Identifiable Information by telefacsimile is not recommended. If information must be faxed, only the minimum necessary protected health information should be transmitted by fax. A MSDH Confidential Fax Transmission Cover Sheet (Form #667 E) must be used which includes a required confidential statement prohibiting redisclosure. The statement reads as follows:

Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from using the information for any reason other than the stated purpose, from disclosing it to any other party without the specific written consent of the person to whom it pertains, and are required to destroy the information after the stated need has been fulfilled, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

The sender must be knowledgeable of what information is being requested and by whom. The sender should confirm receipt with the requesting party. PHI submitted by fax should be documented in the medical record and, when applicable, include the release of information. Refer to the Public Health Nursing Manual of Practice, Documentation/Recordkeeping Standards, for the policy on clinician orders by fax.

Telephone Contact

Telephone contact by MSDH staff, either making or receiving calls with individuals who previously received or are currently receiving direct services at a county health department and require information considered to be PHI or otherwise confidential, should be limited to an “as needed” basis.

Telephone calls received from individuals who identify themselves as a patient and/or request information that is deemed to be PHI, such as “Is my HIV medication in?” “What were the results of my lab work?” or “I am returning your call” require individual identity confirmation before any information is disclosed.

8.4 Medical Records General Information

Confidentiality



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Health care information is contained in medical records and held in strict confidence. Patient information is to be released only with written permission, except to appropriate MSDH employees involved in treatment, payment, or health care operations. Written permission to provide treatment and release information for payment and health care operations is defined below.

Release of Information

The release of patient information related to treatment, payment, and/or health care operation is covered through the use of the PIMS-generated Household Members Income Certification/Consent for Services or the Financial Status (Form #15). Both the Household Members Income Certification/Consent for Services and Financial Status forms require a signature and date.

Treatment, payment, and health care operations are defined as:

Treatment – Protected Health Information may be disclosed to physicians, nurses, and other health care personnel who provide services or are involved in patient care. Examples include: (1) patient referred to provider outside of MSDH operations, when referral is directly related to treatment and/or continued care process such as care records being provided to respective delivering hospital; (2) patient transferring from one MSDH county health department to another county health department does not require release.

Payment - PHI may be disclosed to obtain payment for services, for example, disclosures to claim and obtain payment from a third party provider such as private insurance, Medicare, Medicaid, CHIP, or other sources.

Health Care Operations - PHI may be used and/or disclosed for health care operations which include internal administration, planning, and various activities that improve the quality and cost effectiveness of care that we deliver. For example, PHI may be used to evaluate the quality and competence of physicians, nurses, and other health care workers. PHI may be disclosed to conduct medical reviews, needs assessments, or to check the quality of services available.

Certain Uses and Disclosures Do Not Require a Consent

- A) When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, a disclosure is provided when a law requires a report for information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence.
- B) Select public health activities such as information regarding communicable diseases.
- C) Health oversight activities.
- D) Immunization information to the patient, parent, legal custodian/guardian, caregiver,



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- other provider (private or public), the patient’s school or day care facility.
- E) To avoid harm or serious threat to the health or safety of a person or the public, PHI may be provided to law enforcement personnel or persons able to prevent or lessen such harm.
 - F) Specific government functions. The agency may disclose PHI on military personnel and veterans in certain circumstances such as national security purposes.
 - G) Workers compensation purposes.
 - H) Appointment reminders and health-related benefits or services.
 - I) Deceased person’s information to coroners, medical examiners, and funeral directors.
 - J) Research purposes approved by MSDH.
 - K) Program officials may verify information provided to the agency. This will include, but is not limited to, Social Security Administration match processing.

Release of Information other than Treatment, Payment, or Operation

Patient information, records, or copies of records to be released for purposes other than those described above require a completed and signed Authorization of Release/Request of Information (Form #99). The authorization must be signed by the patient or someone empowered to sign for the patient. This authorization must specify the exact information to be released, the person or organization to which it is to be given, and the date the release is authorized before it is signed by the patient or representative.

MSDH shall charge reasonable fees for copies of medical records provided to patients or third parties designated by patients (other than the exemptions noted below). Payment is required at the time such copies of medical records are provided to the patient or designated third party. The fee schedule is as follows:

\$10.00 base rate	clerical staff time
\$.25 per page	cost of copies

MSDH staff shall make every effort to minimize the cost to the patient. If the cost of copies is expected to be substantial (greater than \$25.00), MSDH staff should provide an estimate of the cost to the patient prior to initiating the copying process. A detailed cash receipt will be provided to patients. Patients should be reminded that there is no charge for medical records transferred directly to another health care provider pursuant to patient care.

The following records are exempt from the requirement of fees to be charged:

- Maternity records
- WIC records given to a WIC client transferring to another provider



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- Initial lab test results
- Immunization records
- Records transferred to another health care provider pursuant to patient care
- Records transferred to the Department of Education, Human Services, or any other social service agency relative patient care, referral, or consultation
- Records provided to an insurance carrier as needed for reimbursement
- Medicaid beneficiaries may not be charged for the cost of copying medical records

Requests for patient information by subpoena or subpoena duces tecum are to be referred to MSDH legal counsel. Legal counsel should be contacted when there is any question regarding the release of a record.

Exceptions include:

- (1) when the patient has a condition or disease described in the Rules and Regulations Governing Reportable Diseases and Conditions, and information must be communicated to any institution or provider of health care services to whom the patient is referred,
- (2) diseases listed in the Human Immunodeficiency Virus (HIV) Infection Policies and Procedures Manual. Authorization for this release must be given by a nurse or clinician and documented in the patient's record.

Security and Control

Access to medical records is limited to MSDH employees and volunteers who must use records in carrying out their assigned duties. Students in health-related professions, who are participating in clinical experiences with MSDH, may have limited access to those records for which their clinical objectives have been approved. Students and volunteers are held to the same policies regarding confidentiality as MSDH employees. It is the responsibility of the Regional Administrator to ensure that records are kept in a secure area or locked cabinet with access limited to authorized personnel. This includes records that have been pulled for processing.

In order to maintain confidentiality and assure the efficient retrieval of medical records, all records are to be kept in a central location with a system in place to track a record when it is removed. Records should be placed in a central location at the end of each day. Records requiring further use should be placed in an identified area and separate from records that are ready to be filed. Whenever a record must be out of the files or clinic for more than one day, for any reason, the record must be officially signed out to the employee responsible for medical records.

Record Audits

Limited access to specific medical records included in an MSDH audit is permitted to the Division of Medicaid, the Mississippi Board of Nursing, Home Health, Health Facilities Licensure and



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Certification, the PEER Committee, and external fiscal auditors preapproved by MSDH.

8.5 Medical Record Content and Organization

Record Order

The placement of forms in a medical record, in a consistent order, is important to enable all employees to locate information efficiently.

All forms should be secured to the folders with fasteners on the right and left sides in a reverse chronological order (with the most recent clinic visit information on top).

The administrative and financial forms should be placed on the left side of the record. Administrative/Financial forms are the following:

- PIMS-generated Household Members Income Certification/Consent for Services and/or Financial Status (Form #15)
- Authorization of Release/Request of Information (Form #99) –(when applicable)
- HIPAA Acknowledgement (Form #663)

All patient care forms should be placed on the right side of the folder with the Service Delivery Worksheet (Form #714) on top.

- Patient Care forms should be grouped by type, using record dividers.

Record Dividers

Record dividers for use in medical records are available from Central Supply. These dividers separate the patient care forms on the right side of the record into the following categories:

- 1) X-Ray/Lab/Med. Reports
- 2) PAPS/Biopsy
- 3) Treatment-Meds
- 4) Medical Record
- 5) WIC/Development
- 6) Old Record
- 7) Miscellaneous
- 8) Early Intervention
- 9) PHRM/ISS
- 10) Social Work



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Color-Coding

The use of color-coded alphabet letters on medical record folders improves efficiency in retrieving and filing records and also alerts staff to misfiled records. The use of a two-digit year color-coded label is also helpful in clearing inactive patient files. This is updated annually by placing a new label over the old one when re-registering a patient. Each program is color-coded above the patients' name label as follows:

- 1) Hypertension – Blue
- 2) Family Planning – Orange
- 3) Child Health – Red
- 4) Sexually Transmitted Diseases – Green
- 5) Chronic Illness – Yellow
- 6) Maternity – Pink
- 7) Tuberculosis – Gray
- 8) Children's Medical – Purple

Correction of Errors

When an error is made in a record entry, it is not permissible to erase or cover over the error. Corrections should be made by drawing one line through the error and writing the corrected information above or immediately after the error. The error correction must be dated and initialed by someone listed on the Service Delivery Worksheet (Form #714).

8.6 Medical Records Retention Policy

Identifying Inactive Records

Records of patients who have not received services for the preceding six years should be pulled from the active files and filed in the inactive files for another six years, if space is available. The use of labels to indicate the last year of service, as described in the section on Color-Coding, is of great value in completing this task.

Record Retention Schedules

MSDH has established retention schedules according to state statutes for the retention of hospital records. These schedules have been approved by the Mississippi Department of Archives and History, Records Management Division. All medical records must be maintained for the length of time indicated in the schedule. If a record falls within more than one category, the longest retention shall apply. Records are to be retained after the patient's last date of service for at least:

- Six years for patients who have died (seven years for Home Health patients).
- Six years after the age of 18 for minors who have not received services in the past six



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years.

- Seven years after the age of 21 for minors receiving services from the Children’s Medical Program and who have not received services in the past ten years.
- Six years from the last date of service for adult patients of sound mind. For mentally incompetent adults (incapable of making decisions for themselves), follow the retention schedule for child health records.
- Ten years for adult Home Health patients of sound mind at the date of service. For mentally incompetent Home Health adult patients (incapable of making decisions for themselves), retain the file for 28 years from the date of the last treatment.
- Twenty years for patients with a positive syphilis test noted in the record.
- One hundred years or seven years after death for Tuberculosis cases (these are to be shipped to the MSDH Tuberculosis Program for scanning).

Financial Records

Financial records shall be maintained for audit until such time that Internal Audit advises individual counties, through the Regional Administrator, which years of information may be destroyed.

8.7 Long-Term Storage with the MSDH

If storage is available in a Mississippi State Department of Health facility to keep records until destruction date, they should be pulled from the files and boxed by date of destruction. Boxes must meet standard storage specifications:

Boxes must be brown corrugated, single piece construction, 15”D x 12”H x 10”W, 200lb test, 42 lbs Kraft with no deviation, C-flute, glued or taped, with an edge crush test of 32lbs, and a gross weight limit of 65 lbs.

For example, if a patient record can be destroyed after March 4, 2025, the folder should be filed in a box labeled “Destroy March 4, 2025”. A Records Transmittal Worksheet (Form #59) must be completed for each box.



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Storage for Inactive Files

If records need to be stored at an off-site facility, prepare the patient records by placing folders in record boxes in alphabetical order. A Records Transmittal Worksheet (Form #59) must be used to list the patient records that have been forwarded for storage. Refer to the Forms Manual for instructions on completing Form #59. Contact the Office of Field Services if record storage is needed at an off-site storage facility.

Shipping

The shipping of records must be coordinated through the Office of Field Services. In preparing records for storage, the following steps should be taken:

- 1) File records in boxes in alphabetical order.
- 2) Call or e-mail the Office of Field Services for Bar Codes and box labels.
- 3) Complete the bar code sheet. This includes county, range of records (last name, first initial of first record and last name, first initial of last record), and destruction date. This information is needed for retrieval of records.
- 4) Make a copy of the bar code sheet and fax to the Office of Field Services.
- 5) Use a storage carton label that identifies: agency, box number, destruction date, series, (last name, first initial of first record and last name, first initial of last record) Place label and bar code on the short end of the box. In addition, write county name on all four sides of the box. Labels can be located on the M:drive OSHO/Field Service/Record Management and Storage/Box labels
- 6) Call the Office of Field Services for a shipping date and fax copies of the bar code pages.

NOTE: Confirm that the bar code numbers match the bar code sheet that is faxed to the Office of Field Services.

Tuberculosis Records

TB records should be prepared for scanning prior to shipment to the Office of Communicable Disease (OCD). OCD will coordinate with the Office of Field Services and contact each county when OCD is ready for records. Data in the electronic record must be verified and reconciled with records prior to shipment.

Retrieval of Stored Records

Upon written or telephone request from a Regional office or local health department, the Office of Field Services will retrieve the medical record that is needed. Provide the box number and barcode of box the record is in order to ensure retrieval of record. The record (or a copy) will be forwarded to



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the requestor within five business days via the courier service.

To retrieve TB records that have been scanned, contact the Office of Disease Control/Tuberculosis and provide the patient's name, date of birth, and Social Security number.

8.8 Record Disposal

Records which are beyond their respective retention schedule (i.e. FP, WIC only) may be destroyed on site by shredding. When shredding a large quantity of records, you may utilize a contracted shredding company if necessary. All records to be destroyed must first be documented on a Transmittal form #59 with the actual date the records were destroyed. The Transmittal should be kept for proof of destruction. Records waiting destruction must be maintained in the same secure manner in which active records are kept.



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9.1 Recruitment

In the role of recruitment and community relations, HR conducts programs to recruit qualified individuals for public health careers. HR also identifies potential candidates within the MSDH for advancement and others outside MSDH who may be interested in placement into an internship program, as appropriate.

9.2 Employment and Promotion Reviews

HR is responsible for reviewing personnel practices and procedures followed in recruitment, employment questionnaires, and the selection of candidates for employment or promotion, to assure adherence with MSDH and MSPB policies and procedure, and all state and federal statutes and/or regulations.

9.3 Investigations

Investigative procedures will be initiated by HR to determine the validity of employee charges (i.e., grievances, complaints,) relating to disparate treatment, promotional opportunities, performance standards, working conditions, compensation, and other employment-related activities when written complaints are submitted prior to becoming a grievance. HR shall conduct or coordinate investigative questionnaires and document reviews.

9.4 Exit Questionnaires

An exit questionnaire is a survey tool designed to track trends reflecting the reasons that employees voluntarily leave MSDH employment. Additionally, exit questionnaires provide feedback on recruitment efforts and insight to the reasonable needs of the employees consistent with developing the agency's most valuable resource (its employees). Providing an exit questionnaire to the employee upon receipt of his/her resignation letter or voluntary separation from the MSDH allows the employee to express emotions and concerns. The information collected is used to improve MSDH operations, maintain efficiency, identify employee needs and concerns, and retain valued employees. The voluntary completion of the questionnaire and data analysis will ensure that policies and procedures are being adhered to and provide supervisors with information regarding areas of personnel management which need addressing.

The following procedures are established for MSDH employees to follow when problems are identified that impact job satisfaction or performance:

1. All MSDH employees will receive an exit questionnaire form from HR upon receipt of their resignation or voluntary termination.



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2. Each employee is requested to promptly return the completed exit questionnaire form to HR for review. Data will be compiled to identify problems and reflect general trends and issues to be addressed.
3. Periodic reviews and/or audits may be conducted with appropriate management and other employees to verify and address statements and concerns identified through exit questionnaire information and comments.
4. Data gathered from exit questionnaires will be analyzed and an inquiry forwarded to the appropriate unit head for a response. Responses to the exit questionnaire inquiries, when requested, should be reported back to HR with an explanation and recommendation(s) for corrective action(s).
5. Reports will be periodically generated with general trends of the reasons for employee voluntary separations. If significant agency-impacting problems are identified, a plan for corrective action shall be submitted for approval by the State Health Officer. Follow-up on the corrective action and its appropriateness will be done by HR.
6. When trends occur and they appear to be fostered by lack of effective management, there shall be individualized counseling or recommendations made to the supervisory staff. All agency standards, policies, and procedures should apply to all employees.
7. Once a corrective action plan has been approved, full implementation should begin within seven (7) work days. This will provide for continuous improvement in service quality and fulfillment of the agency's mission and will assist in retaining trained employees with improved job satisfaction, reducing training costs related to employee turnover.

9.5 Other Pre-Grievance Issues

Human Resources may intervene to resolve issues/problems prior to them becoming grievances or complaints whenever the issues/problems are within the influence or control of MSDH management. This intervention shall include issues/problems which may be classified as “*non-grievable*” as defined in the Mississippi State Employees Handbook.

HR will coordinate intervention activities, as appropriate, to assist employees and managers in their efforts to resolve their issue(s) when possible. HR may enlist assistance from EAP Counselors or suggest other external professional assistance. Any costs incurred for the services of external professionals will be pre- approved and borne by the affected Offices or Districts.

Any employee may contact Human Resources to discuss work-related issues, regardless of title, function or geographical location without fear of retaliation.



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9.6 Grievance Process

The grievance process is detailed in both the Mississippi State Personnel Board’s Policies and Procedures Manual and the Mississippi State Employee Handbook. The current versions may be accessed at the MSPB public website via the worldwide web. The Employee Handbook includes all of the required forms for filing, responding and appealing a grievance.

Please note that the “grievance process” is not available to all state employees nor is it applicable for all workplace differences. Therefore, it is incumbent on all employees to read the sections of the State Employee Handbook which address Discipline, Corrective Action and Separation of Employment; and Grievance and Appeals.

9.7 Formal Complaint Process

MSDH employees wishing to file an official complaint, outside of the grievance process, should do so in writing and in a timely manner with their supervisor or other manager in their chain of command if the complaint is specifically about the immediate supervisor. A copy of the complaint may be forwarded to Human Resources. Sexual Harassment Complaints may be filed directly with Human Resources.

Most differences in the workplace are best resolved locally through open and frank dialogue between the affected parties. It is critical that such discussions are conducted with civility and mutual respect. Communication breakdowns are the root cause of most workplace misunderstandings. Therefore, efforts to discuss issues often results in acceptable resolutions.

[References: MSDH Administrative Manual Section 8.0; Topic: Discipline and Grievance Policies; and Mississippi State Personnel Board Policy & Procedures Manual; Preventing and Reporting Sexual Harassment Behavior.]

Compliance Procedures outline a number of situations/incidences involving employees and the Mississippi Department of Health (MSDH) which Human Resources is required to act upon. These guidelines indicate steps the employee or other agency personnel must take to abide by MSDH and Mississippi State Personnel Board (MSPB) regulations, as well as state and Federal statutes and regulations. It should be understood that each issue is different from the next and must be treated as such. In turn, the guidelines or examples described herein should not be looked upon as rigid or exhaustive. Instead, they should be regarded as a starting point when addressing questions and issues. For issues not addressed or fully discussed herein, or should an employee need further consultation, Human Resources should be contacted with questions and/or for clarification.



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10.1 Written Reprimands

Upon a supervisor's determination that a state service employee has violated a policy, the supervisor may issue a written reprimand to the affected employee, according to the policies and guidelines contained in the MSPB Policies and Procedure Manual and /or the Mississippi State Employee Handbook. At a minimum, the written statement must, along with the requirements of the Mississippi State Employee Handbook, include the specific group offense the employee is being charged with and a brief description of the events surrounding the policy violation. Disciplinary action should be applied in steps of increasing severity, whenever possible.

The supervisory chain shall be made aware of all written reprimands. A copy of the reprimand shall be forwarded to Human Resources to become a part of the employee's official personnel file. Human Resources will review the reprimand to ensure that it complies with all established guidelines. If the reprimand does not comply with regulations or lacks appropriate documentation, the appropriate unit will be contacted relative to corrective action.

10.2 Requests for Disciplinary Action (Disciplinary Demotions, Suspension and/or Termination)

Requests for disciplinary action (i.e., disciplinary demotion, suspension, and/or termination) must be made to/through Human Resources. Such requests should first be routed through the affected employee's chain of command, with concurrence at each level of management. Both concurrence and non-concurrence should be indicated in writing and forwarded to Human Resources along with the original request. Human Resources will proceed to conduct an investigation into the charges as appropriate, and recommend, with the concurrence of the Human Resources Director, further action to the State Health Officer.

10.3 Employee Grievances

In order to assist in the resolution of internal conflict, an aggrieved employee may contact Human Resources relative to the administrative procedure for filing a grievance and/or to discuss alternative resolutions. In the event that a MSDH employee decides to proceed with his/her grievance, the employee should follow the guidelines as set forth in the Mississippi State Employee Handbook. Upon initiation of the grievance, the employee shall forward the original to his/her immediate supervisor and a copy of said grievance to Human Resources with all supporting documentation.

Additionally, the supervisor or appropriate level of management shall forward a copy of the grievance form and any response attachments to Human Resources upon resolution, waiver of advancement, and/or the rendering of a third-level response.



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10.4 Employee Complaints

A copy of all written employee complaints received by the MSDH must be forwarded to Human Resources. Once received, Human Resources will initiate investigation, where necessary. When an investigation is conducted and completed, the written complaint, with all supporting documentation regarding the complaint, is to be forwarded to Human Resources. This documentation will include a copy of any/all correspondence, a description of the action(s) taken to resolve the complaint, and a copy of any additional correspondence associated with the complaint.

10.5 Equal Employment Opportunity Commission (EEOC) Charges

All EEOC inquiries and/or charges will be handled by Human Resources. Human Resources will notify the appropriate supervisor and coordinate any information gathering or agency responses necessary. Any receipt of an EEOC inquiry or charge outside Human Resources shall be routed immediately to Human Resources for appropriate action.

10.6 Performance Development System (PDS) Scores Less Than 3.0 and Performance Improvement Plans (PIP)

Poor performance without improvement may be grounds for disciplinary action. It is the agency's goal to work with each employee to assist him/her in the event that performance is determined to be in need of improvement. To facilitate this process, a PIP is developed when the employee's PDS score is less than 3.0. (For further explanation of the PDS process, contact Human Resources or refer to the MSPB Policy & Procedures Manual and/or the MSPB website.) To provide additional assistance and/or counseling as requested by either the employee or supervisor, Human Resources will maintain a file on each employee who is placed on a PIP and/or receives a less than PDS rating.

10.7 Risk Control Surveys (RCS)

Risk Control Surveys (RCS) and the request for a RCS response, once issued, require immediate response, with a copy of both the RCS and the RCS response being sent to Finance and Administration. For safety compliance purposes, Finance and Administration will maintain RCSs and the RCS response in order to indicate corrective actions taken.

10.8 Tort Claims Inspection Reports/Responses

Tort Claims Inspection Reports are maintained by Finance and Administration. Once received, Finance and Administration will forward the report to the appropriate unit for response. There is



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usually a 30-day time frame to allow for correction of the hazard(s) noted and for a response to Finance and Administration. A response should be sent regarding status or the correction at the end of the 30-day time frame, even if the correction has not been completed.

10.9 Substance Abuse & Drug Free Workplace Policy

MSDH is a substance/drug-free agency and strict adherence to such policies is required by all MSDH employees, contract workers, independent contractors /subcontractors, grantees/sub-grantees, interns and any other persons otherwise working for or representing MSDH in any capacity. Persons violating the MSDH substance/drug-free workplace policy could pose a danger to themselves as well as to others. Human Resources shall be notified immediately in such situations. Human Resources will coordinate any further action and/or reporting.

10.1 Unemployment Compensation

The Department of Human Resources is responsible for all unemployment compensation matters involving former MSDH employees. Any receipt, outside of Human Resources, of a Mississippi Department of Employment Security inquiry or charge filed by a previous MSDH employee, shall be forwarded immediately to Human Resources for appropriate action. Human Resources will consult with the specific unit regarding additional information as needed.

10.11 Workers' Compensation

The Department of Human Resources is responsible for managing workers' compensation actions on MSDH employees. Any receipt, outside Human Resources of a Mississippi Workers' Compensation Commission inquiry shall be forwarded immediately to Human Resources for appropriate action.

10.12 Employee Assistance Program (EAP)

The purpose of an EAP is to assist employees and their families who may be experiencing personal or professional difficulties in their lives. To appropriately address such difficulties, assistance may be provided in the form of psychological counseling and/or treatment, or substance abuse counseling and/or treatment, among others. Confidential referrals can be made through Human Resources, Employee Services/Benefits Branch.



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Introduction

The role of information technology (IT) has transformed in its application in the public health sector, and with it the need for strong security measures to protect IT resources. The Mississippi State Department of Health (MSDH) is committed to safeguarding its IT assets and any data stored or passed through those assets through physical, administrative, and technical means. Sound security policies and procedures and a well-trained workforce can enable the agency to most effectively utilize its IT resources to meet the public health needs of the state and maintain day-to-day administrative operations.

Purpose

The policies and procedures that follow provide direction to the MSDH workforce members, associates and affiliated entities in the proper and safe use of MSDH’s electronic information resources, as well as how to maintain the confidentiality, integrity and operational availability of data utilizing those resources. They also guide the agency’s efforts to ensure compliance with applicable federal and state laws and regulations and industry standards.

Scope

It is the responsibility of all members of the MSDH workforce to know and adhere to the following policies and procedures as applicable to their duties for the agency. Members of the MSDH workforce includes: full-time and part-time employees, trainees, interns, volunteers, contractors, and temporary workers. Note that some duties or rights assigned to an MSDH workforce member with a specific title may at times be fulfilled by subordinates of that workforce member, depending upon the specific duty or right and in accordance with federal and state laws and regulations. Responsibility for completion of those assigned duties, and proper utilization of those assigned rights, ultimately rests with the named workforce member. Any duties or rights assigned to “MSDH” are the responsibility of the workforce member(s) deemed appropriate by agency senior leadership, with input from the ITSO and OHIT Director.

Retention and Application to Other Policies

The following policies and procedures must be reviewed on at least an annual basis. Any other MSDH policies and/or procedures that conflict with the following are considered null and void. This includes, but is not necessarily limited to, policies and procedures found in the *MSDH General Agency Manual* and *MSDH Administrative Manual*. If any of the following policies and procedures conflict with current or future federal and/or state laws and regulations, the agency must defer to the applicable federal and/or state laws and regulations.

Compliance

Violations of any of the following policies or procedures may result in severe disciplinary action up to, and including, termination of employment and possible referral for civil and/or criminal prosecution.

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Questions

Questions concerning the following policies and procedures should be directed to the MSDH IT Security Officer or the Chief of the Office of Health Data, Operations and Research.

IT Security Officer

570 East Woodrow Wilson Drive, O-429B
Jackson, Mississippi 39215
P: 601-576-7821
IT.Security@msdh.ms.gov

Chief Officer

Health Data, Operations and Research
570 East Woodrow Wilson Drive, O-429
Jackson, Mississippi 39215
P: 601-576-7954

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Acronyms

BAA	Business Associate Agreement
CHAP	Challenge-Handshake Authentication Protocol
CHDOR	Chief of Health Data, Operations and Research
DLCI	Data Link Connection Identifier
DRT	Disaster Recovery Team
DSL	Digital Subscriber Line
DUA	Data Use Agreement
HR	Office of Human Resources
IRT	Incident Response Team
ISDN	Integrated Services Digital Network
ISMC	Information Security Management Council
ITSO	IT Security Officer
MSDH	Mississippi State Dept. of Health
NIST	National Institute of Standards and Technology
OHIT	Office of Health Information Technology
PO	Privacy Officer
SSH	Secure Shell
VPN	Virtual Private Network

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11.1 GENERAL

11.1.1 Policies and Procedures Standard

Purpose:

The purpose is to implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of impacted regulations.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will ensure the development of all policies and procedures required by the regulations.

Procedure(s):

- A. MSDH will ensure the development of all policies and procedures required by the regulations.
- B. MSDH will ensure that all members of the workforce, including managers, are trained on MSDH security policies.
- C. MSDH will ensure that the policies and procedures are updated on a regular basis.
- D. Exceptions to any MSDH IT security policies and procedures must be approved by both the ITSO and OHIT Director.

Responsibilities:

The Director of Data Governance, with the assistance of the PO, ITSO and OHIT Director, will be responsible for ensuring the development of MSDH's policies.

11.1.2 Documentation Standard

Purpose:

The purpose is to maintain the policies and procedures implemented to comply with the impacted regulation in written (or electronic) form and if an action, activity or assessment is required to maintain a written (which may be electronic) record of that action, activity or assessment.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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Policy:

MSDH will retain the documentation required by the regulation for six (6) years or longer, from the date of its creation or the date when it was last in effect, whichever is later.

Procedure(s):

Time Limit

MSDH will retain the documentation required by the regulation for six (6) years or longer from the date of its creation or the date when it was last in effect, whichever is later.

Availability

MSDH will make documentation available to those persons responsible for implementing the procedures to which the documentation pertains.

Updates

MSDH will review the documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the confidential information. Additionally, MSDH must review and update its documentation whenever there is a change in the HIPAA Security Rule or related state, federal, or local regulations.

Responsibilities:

The ITSO will be responsible for ensuring the implementation of the requirements of this policy.

11.1.3 Information Security Strategy

Purpose:

The purpose is to provide reasonable and appropriate safeguards to ensure the confidentiality, integrity, and availability (CIA) of information assets by protecting those assets from unauthorized access, modification, destruction, or disclosure.

MSDH will maintain an Information Security Program that complies with core business objectives as well as applicable state and federal regulations. This program as described by MSDH's security policies and supporting plans and procedures, will clearly state the objectives, responsibilities, and enforcement requirements of MSDH.

The purpose of the MSDH Information Security Program is to:

- Establish policies, procedures, plans, and standard tools to secure information in compliance with state, federal and industry security requirements.
- Support MSDH and MSDH's mission to provide continuity of service to customers.
- Maintain unbroken trust with customers and stakeholders through practice of good stewardship of information assets.

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Scope:

This policy applies to all types of confidential information, including all confidential information, created by, received, or held by MSDH. This information will be protected in any form including, but not limited to, paper, electronic, or oral.

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will implement safeguards determined to be reasonable and appropriate to protect its information assets to maintain the confidentiality, integrity, and availability (CIA) of those assets.

Security policies, plans, and procedures created in support of this Information Security Policy are organized into categories and address at a minimum:

- **Administrative safeguards**
 - Security management process
 - Risk analysis
 - Risk management
 - Sanction policy
 - Information system activity review
 - Assigned security responsibility
 - Workforce security
 - Authorization and/or supervision
 - Workforce clearance procedure
 - Termination/modification procedures
 - Information access management
 - Access authorization
 - Access establishment and modification
 - Security awareness and training
 - Security reminders
 - Protection from malicious software
 - Log-in monitoring
 - Password management
 - Security incident procedures
 - Response and reporting
 - Contingency plan
 - Data backup plan
 - Disaster recovery plan
 - Emergency mode operation plan
 - Testing and revision procedures
 - Applications and data criticality analysis
 - Evaluation

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- Business associate agreement and other arrangements
- Written contract or other arrangement

- **Physical safeguards**
 - Facility access controls
 - Contingency operations
 - Facility security plan
 - Access control and validation procedures
 - Maintenance records
 - Workstation use
 - Workstation security
 - Disposal
 - Media re-use
 - Accountability
 - Data backup and storage

- **Technical safeguards**
 - Access control
 - Unique user identification
 - Emergency access procedure
 - Automatic logoff
 - Encryption and decryption
 - Audit controls
 - Integrity
 - Mechanism to authenticate confidential information
 - Person or entity authentication
 - Transmission security
 - Integrity controls
 - Encryption

- **Organizational Framework**
 - Policies and Procedures requirement
 - Documentation requirement

- **Data Breach**
 - Data Breach Discovery and Response
 - Data Breach Notification to HHS
 - Data Breach Notification to Individuals
 - Data Breach Notification to Media

- **Other Policies**
 - Information classification
 - Network security

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- Email security
- Wireless security
- Remote access
- VPN
- Portable devices
- Bring your own device
- Wireless security
- Wireless IP phone
- Social media
- Cell phone and smartphone
- Firewall
- Baseline configuration
- Acceptable use

In addition, all security policies, and procedures must be reviewed and evaluated (based on any environmental and operational changes) on an annual basis by the ITSO and the Information Security Management Council (ISMC).

Procedure(s):

Procedures developed in support of the Information Security Policy must address (but are not limited to):

- a. Information system activity review
- b. Workforce clearance
- c. Termination
- d. Security incident handling
- e. Access authorization, establishment, and modification
- f. Contingency operations procedures
- g. Physical access control and validation procedures
- h. Updating maintenance records
- i. Workstation use
- j. Media disposal and re-use
- k. Accountability
- l. Data backup and storage procedures
- m. Emergency access
- n. Automatic logoff

Responsibilities:

All individuals, groups, and organizations identified in the scope of this policy are responsible for compliance with all security policies.

The MSDH ITSO is responsible for:

- The development, implementation, and maintenance of MSDH security policies
- Working with workforce members to develop procedures and plans in support of security policies

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11.1.4 Security Management Process Policy

Purpose:

The purpose is to implement policies and procedures to prevent, detect, contain, and correct security violations.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will create, administer and oversee policies to ensure the prevention, detection, containment and correction of security violations.

Procedure(s):

Security management process refers to the creation, administration, and oversight of policies to address the full range of security issues and to ensure the prevention, detection, containment and correction of security violations.

MSDH will create, administer and oversee policies to ensure the prevention, detection, containment and correction of security violations. MSDH will develop security policies to identify core activities in the areas of risk analysis, risk management, sanctions and information system activity review.

Responsibilities:

The ITSO and OHIT Director, with oversight from the Information Security Management Council (ISMC), are responsible for the establishment of accountability, management controls (policies and education), electronic controls, physical security, and penalties for the abuse and misuse of agency assets including confidential information.

The ITSO and OHIT Director are responsible for leading compliance activities in the areas of:

- Risk analysis
- Risk management
- Sanction policy
- Information system activity review
-

11.1.5 Assigned Security Responsibility Policy

Purpose:

The purpose of this policy is to identify the security official who is responsible for the development and implementation of the policies and procedures required by the HIPAA Security Rule at 45 C.F.R. §164.308(a)(2).

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will assign final responsibility of security to one individual who will be referred to as the “IT Security Officer” (ITSO).

Procedure(s):

- A. MSDH shall appoint an “IT Security Officer” (ITSO) who assumes final responsibility of information security.
- B. The ITSO shall report directly to the Chief of Health Data, Operations and Research (CHDOR). In absence of the CHDOR, the ITSO will report directly to the State Health Officer and/or the Senior Deputy.
- C. This individual’s ultimate goal is to protect the confidentiality, integrity, and availability (CIA) of critical information assets at MSDH and to ensure compliance with applicable regulations, such as the HIPAA Security Rule.
- D. Responsibilities of the ITSO include (but are not limited to):
 - a. Ensuring all policies, procedures, and plans required by regulations are developed, implemented, and maintained as necessary.
 - b. Monitoring changes in legislation that may affect MSDH and its security position.
 - c. Monitoring changes and advances in technology that may affect MSDH and its security position.
 - d. Performing technical and non-technical evaluations or audits on security processes in order to find and correct weaknesses and guard against potential threats to security.
 - e. Acting as an internal consultant and potentially as an external spokesperson for MSDH in all issues related to security.
 - f. Ensuring a system for reporting and responding to security incidents (as well as violations of regulations) is in place and functioning.
 - g. Delivering, on an ongoing basis, security awareness training to all members of the workforce.
- E. If the ITSO is not able to meet the requirements of this policy, or is no longer affiliated with the organization, MSDH will assign these responsibilities to a new ITSO. The appointment must not be left unfilled and will be documented.

Responsibilities:

All individuals, groups, and organizations identified in the scope of this policy are responsible for supporting and aiding the ITSO whenever necessary when the ITSO is acting in the role described under the policy section.

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The MSDH ITSO, as defined by the Assigned Security Responsibility Policy, is tasked with all aforementioned responsibilities assigned to his/her position.

All management members are responsible for duly appointing a capable ITSO and replacing that person if they are not able to fill their responsibilities or are no longer affiliated with the organization.

11.1.6 Information Security Management Council

Purpose:

The purpose of this policy is to establish the Information Security Management Council (ISMC) which is responsible for the oversight and management of IT security policies, procedures and activities at MSDH.

The formation of the ISMC satisfies various information technology security federal and industry standards and regulations found in:

- National Institute of Standards and Technology (NIST) SP 800-53 (Rev. 4)
- NIST Special Publication 800-61 (Rev. 2)
- HIPAA Security Rule – 45 CFR §164.308(a)
- HHS Office of Civil Rights (OCR) Audit Protocol (Updated July 2018)
- ISO/IEC 27001

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will assign oversight of IT security matters to a council called the “Information Security Management Council”.

Procedure(s):

- A. MSDH shall establish an “Information Security Management Council” (ISMC) tasked with oversight of all IT security matters at the agency.
- B. The ISMC will be comprised of the following individuals: Senior Deputy, Chief of Health Data, Operations and Research, Privacy Officer, IT Security Officer, Data Governance Director, Office of Health Information Technology (OHIT) Director, Legal Director, Communications Director, and Policy Director.
- C. The ISMC will meet monthly and report to the State Health Officer.
- D. The ISMC will also serve as the agency’s Incident Response Team (IRT).

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- E. Tasks and responsibilities of the ISMC include:
- a. Identifying mission critical and daily operations security standards to ensure the delivery of agency business requirements
 - b. Establishing official current and target information technology security profiles for the agency
 - c. Monitoring agency adherence to industry, state and federal information security standards
 - d. Ensuring completion of an annual security risk assessment
 - e. Identifying and addressing gaps and weaknesses in information technology security capabilities at the agency
 - f. Regularly reviewing and updating information security policies, procedures, and control techniques, as needed
 - g. As the Incident Response Team, implementation and management of the agency's response to security incidents and breaches

Responsibilities:

All individuals, groups, and organizations identified in the scope of this policy are responsible for supporting and aiding the ISMC whenever necessary when the ISMC is acting in its the role.

The MSDH ISMC, as defined by this policy, is tasked with all aforementioned responsibilities assigned to it.

11.1.7 Evaluation Policy

Purpose:

The purpose is to perform a technical and non-technical evaluation that establishes the extent to which MSDH's security policies and procedures meet the requirements of impacted regulations.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will evaluate the technical and non-technical implementations of its IT Security Policies and Procedures.

This evaluation must be completed on a regular basis, at least annually, and in response to environmental or operational changes affecting the security of confidential information.

The evaluation will determine the effectiveness of, and adherence to, MSDH policies as well as to ensure compliance with U.S. State and Federal regulations.

Procedure(s):

- A. The ITSO and OHIT Director will follow all other procedures in place for auditing suspicious activity, integrity, and access, physical security management, malicious software detection, security incident reporting and so forth.

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- B. MSDH must evaluate the technical and non-technical implementations of its Security Policies and procedures at least annually, as well as when any of the following events occur:
- a. There is a change to any state or federal regulation that may affect the Security Policies;
 - b. There is a new state or federal regulation that may affect the Security Policies;
 - c. There has been a signification breach of security or other security incident within MSDH, and/or
 - d. Any other time the ITSO feels there is a need to evaluate the Security Policies at MSDH.
- C. Should a policy or procedure be found to be ineffective, missing, or otherwise flawed, MSDH will take these actions:
- a. The ITSO and OHIT Director will review the risk analysis and determine the vulnerabilities to MSDH. They will evaluate current measures and new measures to reduce vulnerabilities and threats associated with safeguarding e-PHI and maintaining its availability.
 - b. The ITSO will meet with the CHDOR and OHIT Director to determine the best course of action to periodically evaluate technical measures and safeguards.
 - c. Amend (or add) the policy or procedure in a timely manner.
 - d. Communicate the new policy or procedure to the affected workforce members and ensure that they understand the changes.

Responsibilities:

The ITSO and OHIT Director, with the assistance of the CHDOR and OHIT Director, will be responsible for ensuring the implementation of the requirements of this policy.

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11.2 ACCEPTABLE USE POLICY & INFORMATION CLASSIFICATION

11.2.1 Acceptable Use Policy

Purpose:

The purpose of this policy is to outline the acceptable use of computer equipment at MSDH. These rules are in place to protect the workforce member and MSDH. Inappropriate use exposes MSDH to risks including virus attacks, compromise of network systems and services, and legal issues.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy applies to all equipment that is owned or leased by MSDH.

Some aspects of this policy affect areas governed by local legislation in certain countries (e.g., employee privacy laws): in such cases the need for local legal compliance has clear precedence over this policy within the bounds of that jurisdiction. In such cases local teams should develop and issue users with a clarification of how the policy applies locally.

Staff members at MSDH who monitor and enforce compliance with this policy are responsible for ensuring that they remain compliant with relevant local legislation at all times

Definitions:

1. **Blogging:** Writing a blog. A blog (short for weblog) is a personal online journal that is frequently updated and intended for general public consumption.
2. **Spam:** Unauthorized and/or unsolicited electronic mass mailings.
3. **Users:** everyone who has access to any of MSDH's IT systems. This includes MSDH workforce members, agencies, consultants, suppliers, customers and business partners.
4. **Systems:** all IT equipment that connects to the corporate network or access corporate applications. This includes, but is not limited to, desktop computers, laptops, smartphones, tablets, printers, data and voice networks, networked devices, software, electronically-stored data, portable data storage devices, third party networking services, telephone handsets, video conferencing systems, and all other similar items commonly understood to be covered by this term.

Policy:

General Use and Ownership

1. While MSDH's network administration desires to provide a reasonable level of privacy, users should be aware that the data they create on the corporate systems remains the property of MSDH. Because

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of the need to protect MSDH's network, management cannot guarantee the confidentiality of information stored on any network device belonging to MSDH.

2. Workforce members are responsible for exercising good judgment regarding the reasonableness of personal use and must adhere to agency policies on personal use. If there is any uncertainty, workforce members should consult their Supervisor or Office Director.
3. For security and network maintenance purposes, authorized individuals within MSDH may monitor equipment, systems and network traffic at any time, in accordance with agency policy.
4. MSDH reserves the right to audit networks and systems on a periodic basis to ensure compliance with this policy.
5. Any information that is particularly confidential or vulnerable must be encrypted and/or securely stored so that unauthorized access is prevented (or at least made extremely difficult). However, this must be done in a way that does not prevent—or risk preventing—legitimate access by all properly-authorized parties.
6. MSDH can monitor the use of its IT systems and the data on it at any time. This may include (except where precluded by local privacy laws) examination of the content stored within the email and data files of any user, and examination of the access history of any users.
7. MSDH reserves the right to regularly audit networks and systems to ensure compliance with this policy

Security and Proprietary Information

1. Users must keep passwords secure and not share accounts. Authorized users are responsible for the security of their passwords and accounts.
2. Users who are supplied with computer equipment by MSDH are responsible for the safety and care of that equipment, and the security of software and data stored it and on other MSDH systems that they can access remotely using it.
3. All PCs, laptops and workstations must be secured with a password-protected screensaver with an automatic activation feature, or by logging-off when the host will be unattended. Because information on portable devices, such as laptops, tablets and smartphones, is especially vulnerable, special care must be exercised with these devices.
4. Whenever possible, confidential information must be stored on a secure network accessible storage in digital format, rather than on a local hard drive or portable device or media. Hard drives or portable devices or media containing confidential information must be properly encrypted by OHIT.
5. Users will be held responsible for the consequences of theft of or disclosure of information on portable systems entrusted to their care if they have not taken reasonable precautions to secure it.
6. Users who have been charged with the management of those systems are responsible for ensuring that they are at all times properly protected against known threats and vulnerabilities as far as is reasonably practicable and compatible with the designated purpose of those systems
7. Users must encrypt information in compliance with MSDH's applicable policies.
8. Postings by workforce members to newsgroups must never come from an MSDH email address or account unless posting is in the course of job duties.
9. All hosts used by the workforce member that are connected to the MSDH Internet/Intranet/Extranet, whether owned by the workforce member or MSDH, shall be continually executing approved virus-scanning software with a current virus database unless overridden by agency policy.

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10. Workforce members must never open email attachments received from unknown senders, which may contain viruses, email bombs, or Trojan horse code.

Unacceptable Use

The following activities are, in general, prohibited. Workforce members may be exempted from these restrictions during the course of their legitimate job responsibilities (e.g., systems administration staff may have a need to disable the network access of a host if that host is disrupting production services).

Under no circumstances is a workforce member of MSDH authorized to engage in any activity that is illegal under local, state, federal or international law while utilizing MSDH-owned resources.

The lists below are by no means exhaustive, but attempt to provide a framework for activities which fall into the category of unacceptable use

System and Network Activities

The following activities are strictly prohibited, with no exceptions:

1. Violations of the rights of any person or entity protected by copyright, trade secret, patent or other intellectual property, or similar laws or regulations, including, but not limited to, the installation or distribution of “pirated” or other software products that are not appropriately licensed for use by MSDH.
2. Unauthorized copying of copyrighted material including, but not limited to, digitization and distribution of photographs from magazines, books or other copyrighted sources, copyrighted music, and the installation of any copyrighted software for which MSDH or the end user does not have an active license is strictly prohibited
3. Exporting software, technical information, encryption software or technology, in violation of international or regional export control laws. The appropriate management must be consulted prior to export of any material that is in question.
4. Introduction of malicious programs into the network or server (e.g., viruses, worms, Trojan horses, e-mail bombs, etc.).
5. Revealing a work-related account password to others or allowing use of that account by others. This includes family and other household members when work is being done at home.
6. Using a MSDH computing asset to actively engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace laws in the user's local jurisdiction.
7. Making fraudulent offers of products, items, or services originating from any MSDH account.
8. Making statements about warranty, expressly or implied, unless it is a part of normal job duties.
9. Effecting security breaches or disruptions of network communication. Security breaches include, but are not limited to, accessing data of which the workforce member is not an intended recipient or logging into a server or account that the workforce member is not expressly authorized to access, unless these duties are within the scope of regular duties. For purposes of this section, “disruption” includes, but is not limited to, network sniffing, pinged floods, packet spoofing, denial of service, and forged routing information for malicious purposes.
10. Port scanning or security scanning unless prior written approval is given by MSDH.

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11. Executing any form of network monitoring which will intercept data not intended for the workforce member's host, unless this activity is a part of the workforce member's normal job/duty.
12. Circumventing user authentication or security of any host, network or account.
13. Interfering with or denying service to any user other than the workforce member's host (for example, denial of service attack).
14. Using any program/script/command, or sending messages of any kind, with the intent to interfere with, or disable, a user's terminal session, via any means, locally or via the Internet/Intranet/Extranet.
15. Providing information about, or lists of, MSDH workforce members to parties outside MSDH.
16. All activities for only personal benefit that have a negative impact on the day-to-day functioning of the agency. These include activities that slow down the computer network (e.g., streaming video, playing networked video games).

Email and Communication Activities

1. Sending unsolicited email messages, including the sending of "junk mail" or other advertising material to individuals who did not specifically request such material (email spam).
2. Any form of harassment via email, telephone or paging, whether through language, frequency, or size of messages.
3. Unauthorized use, or forging, of email header information.
4. Solicitation of email for any other email address, other than that of the poster's account, with the intent to harass or to collect replies.
5. Creating or forwarding "chain letters", "Ponzi" or other "pyramid" schemes of any type.
6. Use of unsolicited email originating from within MSDH's networks or other Internet/Intranet/Extranet service providers on behalf of, or to advertise, any service hosted by MSDH or connected via MSDH's network.
7. Posting the same or similar non-business-related messages to large numbers of Usenet newsgroups (newsgroup spam)

Blogging

1. Unless done as part of job duties, blogging by workforce members, whether using MSDH's property and systems or personal computer systems, is prohibited during work hours. Workforce members must also not use agency-provided systems or devices to blog during non-work hours.
2. MSDH's confidentiality policies also apply to blogging.
3. Workforce members must not engage in any blogging that may harm or tarnish the image, reputation and/or goodwill of MSDH and/or any of its workforce members. Workforce members are also prohibited from making any discriminatory, disparaging, defamatory or harassing comments when blogging or otherwise engaging in any conduct prohibited by MSDH's Non-Discrimination and Anti-Harassment policy.
4. Workforce members must also not attribute personal statements, opinions or beliefs to MSDH when engaged in blogging for non-work purposes. If a workforce member is expressing his or her beliefs and/or opinions in blogs, the workforce member must not, expressly or implicitly, represent themselves as a workforce member or representative of MSDH. Workforce members assume any and all risk associated with blogging.

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5. Apart from following all laws pertaining to the handling and disclosure of copyrighted or export controlled materials, MSDH’s trademarks, logos and any other MSDH intellectual property must also not be used in connection with any blogging activity not done as part of job duties.

Responsibilities:

The ITSO and OHIT Director are responsible for ensuring the acceptable use of computer equipment at the workplaces.

11.2.2 Information Classification Policy

Purpose:

The purpose is to address information classification categories, acceptable access and use of information such as ePHI and other confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will classify information as appropriate and according to its level of sensitivity.

Procedure(s):

All MSDH information will be organized into two main classifications. These classes are “Public” and “Confidential.”

Public information is information that can be shared freely with anyone inside or outside of the organization without the possibility of negative consequences. Public information includes, but is not necessarily limited to:

- General information about MSDH such as the mission statement
- Most marketing information
- Information available through the MSDH public website

Confidential information includes all other information. It is understood that there are varying levels of confidential information, and the lengths workforce members must go to protect the information depends on the sensitivity.

MSDH will rely on the professional judgment of the agency-trained workforce member on a daily basis when using and disclosing confidential information. If a workforce member is unsure of the relative sensitivity of a piece of information, they must contact their Supervisor/Office Director or the IT Security Officer (ITSO).

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Confidential information includes, but is not necessarily limited to:

- Protected health information (PHI)
- Personally identifiable information (PII)
- Financial information
- Operational information
- Most personnel information

If the sensitivity of the information is not readily apparent, the creator of the document may mark the document as “MSDH CONFIDENTIAL” in a prominent location.

Responsibilities:

All workforce members are responsible for understanding and following all security related policies and procedures related to information classification.

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11.3 RISK MANAGEMENT & ANALYSIS

11.3.1 Risk Management Policy

Purpose:

The purpose is to implement security measures sufficient to reduce risks and vulnerabilities to a **reasonable and appropriate level** to comply with impacted regulations.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This includes all facilities and systems that process confidential information.

Policy:

MSDH will implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with impacted regulations.

Risk management is the process of identifying risk, assessing risk, and taking steps to reduce the risk to an acceptable level.

Risk management related activities are essential to help identify critical resources needed to support MSDH and the likely threat to all such resources.

The principal goal of MSDH's risk management policy is to protect the organization, especially its confidential information, and its ability to perform its mission.

The objective of performing risk management is to enable MSDH to accomplish its mission by:

- Better securing systems that store, maintain, process or transmit confidential information
- Enabling management to make well-informed risk management decisions to justify the expenditures that are a part of IT activities and other budgets
- Assisting management in authorizing or evaluating systems based on supporting documentation resulting from the performance of risk management

Procedure(s):

Risk management consists of three phases:

- Phase I: Risk Assessment
- Phase II: Risk Mitigation
- Phase III: Evaluation and Assessment (Residual Risk)

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The activities that MSDH will conduct in each phase are as follows:

Phase I: Risk Assessment

- System characterization
- Threat identification
- Vulnerability identification
- Safeguard analysis
- Likelihood determination
- Impact analysis
- Risk Determination
- Safeguard recommendations
- Results documentation

Phase II: Risk Mitigation

- Prioritize actions
- Evaluate recommended safeguard options
- Conduct cost-benefit analysis
- Select safeguards
- Assign responsibility
- Develop safeguard implementation plan
- Implement selected safeguards

Phase III: Evaluation and Assessment (Residual Risk)

- Evaluate safeguards deployed
- Evaluate security policies

Responsibilities:

The ITSO and OHIT Director have the responsibility to:

- Ensure that an appropriate risk analysis covering, at a minimum, all confidential information is performed at a frequency of at least once a year
- Approve risk mitigation plans, risk prioritization, and the elimination or minimization of risks
- Facilitate timely actions, decisions and remediation activities

The ITSO and OHIT Director must be supported by all system owners, data owners and other managers to identify and prioritize risks to confidential information. Risk management is an essential management function at MSDH.

11.3.2 Risk Analysis Policy

Purpose:

The purpose is to conduct an accurate and thorough assessment of the risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information held by the organization.

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This includes all facilities and systems that process confidential information.

Policy:

MSDH will conduct an accurate and thorough assessment of risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including ePHI. Such risk analysis activities will be conducted at least once per year and must result in a comprehensive Risk Analysis Report that summarizes the risks, vulnerabilities to the confidentiality, integrity and availability of confidential information. This report must also identify recommended safeguards and prioritize all such risks and vulnerabilities.

Background:

Risk is defined as the net negative impact of the exercise of vulnerability, considering both the probability and the impact of occurrence.

All risk analysis activities shall be organized into three phases. These phases are:

- Phase I: Documentation Phase
- Phase II: Risk Assessment Phase
- Phase III: Safeguards Determination Phase

The minimal activities that MSDH will conduct in each phase are as follows:

Phase I: Documentation Phase

- Identify what confidential information is collected
- Identify systems with confidential information
- Document the purpose of these systems
- Document the flow of confidential information

Phase II: Risk Assessment Phase

- Identify vulnerabilities and threats to confidential information
- Describe the risks
- Identify controls
- Describe the level of risk

Phase III: Safeguards Determination Phase

- Recommend safeguards for confidential information
- Determine residual risk to confidential information

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Procedure(s):

- A. The IT Security Officer (ITSO) and OHIT Director shall facilitate a complete Risk Analysis of MSDH every two years.
 - a. The results of all identified risk analysis activities along with the safeguard and other recommendations must be summarized with supporting documentation in a Risk Analysis Report.
- B. The ITSO and OHIT Director shall document or review documentation of the complete Risk Analysis.
- C. The ITSO and OHIT Director will review the risk analysis and update if appropriate once each six months with approval from the Chief of Health Data, Operations and Research (CHDOR).
- D. Based on periodic review of the risk analysis or updates, the ITSO and OHIT Director will modify the procedures to ensure that any new threat or increased probability of a threat is covered by a sufficient security measure. The CHDOR will approve all modified procedures.

Responsibilities:

The ITSO and OHIT Director are responsible for coordinating all activities associated with risk analysis. All involved workforce members who assist with risk analysis activities will be trained in appropriate security compliance requirements and MSDH's security policies with the objective that they understand their responsibilities and duties to reduce the risk of security violations.

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11.4 NETWORK SECURITY

11.4.1 Wireless Security Policy

Purpose:

The purpose is to implement security measures sufficient to reduce risks and vulnerabilities of MSDH's wireless infrastructure to a reasonable and appropriate level.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will operate all wireless networks in a secure manner so as to ensure the confidentiality, integrity, and availability of all confidential information transmitted over wireless networks.

MSDH will ensure that all wireless devices are configured and operated according to the requirements set forth in this policy.

Procedure(s):

MSDH wireless infrastructure must comply with the following guidelines:

A. Design

- a. Configure a firewall between the wireless network and the wired infrastructure.
- b. Ensure that 128-bit or higher encryption is used for all wireless communication.
- c. Fully test and deploy software patches and updates on a regular basis.
- d. Deploy Intrusion Detection Systems (IDS) on the wireless network to report suspected activities.

B. Access Points (AP)

- a. Maintain and update an inventory of all Access Points (AP) and wireless devices.
- b. Locate APs on the interior of buildings instead of near exterior walls and windows as appropriate.
- c. Place APs in secured areas to prevent unauthorized physical access and user manipulation.
- d. The default settings on APs, such as those for SSIDs, must be changed.
- e. APs must be restored to the latest security settings when the reset functions are used.
- f. Ensure that all APs have strong administrative passwords.
- g. Enable user authentication mechanisms for the management interfaces of the AP.
- h. Use SNMPv3 and/or SSL/TLS for Web-based management of APs.
- i. Turn on audit capabilities on AP; review log files on a regular basis.

C. Mobile Systems

- Install anti-virus software on all wireless clients.
- Install personal firewall software on all wireless clients.

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- Disable file sharing between wireless clients.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring that all wireless end systems, such as laptops, tablets, PDAs, smartphones and APs, are deployed based on policy requirements.
- Reviewing log files from APs and other systems on a regular basis.
Sending reminders to all workforce members about wireless network security.

11.4.2 Network Security Policy

Purpose:

The purpose of this policy is to establish standards for secure communication devices and data on equipment that is owned and/or operated by MSDH. By securing MSDH's network and infrastructure, MSDH will minimize unauthorized access to the organization's proprietary information and technology.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will evaluate the need for secure communication on all networks, public and private, that are utilized to transmit MSDH confidential information.

Where secure communications are required, technology and processes will be put in place to ensure the confidentiality and integrity of confidential information.

Procedure(s):

Where secure communications are required, technology and processes will be put in place to ensure the confidentiality and integrity of confidential information.

The standard for network protocols in the MSDH infrastructure is TCP/IP.

MSDH will:

- Use encryption as much as possible to protect data;
- Use firewall(s) to secure critical segments;
- Deploy Intrusion Detection Systems (IDS) and Intrusion Prevention Systems (IPS) on all critical segments;
- Disable all services that are not in use or services that have use of which we are not sure, and
- Use wrappers around all services to log their usage as well as to restrict connectivity.

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Responsibilities:

The ITSO, with the Director of the Office of Health Information Technology (OHIT), will be responsible for ensuring that network protocols are configured securely.

11.4.3 Baseline Configuration Policy

Purpose:

The purpose of establishing baseline configurations is to ensure that systems are securely configured and deployed in a repeatable manner that addresses the confidentiality, integrity, and availability of confidential information that may be stored, processed, or transmitted by such systems. MSDH establishes baseline configurations for systems based on identified best practice and vendor recommendations, including standards created by the National Institute of Standards and Technology (NIST) and the International Organization for Standardization (ISO).

Scope:

This procedure applies to all information systems and devices including, but not limited to, servers, workstations, firewalls, routers, and switches that are deployed in the MSDH production environment.

Policy:

Prior to information systems being deployed in the MSDH production environment, the OHIT Director will ensure they are properly configured according to established baseline configurations. Additionally, any deviation from the baseline configuration will be documented, including the business reason for the deviation.

MSDH must periodically inspect information systems at least annually to ensure that system configurations still meet the baseline configurations and/or any documented deviations. Additionally, MSDH must periodically, but no less frequently than annually, review current baseline configurations to identify and apply updates to address changes in best practice, vendor recommendations, and standards.

Procedure(s):

Servers (Windows and Linux/Unix)

MSDH utilizes the “Security Configuration Benchmarks” published by the Center for Internet Security (CIS) for applicable server operating systems as the baseline configuration. MSDH applies the settings identified by the CIS Benchmark in their entirety, to the extent possible, documenting any deviations.

Workstations (Windows)

MSDH utilizes the “Security Configuration Benchmarks” published by the Center for Internet Security for applicable workstation operating systems as the baseline configuration. MSDH applies the settings identified by the CIS Benchmark in their entirety, to the extent possible, documenting any deviations.

Firewalls (Cisco)

MSDH utilizes the “Cisco Firewall Benchmark” published by the Center for Internet Security as the baseline configuration. MSDH applies the settings identified by the CIS Benchmark, in their entirety, to the extent possible, documenting any deviations.

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Routers & Switches (Cisco)

MSDH utilizes the “Cisco IOS Benchmark” published by the Center for Internet Security as the baseline configuration. MSDH applies the settings identified by the CIS Benchmark in their entirety, to the extent possible, documenting any deviations.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring systems are properly configured prior to deployment
- Periodically reviewing systems to ensure they are securely configured according to this policy

11.4.4 Protection from Malicious Software Policy

Purpose:

The purpose is to implement procedures for guarding against, detecting, and reporting malicious software.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH will deploy malicious software identification, prevention, and removal technology at the perimeter of its network, on all servers (including email servers), and on individual end-user systems.

Procedure(s):

- A. The ITSO will work with the OHIT Director in identifying, isolating, and removing malicious software from MSDH equipment.
- B. The ITSO and OHIT Director will meet with vendors to determine the best way to guard, detect, and report malicious software.
- C. OHIT Staff, at the direction of the OHIT Director and ITSO, will implement and maintain antivirus, spy-ware software on every device capable of running such programs. The automatic live update feature can be enabled on all devices for this software, and the user must not have rights to disable this software.
- D. OHIT Staff will test, install and document all applicable security updates for all network operating systems installed on the MSDH network. These updates will be installed as soon as testing has been completed and they are deemed safe and necessary for servers. The ITSO and OHIT Director will periodically review updates and verify installation.

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- E. The OHIT Director and ITSO will continually update and train users on the importance of these programs. Staff will also be trained not to open email attachments from unknown parties, suspicious email messages or attachments, or email that is not expected.

Additional security training topics include (but are not limited to):

- Potential harm that can be caused by malicious software, and
- Steps to take if a malicious software such as a virus is detected.

- F. MSDH staff are required to report any unusual activity or messages that appear on their workstation by contacting their Supervisor/Office Director and (either through their Supervisor /Office Director or directly), the ITSO and PO by phone or in-person. To memorialize the report, an email must also be sent to the PO, ITSO, and IT.Security@msdh.ms.gov.

NOTE: Any suspicious emails must NEVER be responded to or forwarded.

- G. MSDH staff will review all applicable IT security policies.
- H. Unless part of their duties as an OHIT Staff member, MSDH workforce members are not permitted to install any application without written (email) approval from the ITSO or the OHIT Director.
- I. Only MSDH approved screen savers will be used to protect MSDH systems.
- J. OHIT and the ITSO will setup automated monthly (more often if necessary) virus scan and spy-ware scans on the MSDH network server and workstations. Malicious software detected will be quarantined and removed per vendor specifications. Documentation of the sweeps will be maintained by OHIT Staff and stored in the server file.

MSDH will subscribe to updates to malicious software checking programs.

- K. OHIT will operate a spam filter on all email systems, with virus protection enabled on all incoming and outgoing mail

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Not configuring or introducing any modifications to systems or applications to prevent the execution of malicious software checking programs
- Immediately contacting their Supervisor/Office Director and (either through their Supervisor/Office Director or directly), the ITSO and PO by phone or in-person if there are any indications of a threat or malicious software infection. To memorialize the report, an email must also be sent to the PO, ITSO, and IT.Security@msdh.ms.gov. NOTE: Any suspicious emails must NEVER be responded to or forwarded.
- Participating in all security awareness training programs and applying the knowledge in preventing, detecting, containing and eradicating malicious software

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The ITSO and OHIT Director are responsible for:

- Ensuring that malicious software checking programs are installed both on the perimeter of the network and on individual end-user systems
- Identifying all critical systems and network components that are vulnerable to malicious software
- Implementing malicious software checking capability on all such identified systems.

11.4.5 Firewall Policy

Purpose:

To ensure that MSDH establishes configuration standards, installs and maintains firewall configurations, and restricts connections between untrusted networks and networks/systems containing, or providing access to, confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH installs and maintains a firewall configuration to protect confidential information and establishes firewall configuration standards.

The ITSO and OHIT Director will ensure the firewall is enabled and running the most appropriate Internet Operating System (IOS) and enabled to the highest level of protection. The ITSO and OHIT Director will periodically review the firewall protection and hardware vendors to ensure it is compatible with all network operating systems and is fully protecting the MSDH network.

Periodically the OHIT Director and/or the ITSO will review the firewall security report to determine if there have been attempts to penetrate the information system that are not authorized. All suspicious or successful intrusions will be documented and reported to the ITSO.

All MSDH systems must be protected from unauthorized access from untrusted networks, whether entering the system via the Internet as e-commerce, workforce members' Internet access through desktop browsers, workforce members' email access, dedicated connections such as business-to-business connections, via wireless networks, or via other sources. Often, seemingly insignificant paths to and from untrusted networks can provide unprotected pathways into key systems.

MSDH understands that firewalls are a key protection mechanism for any computer network. As such, proper configuration and deployment is a must.

Procedures:

A. MSDH deploys the Cisco firewall system.

B. MSDH establishes firewall configuration standards that include the following:

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- a. **Demilitarized Zone (DMZ)**. A firewall is required at each Internet connection and between any DMZ and the internal network zone.
 - i. MSDH implements a firewall on every connection coming into and out of the MSDH network. This allows the organization to monitor and control access in and out, and to minimize the chances of malicious individuals obtaining access to the internal network or information from the network traffic.
- b. **Roles and Responsibilities**. MSDH creates a description of groups, roles, and responsibilities for logical management of network components. The ITSO is responsible for the security of all components and no devices are left unmanaged.
- c. **Change Control**. All changes to firewall configurations and rules must go through MSDH's Change Control process. This is to ensure that changes do not negatively impact business processes or functions or introduce new security risks/vulnerabilities. Additionally, this helps to ensure that new rules have a valid business justification.
- d. **Software Updates**. All firewalls must run the most current version of software supported. This helps to ensure that the devices are not susceptible to known vulnerabilities. All software updates that patch security vulnerabilities will be applied within thirty (30) days of release from the vendor.
- e. **Logging**. A minimum level of activity logging will be configured on all firewalls. Logging of connections through the firewall, as appropriate, will be configured to assist in troubleshooting or security investigations. At a minimum, actions logged must include:
 - i. Successful and failed connection/login attempts to management interfaces
 - ii. Elevation of privileges
 - iii. Administrative actions
 - iv. Configuration/rule changes
- f. **Documentation**. MSDH maintains documentation and business justification for use of all services, protocols, and ports allowed. The documentation includes the security features implemented for those protocols considered to be insecure.
 - i. MSDH clearly documents the decisions to open services, protocols, and ports, ensuring that all other services, protocols, and ports are disabled or removed.
 - ii. There may be times when MSDH identifies commonly-attacked or insecure services, protocols, or ports that are necessary for current business needs. MSDH's senior management and the ITSO will clearly understand and document the risk exposed by use of these services, protocols, or ports. If necessary to use these services, protocols, or ports, business justification shall be documented along with any security features that allow these protocols to be used securely.
 - iii. If these insecure services, protocols, or ports are not necessary for current business needs, they are disabled or removed as soon as possible and according to change management processes.

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- g. **Firewall Review Requirements.** Firewall rule sets are reviewed at least every six (6) months.
- i. These reviews provide MSDH an opportunity to clean up any unneeded, outdated, or incorrect rules, and ensure that all rule sets allow only authorized services and ports that match current business requirements.
 - ii. If appropriate, MSDH reviews occur more frequent than every six (6) months, such as monthly, to ensure that the rule sets are current and match the needs of the business without opening security holes and running unnecessary risks.
- h. **Backups.** Periodic backups of firewall configurations and rules will be created and securely stored in a location remote to the device itself. Backups will also be created prior to any rule or configuration change.

C. MSDH builds firewall rule configurations that restrict connections between untrusted networks and internal networks.

Note: An “untrusted network” is any network that is external to the networks belonging to MSDH, and/or which is out of MSDH's ability to control or manage.

- a. In order to restrict these connections, MSDH will:
- i. Restrict inbound and outbound traffic to that which is necessary.
 1. This requirement is intended to prevent malicious individuals from accessing MSDH’s network via unauthorized IP addresses or from using services, protocols, or ports in an unauthorized manner, such as an intruder sending data to an untrusted server.
 2. All firewalls will include a rule that denies all inbound and outbound traffic not specifically needed. This will prevent inadvertent holes that would allow other, unintended and potentially harmful traffic in or out.
 3. Firewall rules will only allow necessary IP protocols through.
 - a. Restricted, whenever possible, to the specific hosts and networks with a need to use them.
 4. Firewall rules will only permit appropriate source and destination IP addresses to be used.
 - a. Traffic with invalid source or destination addresses will always be blocked.
 - b. Traffic with an invalid source address for incoming traffic or destination address for outgoing traffic (an invalid “external” address) will be blocked at the network perimeter.
 - c. Traffic with a private destination address for incoming traffic or source address for outgoing traffic (an “internal” address) will be blocked at the network perimeter.
 - d. Outbound traffic with invalid source addresses will be blocked.
 - e. Incoming traffic with a destination address of the firewall itself will be blocked unless the firewall is offering services for incoming traffic that require direct connections.

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5. To provide additional protection, perimeter firewalls will also block:
 - a. Traffic containing IP source routing information
 - b. Traffic from outside the network containing broadcast addresses that is directed to inside the network
 - c. All incoming traffic to networks and hosts that should not be accessible from external networks

- D. To the extent possible all firewall rules will be able to use IPv6, in addition to IPv4, addresses for filtering decisions.

- E. Should confidential information be accessible over a wireless network, perimeter firewalls will be installed between any wireless networks and the internal network.
 - a. These firewalls will be configured to deny any traffic from the wireless environment to systems containing confidential information or to control any such traffic (if such traffic is necessary for business purposes).
 - b. If firewalls do not restrict access from wireless networks to confidential systems, malicious individuals that gain unauthorized access to the wireless network can easily connect to the systems and potentially compromise MSDH data.

Responsibilities:

Compliance with and review of these policy and procedures are the responsibility of the ITSO and OHIT Director.

11.4.6 VPN Policy

Purpose:

The purpose of this policy is to implement security measures sufficient to reduce the risks and vulnerabilities of MSDH's VPN infrastructure to a reasonable and appropriate level.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will ensure the VPN is appropriately secured at all times and will adhere to the requirements defined in this policy.

Procedure(s):

MSDH VPN infrastructure must comply with the following guidelines:

- A. Members of the workforce with VPN privileges must ensure that unauthorized users are not allowed access to MSDH internal networks.

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- B. VPN use is to be controlled using either a one-time password authentication such as a token device or a strong password solution.
- C. When actively connected to the corporate network, VPNs will force all traffic to and from the PC over the VPN tunnel; all other traffic must be dropped.
- D. Dual (split) tunneling is NOT permitted; only one network connection is allowed.
- E. VPN gateways will be set up and managed by MSDH network operational groups.
- F. All computers connected to MSDH internal networks via VPN or any other technology must use the most up-to-date anti-virus software that is the corporate standard (webvpn.msdh.ms.gov). This includes personal computers.
- G. VPN users are automatically disconnected from MSDH network after fifteen (15) minutes of inactivity. The user must then logon again to reconnect to the network. Pings or other artificial network processes are not to be used to keep the connection open.
- H. The VPN concentrator is limited to an absolute connection time of 24 hours.
- I. Users of non-MSDH-owned equipment must configure the equipment to comply with MSDH VPN and other policies.
- J. Only approved VPN clients are allowed to be used.
- K. By using VPN technology with personal equipment, users must understand that their machines are a de facto extension of MSDH network, and as such are subject to the same rules and regulations that apply to MSDH-owned equipment. In other words, their machines must be configured to comply with MSDH Security Policies.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring that all VPN end systems, such as laptops and desktops, are deployed and used based on policy requirements
- Reviewing log files from VPN devices, such as concentrators and other systems, on a regular basis.

11.4.7 Remote Access Policy

Purpose:

The purpose is to implement security measures sufficient to reduce risks and vulnerabilities of remote access connections to MSDH's enterprise infrastructure to a reasonable and appropriate level.

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Remote access implementations that are covered by this policy include, but are not limited to, dial-in modems, frame relay, ISDN, DSL, VPN, SSH, and cable modems.

Policy:

MSDH will take all reasonable and appropriate steps to ensure the secure and authorized use of all remote access capabilities and solutions.

Procedures:

The MSDH remote access infrastructure must follow these guidelines:

- A. It is the responsibility of MSDH workforce members, vendors and agents with remote access privileges to the MSDH corporate network to ensure that their remote access connection is given the same consideration as the user's on-site connection to MSDH.
- B. Secure remote access must be strictly controlled. Control will be enforced by using strong passwords. Refer to Password Management Policy.
- C. At no time will any MSDH workforce member provide their login or email password to anyone, not even family members.
- D. MSDH workforce members with remote access privileges must ensure that their MSDH-owned or personal computer or workstation, which is remotely connected to MSDH corporate network, is not connected to any other network at the same time, with the exception of personal networks that are under the complete control of the user.
- E. MSDH workforce members with remote access privileges to MSDH's corporate network must not use non-MSDH email accounts (for example, Gmail, Hotmail, Yahoo, AOL), or other external resources to conduct MSDH business. This ensures that official business is never confused with personal business.
- F. Routers for dedicated ISDN lines configured for access to the MSDH network must meet minimum authentication requirements of CHAP.
- G. Reconfiguration of a home user's equipment for the purpose of split-tunneling or dual homing is not permitted at any time.
- H. Frame Relay must meet minimum authentication requirements of DLCI standards.
- I. Non-standard hardware configurations must be approved by the ITSO.

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- J. All hosts that are connected to MSDH internal networks via remote access technologies must use the most up-to-date anti-virus software. This includes personal computers.
- K. Organizations or individuals who wish to implement non-standard Remote Access solutions to the MSDH production network must obtain prior approval from the ITSO.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring that all remote access connections are used in accordance with policy requirements;
- Reviewing related log files from key systems on a regular basis, and
- Sending reminders to all workforce members about remote access security.

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11.5 DATA, DEVICES, MEDIA AND INTEGRITY

11.5.1 Confidential Data Storage Policy

Purpose:

The purpose is to provide basic standards for how all data deemed confidential is to be properly stored.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

Confidential data will only be stored in secured digital format or, when necessary, hard copies and/or using portable drives and media with encryption capabilities.

Procedure(s):

- A. Whenever possible, confidential information must be stored in a secure digital format located on agency enterprise storage, rather than on a local system hard drive or portable device or media.**
- B. Hard drives or portable devices or media containing confidential information must be properly encrypted by OHIT.**
- C. The ITSO and OHIT Director will select, establish, and manage secure network accessible space for the agency.
- D. The ITSO and OHIT Director will select the encryption and decryption capabilities to properly secure confidential data on hard drives and/or portable devices or media when secure network storage is not sufficient or unavailable.
- E. In situations where data must be stored in hard copy (paper) format, the data **MUST** be kept in a secure and locked drawer, box, or other pre-approved type of container when not being viewed. Only designated MSDH workforce members will have ability to lock and unlock such containers. The chosen container(s) and procedures must be pre-approved by the Office Director and Data Governance Director.

Responsibilities:

The ITSO, OHIT Director, and Data Governance Director will be responsible for ensuring the implementation of this Data Storage Policy.

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11.5.2 Data Backup and Storage Policy

Purpose:

The purpose is to create a retrievable, exact copy of confidential information, when needed, prior to the movement of equipment.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will determine when backups are needed, including prior to the movement of any systems collecting, storing, processing, or transmitting confidential information.

Procedure(s):

- A. The ITSO and OHIT Director will determine when backups are needed, including prior to the movement of any systems collecting, storing, processing, or transmitting confidential information.
- B. OHIT Staff will perform a daily backup of all critical systems and periodically test the data for integrity and availability.
- C. If the designated backup operator (a member of OHIT) is not able to perform his/her duties due to the following reasons, the ITSO and OHIT Director will make arrangements for the backup to continue as required
 - a. Illness, vacation, or other absence.
 - b. Workload and overtime prevented users to log off to run the backup.
 - c. System problem prevented the backup from being done
- D. The ITSO and OHIT Director will ensure the backup is run as soon as practical that day or the next day. They are responsible for ensuring an alternate staff person runs the backup in case the primary backup operator is absent.
- E. OHIT will handle all MSDH failed backup occurrences and report all full backup failures to the OHIT Director and ITSO. The OHIT Director and ITSO will report all failed backups to the CHDOR.
- F. OHIT will cycle media per the manufacturer's recommended usage policy and shall not extend usage past the effective dates.

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- G. The ITSO and OHIT Director will maintain a database of all failed backup operations, available for review at any time.
- H. The ITSO and OHIT Director will update the backup procedure to include new applications or data.
- I. The ITSO and OHIT Director will train workforce members through orientation and reminders to store all files on the network to ensure data backup.
- J. OHIT will ensure the monthly tape is stored offsite in a secure location if other network offsite backup procedures for system are not in place. OHIT will verify all data for accuracy and integrity before being stored offsite at the designated secure location.
The ITSO and OHIT Director will ensure that the appropriate access controls are implemented to only allow authorized access to all such data.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Data Backup and Storage Policy.

11.5.3 Device and Media Controls Policy

Purpose:

The purpose is to implement policies and procedures governing the receipt, movement, and removal of hardware, software, devices and electronic media that may or may not contain confidential information into, out of, and within MSDH facilities. This policy relates to disposition and re-use of any MSDH device, software, hardware, jump drive, system, and all other forms of media and devices that may or may not contain confidential information.

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential or public information.

Policy:

MSDH will ensure compliance with the Device and Media Controls standard (45 CFR §164.310(d)) and its associated implementation specifications of: Disposal, Media re-use, Accountability and Data Backup and Storage.

Procedure(s):

- A. Only authorized personnel will have access to confidential information.
- B. Unless authorized to do so, workforce members are not allowed to procure or purchase hardware, software, applications electronic media, and/or devices for the agency. This policy applies even if the workforce member uses his/her own funds without expectation of reimbursement.

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- C. Inventory and movement of all hardware, software, and electronic media will be tracked and logged.
- D. The movement of all confidential information must be tracked and logged. This includes, but is not necessarily limited to, documentation of transfer of ownership, destruction, disposal, and/or re-use.
- E. Software and/or applications that are not licensed by MSDH and approved by OHIT must not be loaded on an MSDH Resource (e.g. MSDH computer, laptop, cellphone, iPad, etc.). Games and personal software packages and data are not to be stored or used on MSDH equipment. Only properly licensed business-related software packages will be used. All systems are audited regularly, and unauthorized software may be removed without prior notification and could be reported to the appropriate authorities for further action.
- F. To ensure MSDH remains compliant with software support and maintenance fees, OHIT maintains a log of all software licensed to MSDH. Software or applications to be downloaded or installed on MSDH devices must be performed by OHIT staff with the approval of the Director of OHIT.
- G. All software on MSDH desktop and laptop computers is licensed for MSDH use only. It is against Federal copyright law to copy software to another computer. No software is to be downloaded or copied to MSDH's computers from any external source. All software must be approved and loaded to computers by OHIT Staff. Software on MSDH workforce members' workstations must be approved by the Director of OHIT and ITSO in writing before loading or installing on a MSDH resource (e.g. MSDH computer, laptop, cellphone, iPad, etc.). This does not require approval for each workforce member. One approval can suffice for all workforce members using that software.
- H. If an MSDH workforce member needs/desires any additional software to be installed on the system, the staff member shall submit a request to their Supervisor/Office Director. The Supervisor/Office Director shall determine if the need is justified. If the Supervisor/Office Director determines the software request is justified, he/she must make a formal request to OHIT and the ITSO for approval. OHIT and the ITSO must decide as to whether the software would pose a threat to MSDH's information systems. If OHIT and the ITSO determine the software to be innocuous, OHIT shall be responsible for the installation of the software in question, as well as having documentation of the software's installation, licensing agreements, and software updates on the MSDH workforce member's workstation. Any purchase of new software must be submitted for approval in accordance with agency purchasing policies and procedures.
- I. In the case where a MSDH workforce member has an explicit justifiable need to transport and/or copy confidential information to removable media (e.g., jump drive, CD-ROM, laptop not already deemed a repository of confidential information, etc.) and remove it from MSDH property, the MSDH workforce member must receive authorization from their Supervisor/Office Director and the ITSO. The Supervisor/Office Director and ITSO, shall, if deemed necessary under the principle of "minimum necessary", authorize the MSDH staff member to copy/transfer the PHI in question to the removable media and track the media onto which the PHI was transferred/copied. The data transferred/copied onto the removable media must be encrypted. Strong password controls must be implemented on the encrypted data. Once this copy is no longer necessary for use by the MSDH

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workforce member who requested authorization, the MSDH staff member must return the media to the Supervisor/Office Director for proper data destruction by OHIT. If the removable media is lost or stolen, it must immediately be reported to OHIT, MSDH's Privacy and IT Security Officers, and the MSDH staff member's Supervisor/Office Director. When the incident is reported, a complete log of all data stored on the device must be provided with a detailed report of the loss or theft of the device. Failure to maintain the log of information stored on the portable storage device shall be considered a breach of security.

- J. Unless meant to be portable as part of a workforce member's day-to-day work for the agency, approval must first be obtained by the Property Management Office, ITSO and OHIT prior to inventoried hardware or other physical IT assets or resources being moved from the facility where they originally reside. Requests must be made according to policies and procedures of the Property Management Office. OHIT and the ITSO will assess the reason(s) for a given request and make a decision that considers the requestor's access, job requirements, sensitivity of the components, period/frequency of removal, and any applicable policies and agreements. Requests must be documented in writing.
- K. Upon returning equipment to MSDH, the equipment will be inspected by OHIT to the degree necessary. Virus checks must be performed on any writeable media. The components will then be returned to their appropriate location within MSDH. Procedures for loan and return of hardware from inside MSDH are documented in the policies and procedures of the MSDH Office of Property Management.
- L. OHIT Staff must ensure hardware, software, workstations and electronic media do not contain readable confidential information before they are re-used if the new user is not granted access to that confidential information.
- M. Disposal of hardware, software, workstations and electronic media must be consistent with regulations, policies and procedures established by the Office of the State Auditor and the MSDH Property Management Office. OHIT must determine and perform the proper method of disposal (e.g., salvage, sell, trade, throw away).
- N. A backup copy of all confidential information and other critical software and applications will be stored in a secure location. Retention will follow applicable agency policies.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of this policy.

11.5.4 Accountability Policy

Purpose:

The purpose is to maintain a record of the movements of hardware and electronic media and any person responsible thereof.

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain or transmit confidential information.

Policy:

MSDH will ensure that a record is maintained to identify movements of confidential information including all related hardware and devices.

Procedure(s):

- A. OHIT will maintain an inventory database of all electronic equipment and keep an up-to-date inventory for review. Whenever hardware is received, moved or discarded, the database will be updated.
- B. All electronic equipment will be inventoried at least annually by OHIT and discrepancies will be handled on an as needed basis.
- C. OHIT will track the following in the inventory database
 - 1. MSDH inventory number
 - 2. Unit serial number
 - 3. Description of inventory
 - 4. Individual assigned to inventory
 - 5. Location of inventory
- D. The movement of hardware, electronic media and devices includes the receipt, removal, storage and/or disposal of confidential information systems. Such information will also include the identity of responsible persons associated with the movement.
- E. Movement of assets will comply with the Device and Media Controls Policy.
- F. Disposal of assets shall comply with the Disposal Policy.
- G. Re-Use of Media will comply with the Media Re-Use Policy.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of the Accountability Policy.

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11.5.5 Media Re-Use Policy

Purpose:

The purpose is to implement procedures for removal of confidential information from electronic media before the media are made available for re-use.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will ensure that all electronic media including hard disk drives, optical media, USB keys, memory cards, or any other electronic or portable media has been cleaned of all confidential data prior to any re-use.

Procedure(s):

- A. Whenever hardware is relocated, and the hardware contains ePHI that is not already backed up, an exact backup will be done of the ePHI on that hardware prior to moving or relocating. OHIT Staff will ensure that the backup is accurate and will ensure the backup is available until the hardware is relocated and operational.
- B. OHIT Staff are responsible for properly and efficiently “imaging” each and every computer within the agency when the computer is not in use by an active workforce member. This shall comprise of industry standard methods to remove all documents from the existing drives, to include any image present which represents previous access user names and/or passwords. This new “image” must remain consistent with the needs of the agency and provide the operating system, software, anti-virus, updates, and connectivity features needed for the workforce member to effectively complete the tasks assigned.
- C. Whenever backup media or hardware is re-used, it will be completely cleaned of any ePHI. OHIT Staff must test all re-usable media before releasing media to another individual or group.
- D. The OHIT Director and ITSO will ensure that prior to re-use such actions are verified and documented.
- E. OHIT Staff will ensure that the previous label on such media that is to be overwritten is removed and destroyed.
- F. The OHIT Director and ITSO will ensure that the master inventory list or asset tracking system is appropriately updated upon the re-use of media components containing confidential information.

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Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of the Media Re-use Policy.

11.5.6 Disposal Policy

Purpose:

The purpose is to implement policies and procedures to address the final disposition of confidential information and/or the hardware or electronic media on which it is stored.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will ensure that its master inventory list or asset tracking system is appropriately updated upon the disposal of components containing confidential information.

MSDH will ensure that the disposal of all confidential information is conducted securely and that the destruction of the information is permanent.

Disposal of hardware, software, workstations and electronic media must be consistent with regulations, policies and procedures established by the Office of the State Auditor and the MSDH Property Management Office. OHIT must determine and perform the proper method of disposal (e.g., salvage, sell, trade, throw away).

Procedure(s):

- A. Whenever hardware is disposed of, OHIT Staff will ensure that all data has been removed using a reformatting utility or similar option to clear the permanent memory, and any RAM memory. The ITSO will work with the OHIT Director and OHIT Staff on developing procedures and processes to ensure that all data has been removed. This action and method used must be logged for future reference.
- B. All removed hard drives and other media that will be used in other computers, sold or donated, will first be cleaned using a sanitation program.
- C. If a hard drive/media cannot be cleaned as described in item A or it has reached the end of its shelf life, it will be disposed of consistent with regulations, policies and procedures established by the Office of the State Auditor and the MSDH Property Management Office. OHIT must determine and perform the proper method of disposal (e.g., salvage, sell, trade, throw away).

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- D. OHIT will track the status and condition of media through the inventory management database. The ITSO and/or OHIT Director shall request printout of the database and tracking from OHIT Staff, as needed.
- E. OHIT Staff will maintain an inventory tracking system that will identify how hardware was disposed of and to whom the hardware was transferred, with the appropriate contact information attached. The ITSO and/or OHIT Director shall request printout of the database and tracking from OHIT Staff, as needed.
- F. This policy will apply, but not be limited to, to the organization’s tablets and laptops, as well as the servers and desktop computers.
- G. OHIT will ensure that all labels have been removed from data to be disposed.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of the Disposal Policy.

11.5.7 Audit Controls Policy

Purpose:

The purpose is to implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will:

- Identify critical systems that require event auditing capabilities;
- Define the events to be audited on all such systems, and
- Protect all collected logs from alteration or destruction.

Procedure(s):

A. OHIT and/or the ITSO shall enable file audit on all systems that contain ePHI and report unauthorized access as soon as practical.

Audits may be conducted to:

- a. Ensure confidentiality, integrity, and availability of confidential information.
- b. Investigate possible security incidents and ensure conformance to MSDH security policies.

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- c. Monitor user or system activity where appropriate.
- B. OHIT and/or the ITSO shall set up a logging server that will maintain a log of all server logs and delete old logs as space is required.
- a. MSDH will define the events to be audited on all such systems. At a minimum, event auditing capabilities will be enabled on all systems that process, transmit, store, and/or maintain confidential information. Events to be audited may include, and are not limited to, logins, logouts, and file accesses, deletions and modifications.
 - b. MSDH will ensure the protection of all audit reports and log files.
 - c. MSDH will protect all collected logs from improper alteration or destruction even by MSDH privileged users such as Administrators or ROOT accounts.
- C. The OHIT Director and ITSO shall continue to evaluate new technology to assist in the logging and monitoring of MSDH equipment.
- D. Internet activity will be monitored and logged for periodic review by the ITSO and/or OHIT Director as requested by the Chief of Health Data, Operations and Research (CHDOR) or the State Health Officer.
- E. Network usage will be monitored continually to identify inappropriate usage and unlawful activities.
- F. When requested, and for the purpose of performing an audit, any access needed will be provided to authorized MSDH workforce members and/or auditing parties. This access may include:
- a. User level and/or system level access to any computing or communications device.
 - i. Access to information (electronic, hardcopy, and so on) that may be produced, transmitted, maintained, or stored on MSDH equipment or premises.
 - ii. Access to work areas (labs, offices, cubicles, storage areas, and so on).
 - iii. Access to interactively monitor and log traffic on MSDH networks.
- G. MSDH logs will seek to follow “Write Once, Read Many” standards so that they cannot be altered once they are written.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Audit Controls policy.

11.5.8 Encryption and Decryption Policy

Purpose:

The purpose is to implement a mechanism to encrypt and decrypt confidential information.

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The Encryption Policy is intended to assist workforce members of MSDH in making a decision about the use of encryption technologies as a method of protecting data stored on systems that process confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

More specifically, this policy applies to MSDH workforce members that have the authority to evaluate, purchase (or develop), and implement systems or devices that store, maintain, or process confidential information.

This policy also applies to all devices, systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

Unless authorized otherwise by the ITSO, all media and devices containing ePHI must utilize encryption and decryption to protect the ePHI from unauthorized disclosure. Encryption and Decryption may also be utilized in combination with other access controls where indicated by risk analysis.

Procedure(s):

- A. OHIT will make use of a VPN and/or SSL connection between all remote computers back to the MSDH network. OHIT will utilize IPSEC as the standard security method until a more secure method is developed or becomes available.
- B. OHIT will utilize secure web-servers for remote access to the MSDH network which will include remote applications and email.
- C. MSDH recognizes the need for encryption and will continue to evaluate new technology as it becomes available for transmitting ePHI outside its trusted network.
 - a. Proven, standard algorithms such as AES, Blowfish, RSA, RC5 and IDEA must be used as the basis for encryption technologies. These algorithms represent the actual cipher used for an approved application. For example, Network Associate's Pretty Good Privacy (PGP) uses a combination of IDEA and RSA or Diffie-Hellman, while Secure Socket Layer (SSL) uses RSA encryption.
 - b. Symmetric cryptosystem key lengths must be at least 128 bits.
 - c. Asymmetric crypto-system keys must be of a length that yields equivalent strength.
 - d. MSDH key length requirements will be reviewed annually and upgraded as technology allows. All keys generated will be secured in escrow (available to a third party for retrieval in an emergency).
 - e. The use of proprietary encryption algorithms is not allowed for any purpose, unless reviewed by qualified experts outside of the vendor in question and approved by the ITSO.

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- D. The ITSO and OHIT will train users on encrypting and decrypting documents.
- E. The ITSO and OHIT will ensure that all critical data files are kept in read-only format wherever possible and that the fewest number of individuals possible have access to modify these files.
- F. The ITSO and OHIT will ensure that all data transmissions are done through a secure transmission protocol. MSDH workforce members will be trained and reminded never to transmit ePHI unless it is encrypted at rest and in transit.
- G. When possible, MSDH will utilize digital certificates or other accepted authentication methods when exchanging ePHI with outside entities.
- H. MSDH will need to balance the challenge of protecting “data at rest” such as that defined in the Access Control standard of the HIPAA Security Rule against the increase in security technology complexity and administrative overhead including performance considerations and usability.
- I. MSDH will review the viability of securing ePHI on critical databases, file servers, and on mobile devices such as laptops, smartphones, and portable flash drives.
- J. MSDH will test encryption and decryption capabilities of products and systems to ensure proper functionality.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Encryption and Decryption Policy.

11.5.9 Integrity Policy

Purpose:

The purpose is to implement policies and procedures to protect confidential information from improper alteration or destruction.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will review the results of risk analysis to identify the data that must be protected from improper alteration or destruction.

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MSDH will ensure that data is only altered by properly authorized members of the workforce or automated processes.

Procedure(s):

MSDH will review the results of risk analysis to identify the data that must be protected from improper alteration or destruction. The files and associated directories where such data is stored will be checked for data integrity.

- A. MSDH workforce members shall make every reasonable effort to verify and protect the integrity of the data it holds for MSDH.
- B. The ITSO and OHIT Director will evaluate both software and hardware utilities designed to protect data as it travels from the MSDH trusted network to the internet to its destination.
- C. MSDH workforce members must utilize encryption capabilities when exchanging data electronically.
- D. The ITSO and OHIT Director will train members of the workforce to report unauthorized data modification or destruction.
- E. The ITSO and OHIT Director will ensure that systems maintain the integrity of data altered by members of the workforce even if those members change their legal names, depart the organization, or are deceased after alterations have been made.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Integrity Policy.

11.5.10 Integrity Controls Policy

Purpose:

The purpose is to implement security measures to ensure that electronically transmitted confidential information is not improperly modified without detection until disposed of.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

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Policy:

MSDH will maintain integrity controls to ensure the validity of information transmitted over the network infrastructure. MSDH will implement measures to ensure that confidential information is not improperly modified without detection until disposed of by an authorized member of the workforce.

Procedure(s):

- A. Email which contains PHI must be limited to those email recipients who have a need and/or right to gain access to the information. Unless otherwise allowed or mandated by law or regulation, the information must be limited to the minimum necessary to accomplish the proposed function.

- B. Prior to transmitting an email or electronic message containing ePHI from the MSDH network to another party within the MSDH network or outside the MSDH network, the sender must confirm that the chosen recipient is the proper and intended recipient.

- C. The transmission of ePHI from MSDH to an outside or internal party via an email or messaging system is permitted if the sender has ensured that the following conditions are met:
 - a. Transmission is not being done through texting with a cellphone or smartphone.
 - b. The receiving entity has been confirmed as the proper and intended recipient.
 - c. The receiving entity is aware of the transmission and is ready to receive said transmission.
 - d. The device used to send the ePHI implements encryption at rest and in transit.
 - e. The sender and receiver can implement a compatible encryption mechanism.
 - f. All attachments containing ePHI are encrypted

- D. Whenever possible, PHI should not be sent using fax. However, if necessary, the following steps must be taken:
 - a. An MSDH Confidential Fax Transmission Cover Sheet (Form #667) must be used which includes a required confidential statement prohibiting redisclosure. (See Privacy Policy, Section 22)
 - b. The sender must confirm the fax number to which they are sending the information and confirm they have entered it correctly into the fax machine.
 - c. The sender must be knowledgeable of what information is being requested and by whom.
 - d. The sender must confirm receipt with the requesting party.

- E. If using removable media for the purpose of system backups and disaster recovery, the removable media must be encrypted. It must also be stored and transported in a secured environment.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Integrity Controls Policy.

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11.5.11 Mechanism to Authenticate Confidential Information Policy

Purpose:

The purpose is to implement electronic mechanisms to corroborate that confidential information has not been altered or destroyed in any unauthorized manner.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will review the use of digital signature and/or checksum technology to corroborate that confidential information has not been altered or destroyed in any unauthorized manner.

MSDH will evaluate the need for and use of encryption to maintain the integrity of confidential information.

Procedure(s):

MSDH will establish a baseline of information to compare future data integrity checks against. This includes checking actual file and directory contents and attributes against a reference, such as a cryptographic checksum matching.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of the Mechanism to Authenticate Confidential Information Policy.

11.5.12 Information System Activity Review Policy

Purpose:

The purpose is to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This includes all systems that process confidential information.

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Policy:

MSDH will clearly identify all critical systems that process confidential information. MSDH will implement security procedures to regularly review the records of information system activity on all such critical systems that process confidential information.

Procedure(s):

- A. The ITSO will immediately review any security incident report and follow up on suspected or actual violations.
- B. MSDH will clearly identify all critical systems that process confidential information. MSDH will implement security procedures to regularly review the records of information system activity on all such critical systems that process confidential information.
- C. The ITSO and/or OHIT Director will run the anti-virus scan on a weekly basis and determine if there are infected files.
 - a. If the ITSO and/or OHIT Director determines there are infected files they will contact the user and, if at all possible, disconnect the infected machine from the network. All infected files must be quarantined and cleaned of any virus before allowing the user access to the file again. OHIT Staff will follow the anti-virus software recommendations for cleaning files.
- D. Periodically, the ITSO and/or OHIT Director will review the firewall security report to determine if there have been attempts to penetrate the information system that are not authorized. All suspicious or successful intrusions will be documented and reported to the ITSO.
- E. On a weekly basis, OHIT will review the event audit report. OHIT will focus on unusual time-of-day access by authorized persons or attempts using invalid or obsolete passwords. OHIT will setup a central logging server and export all log files to the logging server. The logging server will overwrite older logs as space is needed for newer logs. These logs are not for an audit but for information for systems. Old logs will be archived or deleted (as space permits) according to MDAH approved records control schedule.
- F. The information that will be maintained in audit logs and access reports, including security incident tracking reports, must include as much as possible of the following as reasonable and appropriate:
 - a. User IDs;
 - b. Dates and times of log-on and log-off;
 - c. Terminal identity, IP address and/or location, if possible, and
 - d. Records of successful and rejected system access attempts.
- G. MSDH will attempt wherever reasonable, appropriate, and technically feasible to record:
 - a. Unique User ID (user's identity);
 - b. Action completed (examples: read, write, edit, delete, print, etc.);
 - c. Data accessed (examples: server, DB, instance, table, row, field);
 - d. Time of action (example: enterprise wide timestamp); and

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e. Location of action (examples: terminal ID, IP address, local or remote access).

H. Safeguards must be deployed to protect against unauthorized changes and operational problems including:

- a. The logging facility being deactivated;
- b. Alterations to the message types that are recorded;
- c. Log files being edited or deleted; and
- d. Log file media becoming exhausted, and either failing to record events or overwriting itself.

Responsibilities:

The ITSO and OHIT Director will clearly identify:

- The systems that must be reviewed;
- The information on these systems that must be reviewed;
- The types of access reports that are to be generated;
- The security incident tracking reports that are to be generated to analyze security violations, and
- The individual(s) responsible for reviewing all logs and reports.

NOTE: When determining the responsibility for information review, a separation of roles must be established (when appropriate) between the person(s) undertaking the review and those whose activities are being monitored.

11.5.13 Transmission Security Policy

Purpose:

The purpose is to implement technical security measures to guard against unauthorized access to confidential information that is being transmitted over an electronic communications network.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will develop security policies to identify core activities for the Integrity Controls and Encryption implementation specifications.

Procedure(s):

Data in motion will follow NIST Special Publications 800-52, 800-77, and 800-113 whenever possible and appropriate.

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Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of the Transmission Security Policy.

11.5.14 Encryption in Transit Policy

Purpose:

The purpose is to implement a mechanism to encrypt confidential information in transit whenever deemed appropriate.

The Encryption in Transit Policy is intended to assist authorized workforce members of MSDH when making decisions about purchasing or developing software and other systems that make use of encryption technologies as a method of protecting “data in motion.”

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

More specifically, this policy applies to MSDH workforce members that have the authority to evaluate, purchase (or develop), and implement systems that store, process, and maintain confidential information.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, transmit, or maintain confidential information.

Policy:

MSDH will evaluate the need for and use of encryption to maintain the confidentiality and integrity of confidential information being transmitted over a network.

Procedure(s):

- A. All transmissions of ePHI must utilize an encryption mechanism between the sending and receiving entities. A member of the MSDH workforce sending or receiving ePHI must encrypt the ePHI at rest and in transit regardless of the network from which they are sending or receiving the ePHI.
- B. The transmission of ePHI from MSDH to a patient via an email or messaging system is permitted if the sender has ensured that the following conditions are met:
 - a. The patient has been made fully aware of the risks associated with transmitting e-PHI via email or messaging systems.
 - b. The patient has formally authorized MSDH to utilize an email or messaging system to transmit e-PHI to them.
 - c. The patient’s identity (including email address, if applicable) has been verified.
 - d. The email or message contains no excessive history or attachments.

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- C. When transmitting ePHI via removable media, including but not limited to, floppy disks, CD-ROM, memory cards, magnetic tape, and removable hard drives, the sending party must:
- a. Use an encryption mechanism to protect against unauthorized access or modification.
 - b. Authenticate the person or entity requesting said ePHI in accordance with the Person or Entity Authentication Policy
 - c. Send the minimum amount of said ePHI required by the receiving person or entity.
 - d. Route all requests from outside the agency for ePHI to the office, program or application designated to handle such requests.
- D. The transmission of ePHI over a wireless network within MSDH is permitted if the following conditions are met:
- a. The local wireless network is utilizing an authentication mechanism to ensure that wireless devices connecting to the wireless network are authorized.
 - b. The local wireless network is utilizing an encryption mechanism for all transmissions over the aforementioned wireless network.
- E. If transmitting e-PHI over a wireless network that is not utilizing an authentication and encryption mechanism, the e-PHI must be encrypted before transmission.
- F. The authentication and encryption security mechanisms implemented on wireless networks within MSDH are only effective within those networks. When transmitting outside of those wireless networks, additional and appropriate security measures must be implemented in accordance with this Policy.

Responsibilities:

All workforce members are responsible for:

- a. Understanding and following all security related policies and procedures related to encryption

The ITSO and OHIT Director are responsible for:

- Ensuring all workforce members understand and follow security related policies and procedures related to encryption

11.5.15 Email Security Policy

Purpose:

The purpose of this policy is to protect the confidentiality and integrity of confidential information that may be sent or received via email.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will identify whether confidential information is permitted to be transmitted over email and secure all email transmissions of confidential information whenever it is permitted.

Procedure(s):

- A. MSDH recognizes that using email without the use of an encryption mechanism is an insecure means of sending and receiving messages. MSDH will evaluate emerging encryption solutions for email and implement one or more that are:
 - a. Technically sound;
 - b. Reasonable to implement and use by workforce members, and
 - c. Financially reasonable.

- B. General Email Requirements
 - a. MSDH email systems are intended for official and authorized purposes only.
 - b. MSDH considers email messages to be company property. Therefore, email equipment operated by or for MSDH workforce members are subject to the same restrictions on their use as any other company-furnished resource provided for use by members of the workforce.
 - c. Workforce members must use the MSDH email system for all official email correspondence.
 - d. Workforce members must have no expectation of privacy in the use of the email system.

- C. General Guidance about Email: Every email transmitted by an individual reflects on the agency's credibility and the professionalism of the writer. Adherence to basic rules of "netiquette" that follow will alleviate problems and help cast workforce members and MSDH in a favorable light.
 - a. Before sending, workforce members should always check to ensure the list of intended recipients of a message is accurate.
 - b. Workforce members must never reply to spam nor try to unsubscribe from email lists they did not subscribe to. A reply merely confirms a workforce member's email address and encourages the sender to sell that address to other spammers.
 - c. Workforce members must not post a business/agency email address on a personal website. Spambots automatically search the web for email addresses for use by spammers.
 - d. Workforce members are prohibited from sending agency-wide email messages to all agency staff without prior approval of the individual's Office Director. Agency-wide email messages must be submitted by Office Directors to the Email Broadcast Request email group.

- D. Authorized Access to Email Messages: Email system administrators and others with special system-level access privileges are prohibited from reading electronic messages of others unless authorized by appropriate MSDH management officials. However, designated MSDH officials will have access to email messages whenever there is a legitimate purpose for such access, e.g., technical or administrative problems.

- E. When email is not in use, users are to exit the software to prevent unauthorized access.

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Responsibilities:

All individuals identified in the scope of this policy are responsible for abiding by the terms and guidelines set forth by this policy.

The ITSO and OHIT Director are responsible for:

- Evaluating, on a periodic basis, emerging encryption solutions for email and implementing them when one is found that meets the criteria described in the policy section of this document.
- Maintaining procedures and forms in support of this policy.
- Monitoring and enforcing workforce compliance with this policy.

11.5.16 Portable Devices Policy

Purpose:

The purpose is to secure the use of portable devices used by members of the workforce.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

The policy applies to all types of portable devices, including and not limited to laptops, notebooks, tablets, PDAs, smartphones, medical devices, and any other mobile device that is capable of storing or transmitting confidential information.

Policy:

MSDH will ensure that wherever and whenever the use of portable devices is deemed necessary, these devices will be appropriately secured and used only by properly authorized members of the workforce.

MSDH will ensure that all portable devices will be used according to the guidelines defined in this policy.

Procedure(s):

- A. Confidential or confidential data must be accessed only on server systems.
- B. Confidential information is allowed to be stored on portable systems only if appropriate encryption software authorized by the ITSO and OHIT is installed on the device(s).
- C. Any information stored on the portable system must be saved only in those folders that keep information encrypted.
- D. Strong password controls must be implemented for all users of portable devices. This includes requirements for minimal password length and frequency of password changes. Refer to the Password Management Policy.

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- E. When working on portable devices from a remote location, including from home, only secure connections must be used to access confidential information. If wireless communication is used with portable devices, then the device must be configured as defined by the ITSO and OHIT to ensure use of secure protocols. Please refer to the Remote Access Policy.
- F. Backups of information from portable devices must be conducted regularly and stored securely.
- G. Portable devices must not be left unattended. When not in use, portable devices must be locked away or special locks used to secure the equipment.
- H. Workforce members must logoff and shut down portable devices with confidential data before leaving the work space.
- I. Protection against malicious software must be installed and be kept up to date on portable devices.
- J. Devices must be configured to automatically logoff users according to the Automatic Logoff Policy.
- K. Text messaging is typically not secure and can be obtained by unauthorized individuals; therefore, ***texting PHI is prohibited***. This includes text paging.

Responsibilities:

Members of the workforce are responsible for:

- The security of portable devices they use for work
- Taking special care to ensure that confidential information is not compromised

The ITSO and OHIT Director are responsible for:

- Ensuring that key elements of this policy are included in annual training provided to all members of the workforce.
- Including elements of this policy as security reminders sent to members of the workforce.
- Training members of the workforce on any encryption software or password controls that are installed or implemented on portable devices.
- Conducting random audits of portable systems to check for unauthorized or unsecured files.

11.5.17 Phone Policy

Purpose:

The purpose is to implement security measures sufficient to reduce risks and vulnerabilities of MSDH's agency-provided phones to a reasonable and appropriate level.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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Policy:

MSDH will ensure the reasonable and appropriate use of agency-provided telephones (analog, IP, wireless, cellular, etc.) and will provide guidance for the use of such devices.

Procedure(s):

A. Acquisition and Maintenance

- a. Office Directors are responsible for requesting telephones for their staff.
- b. MSDH workforce members have the responsibility to maintain their assigned telephones and notify OHIT immediately of any operational problems with the telephones.

B. Usage/Coverage Areas

- a. Telephones may be assigned a four-digit extension depending on their type.
- b. Analog, IP, and wireless IP phones are intended for use in the organization's facility only and must not be operated outside of the facility.

C. Security and Conduct

- a. The end-user must exercise discretion when talking about confidential information in populated areas.
- b. Staff members using telephones are responsible for securing them using reasonable safety measures. All losses must be reported immediately to the workforce member's respective Office Director/Supervisor, the ITSO and the OHIT Director.
- c. Offices will be charged for any lost, stolen or excessively damaged organization-owned telephone equipment which could have been prevented if the workforce member(s) assigned to the phone had taken reasonable safety measures.

Responsibilities:

The ITSO and OHIT Director are responsible for the implementation of this policy.

11.5.18 Cell Phone and Smartphone Policy

Purpose:

The purpose is to provide reasonable and appropriate safeguards to ensure the confidentiality, integrity, and availability (CIA) of information assets by protecting assets such as cell phones and smartphones from unauthorized access.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data such as ePHI on devices such as cell phones and smartphones by MSDH.

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Policy:

It is the policy of MSDH to implement reasonable safeguards while using cell phones, smartphones, or similar equipment. These safeguards relate to protecting confidential information, equipment security, and security of data.

Procedure(s):

A. General Guidance

- a. MSDH workforce members may use cell phones to communicate during non-work hours (before or after shifts, during breaks or meal periods) and during emergencies.
- b. Cell phone conversations should not occur in any area where patients or visitors are present.
- c. Cell phones should be turned off or set to silent or vibrate mode during meetings, conferences and in other locations where incoming calls may disrupt normal workflow.
- d. To determine if use is excessive, Office Directors reserve the right to ask a workforce member in their office to provide bills and usage reports of calls made during working hours with their agency-provided cell phone.
- e. Confidentiality must always be considered when using cell phones within the organization. An overheard cell phone conversation could put the agency at risk.

B. Confidential Information

- a. All cell phone/smartphone users must hold confidential information such as ePHI in confidence and in accordance with the HIPAA Privacy Rule, HIPAA Security Rule, the HITECH Act, as well as the terms of any confidentiality agreements, and all MSDH policies and procedures.
- b. Protected ePHI and other confidential information must only be read, taken, used, copied or discussed in conjunction with the direct performance of the users' duties.
- c. Text messaging is typically not secure and can be obtained by unauthorized individuals; therefore, **texting PHI is prohibited**. This includes text paging.
- d. Any violation of this policy or unauthorized use or disclosure of patient information will result in MSDH taking appropriate HR and/or legal action against the user.

C. Security of the Equipment

- a. Portable devices such as cell phones and smartphones must not be left unattended in public locations.
- b. Upon request at any time, a workforce member will be responsible for returning all portable devices (e.g. MSDH-provided cell phones, smartphones) and media.
- c. Devices requiring repair are to be returned to OHIT on a timely basis. A workforce member must never attempt to repair any device or authorize repairs by any third party.
- d. Stolen or misplaced portable devices that contain PHI must be reported immediately to OHIT, the PO, ITSO, and the MSDH workforce member's Supervisor/Office Director. All passwords will immediately be changed to prevent unauthorized access.

D. Security of Data

- a. It is the responsibility of the workforce member to adhere to all MSDH policies and procedures regarding the appropriate access, use, storage and disposal of ePHI on devices such as cell phones, smartphones and others.

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- b. Regular backups must be performed on portable devices to ensure information is protected from device failure. Questions regarding appropriate backup processes and technology should be forwarded to OHIT.
- c. It is the workforce member's responsibility to ensure that the media used to back up a portable device such as cell phones or smartphones is secured, protected and disposed of according to established policies.
- d. Electronic PHI (ePHI) residing on a portable device must be encrypted and password-protected whenever possible.
- e. All information present on an MSDH-provided mobile device shall be the property of MSDH.

Responsibilities:

The ITSO and OHIT Director are responsible for the implementation of this policy and associated controls.

All individuals, groups, and organizations identified in the scope of this policy are responsible for ensuring compliance with this policy.

11.5.19 Bring Your Own Device (BYOD) Policy

Purpose:

The purpose of this policy is to address the rights and obligations of owners of a device used for MSDH work and MSDH's rights and obligations to protect and own its data on these devices.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

The policy applies to all personal mobile computing equipment used for work purposes that is capable of storing or transmitting confidential information.

Definitions:

Cloud Service: For the purpose of this policy, a cloud service is virtual data storage or other service located on the Internet and usually managed by a third party.

Personal Computing Device (Device): A device owned by a workforce member or other individual and used to accomplish work for MSDH. A cloud service which stores data is considered a device for the purpose of this policy. Another definition is a device owned by an agent of MSDH used to produce, modify or view MSDH data. A personally-owned device may include, but not necessarily be limited to, a home desktop or laptop, a smartphone or tablet, a pager or cell phone.

Bring Your Own Device (BYOD): A MSDH supported program that allows MSDH workforce members to use their own personal computing device to accomplish work for MSDH.

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Workforce member: Anyone using MSDH Information Infrastructure and acting on MSDH’s behalf.

Workforce member’s personal data: Any and all data on the device that does not belong to MSDH and any data that is not a work product. This includes but is not limited to:

- Any file not agency related.
- Any location or GPS data.
- Any credentials used to access other non-MSDH services, particularly social media sites.
- Device PINs and passwords.
- Any contact information.
- Any device logs including web logs and system logs.
- Personal email or personal social media communications.
- Any personally purchased movies, music, e-books, or applications.
- Any phone conversations, text messages or other communications.
- Any screenshots, input or output of microphones, cameras, keyboards or pointing devices not explicitly shared with MSDH.
- Any publicly published MSDH data that is freely available to the public.
- Any healthcare information for any individual unless that information is a work product.
- Any financial information for any individual unless that information is a work product.

Work Product: Data produced or accessed in the course of accessing MSDH systems to do MSDH business or is data produced on a Personal Computing Device as part of an individual's duties as an agent of MSDH.

Virtual Private Network (VPN): An MSDH network service allowing remote access to information systems and data. The VPN may require specific configurations, patch levels, and antivirus software for certain devices.

Policy:

It is MSDH’s policy to protect the integrity of the organization’s data and ensure that data remains safe and secure, and under MSDH’s control.

Procedure(s):

The use of a mobile electronic device (smartphones, tablets, PDAs, etc.) in connection with MSDH business is a privilege granted to workforce members through approval of their management. MSDH reserves the right to revoke these privileges at any time without notice.

A. Device Requirements and Configuration

- a. The OHIT Director and ITSO are responsible for developing procedures for types of permitted devices and configuring those devices. These procedures may include mobile device management solutions.
- b. Devices used as BYOD must be one of MSDH’s standard approved devices. Other devices are not allowed to connect to MSDH’s systems/network. Personal smartphones are not permitted to connect to MSDH’s infrastructure without documented consent from OHIT. Furthermore,

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MSDH and OHIT reserve the right to disable or disconnect some or all services as well as monitor all activity without prior notification.

- B. Passwords
- a. The device must be configured to include a password.
 - b. The password must be a minimum of six characters and contain at least one letter or number (except on devices that cannot accept alphanumeric passwords).
 - c. Passwords must be rotated every ninety (90) days.
 - d. The password must not be one of the workforce member's previous four passwords.
- C. The device must be configured to lock after ten (10) failed login attempts.
- D. The device must be configured with an inactivity screen that requires a PIN or password to unlock.
- E. Devices must be configured to use SSL or other encryption communications.
- F. If the workforce member disposes or replaces (example: upgrades) the device, the permanent memory of the device must be wiped. Simple deletion is not enough.
- G. Security software that can locate or wipe a lost or stolen device must be installed.
- H. The workforce member must not change or disable configuration settings made or dictated by OHIT.
- I. Workforce members are expected to use their device in an ethical manner. Using their device in ways not designed or intended by the manufacturer is not allowed. This includes but is not limited to "jail breaking" or "rooting" the device.
- J. The workforce member and MSDH must follow all other administrative policies when a device is connected to MSDH internal networks or when social media or other collaboration solutions are applied.
- K. Workforce members' devices must contain the following controls:
- a. Anti-virus protection must be maintained and updated.
 - b. Patches:
 - Automatic Updates must always be configured and applied.
 - Applications must be configured to update automatically when possible.
 - Workforce members must regularly check that applications are updated.
 - c. Additional Software and Applications
 - Workforce members are expected to understand the consequences of installing applications on devices used to access MSDH data.
 - If the workforce member does not understand the consequences of installing a particular application, then they must not do so until they do more investigation into the application.
 - Only well-known and well-respected application vendors and online repositories should be used. Common repositories by the workforce member's Internet Service Provider, Operating System, Hardware Vendor or default Market Place should be used.
 - MSDH may require applications to be installed on the device. Any software required by MSDH will comply with all MSDH policies, including this one, as well as Federal, State, and local laws.
 - d. Root, Administrative and Workforce Member Access and Accounts
 - Workforce members should not use a local device account with administrator or root rights to access the Internet for devices that support multiple local accounts.

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- Workforce members should use a restricted account on the device for accessing information into MSDH.
 - Workforce members who accesses confidential MSDH data should not share devices with family members.
- e. MSDH Data
- Many state and federal laws as well as MSDH policies make the workforce member responsible for safeguarding MSDH data in their possession.
 - Never keep the only copy or the newest copy of MSDH data on a personal device. This opens the workforce member to legal actions including confiscations and searches beyond this policy.
 - If MSDH data is created on the device then the only copy or newest copy of MSDH data should be moved to MSDH’s network as soon as practical.
 - Workforce members must not publicize MSDH data without prior approval from MSDH. MSDH data that workforce members purposefully or inadvertently publish on social sites, cloud sites, or personal servers is subject to all laws, regulations and MSDH policies and procedures.
 - Workforce members must immediately report lost or stolen devices that have been used to access MSDH data to their Supervisor.
 - Breaches, disclosures, possible disclosures or malware infections on personally owned devices or cloud services utilized through personally owned devices must be reported in accordance with agency Security Incident and Breach policies and procedures as applicable.

L. Contents of Security Agreements

Workforce member:

- a. Retains absolute ownership of the device.
- b. Understands that MSDH may inadvertently come into contact with their personal data. If a workforce member discovers that MSDH has come in contact with their personal data, they should inform their Supervisor or Office Director.
- c. Agrees that MSDH may obligate them to set or maintain certain configurations and practices before the workforce member is allowed access to MSDH data. If the workforce member disagrees with any of these requirements, or if the workforce member circumvents them, then the workforce member must not access or process MSDH data via the device.
- d. Understands that MSDH might require software be installed on the device if the workforce member wishes to access MSDH data.
- e. Is obligated to remove all MSDH data from personally owned devices upon separation from MSDH or by MSDH’s request.
- f. Agrees that MSDH has the right to manage the device including remote wiping of data including destruction or loss of any and all data on the device. This is including, but not limited to, application installation/removal, configuration setting changes, application/system updates, and resetting the device and may be done without prior notification.
- g. Upon separation from MSDH or by MSDH request, the workforce member must reconcile software licenses purchased by MSDH and installed on personally owned devices. Depending on

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the licensing of the software and MSDH requests, this might mean a workforce member must reimburse MSDH for the software, destroy the software or otherwise release the license.

MSDH:

- a. Retains absolute ownership of the work product of its agents and has the right and obligation to govern this data.
- b. Respects the ownership rights of these devices and will never configure, modify, delete, monitor, or install anything on the device, including wiping the device or resetting the device PIN or password, unless a business or security reason is required.
- c. Reserves the right to search a User’s device for MSDH’s data without the prior consent of the workforce member unless required by law.
- d. May limit what data may be accessed remotely.
- e. Must permanently delete all its copies or records of personal data discovered from a User’s Personal Computing Device and inform the workforce member as soon as discovered and practical.

M. MSDH and the workforce member must comply with all Federal, State and Local laws. In this context the law might require MSDH to access its data as well as the data on the Workforce member’s device. The workforce member may be compelled to provide any data from their device because of these laws. The workforce member understands that because of these laws they are giving up some rights to their device by accessing MSDH data.

Responsibilities:

The ITSO and OHIT Director are responsible for the implementation of this policy.

Workforce Member Responsibilities:

- maintain security and integrity of their device and MSDH data as outlined in this policy and related HIPAA security policies.

MSDH Responsibilities:

- MSDH will not access a workforce member’s device or data for any reason, nor configure any services to do so, that does not conform to agency policies.
- MSDH may offer security services for lost or stolen devices that wipe or locate these devices.

11.5.20 Computer, Network, System, and Device Maintenance Records Policy

Purpose:

The purpose is to implement policies and procedures to document repairs and modifications to the physical components of a facility which are related to security (for example, hardware, walls, doors, and locks).

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will document all repairs and modifications to the facility that could affect the confidentiality, integrity, or availability of ePHI. All records will be securely retained for a time period as dictated in MSDH's records retention policy.

Procedure(s):

- A. Whenever possible, facility maintenance should be reported to the workforce members. However, every MSDH location will track maintenance and document the following:
 - a. Company performing work
 - b. Technician name
 - c. Detail of work to be performed
 - d. What access is requested
 - e. Duration of work, start and finish time
- B. Before any technician is allowed access to the MSDH network, computer room, computer equipment or phone equipment, the MSDH workforce member meeting with the technician must do the following:
 - a. If the MSDH workforce member was expecting the technician:
 - i. Contact OHIT Staff that can verify the access is appropriate;
 - ii. If access is granted by OHIT, the MSDH workforce member must find out whether the technician must be escorted and/or monitored while performing such maintenance
 - iii. OHIT Staff will log maintenance through a designated program.
 - b. If the MSDH workforce member was not expecting the technician:
 - i. He/she must gather the information in section A (above) and verify that information with OHIT Staff;
 - ii. If the information is verified and access granted by OHIT, the MSDH workforce member must find out whether the technician must be escorted and/or monitored while performing such maintenance; and
 - iii. OHIT Staff will log maintenance through a designated program.
- C. The ITSO and OHIT Director will periodically review the maintenance database.
 - a. A maintenance record must be created for each modification made to the physical site, facility or building. Such information must be securely stored.

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Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the Maintenance Records Policy.

11.5.21 Social Media Policy

Background:

MSDH recognizes that the use of the internet has many benefits for MSDH and its staff. The internet and email make communication more efficient and effective. Therefore, staff is encouraged to use the internet and email appropriately.

Today, social media encompasses a broad range of online activity, all of which is track-able and traceable. Social media networks include, but are not limited to:

- Blogs;
- Social networks, such as Facebook and MySpace;
- Professional networks, such as LinkedIn;
- Live blogging tools, such as Twitter;
- Photo- and video-sharing sites, such as Flickr, Pinterest, and YouTube, and
- Social bookmarking tools, such as Digg and Delicious.

New online tools and technical advances introduce new opportunities to build a “virtual” footprint.

Purpose:

The purpose is to ensure staff members who use social media, either as part of their job or in a personal capacity, understand the organization’s expectations for social media engagements concerning MSDH, its services, MSDH workforce members, MSDH’s patients, its competitors, its vendors and/or business-related individuals or organizations.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH and its workforce members, at the guidance of the Office of Communications, will maintain effective electronic communications that are consistent with the MSDH’s beliefs, mission and workforce standards. The requirements contained within this policy apply whether the workforce member is using MSDH or personal equipment or devices to utilize social media as part of their job or for personal reasons but utilizing MSDH resources, data or references.

This policy is based on the following Three R’s:

- A workforce member must be clear about whom they are **Representing**.

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- They must take **Responsibility** for ensuring that any references to MSDH are factually correct and do not breach confidentiality requirements.
- They must show **Respect** for the individuals and communities with whom/which they interact.

Procedure(s):

A. Internet Posts (examples: blog posts, social media posts)

- A workforce member must not presume their activities on the internet are private or their business alone. Outside the workplace, his/her rights to privacy and free speech protect online activity conducted on personal social networks and using personal email addresses. However, what is published on such personal online sites must never be attributed to MSDH and must not appear to be endorsed by or originated by MSDH. This means, whether working on MSDH equipment during business hours, or on personal technology tools at home after work, posting text, photos, or videos about the organization, MSDH workforce members, MSDH patients, products or services, etc., without express permission from the Office of Communications may be considered a violation of this policy.
- If a workforce member chooses to list their work affiliation on a social network, then they must regard all communications on that network as they would in a professional network. Online lives are ultimately linked whether they choose to mention MSDH in their personal online networking activity.
- Workforce members are responsible for what they post. They are personally responsible for any of their online activity conducted with the MSDH email address, and/or which can be traced back to the organization's domain, and/or activity which uses organization assets. The MSDH email address (msdh.ms.gov) attached to a workforce member's name implies they are acting on the organization's behalf in any context.
- While utilizing MSDH-provided tools, workforce members should disclose they are employed by MSDH, be clear about what office or service they are representing and what are their roles and accountabilities.
- Personal blogs should display a clear disclaimer that the views expressed by the author in the blog are the author's alone and do not represent the views of MSDH. A workforce member should make it clear in a post that they are speaking for *themselves only* and **not** on behalf of the agency.
- Workforce members must not disclose any confidential or proprietary information about MSDH, its patients, affiliates, vendors, or suppliers.
- Workforce members must not use or disclose any patient identifiable information, or any patient scenarios of any kind on any social media.
- MSDH logos must not be utilized without consent from the Office of Communications.
- While at work, workforce members are asked to please refrain from online activities that do not bring value to MSDH. They should think of their personal time online as they think of personal phone calls or emails. If not required for their particular job role/activity, online activities must be limited to non-work time. "Non-work time" is defined as before a shift begins, during breaks or meal periods, or after a shift ends. Social media activities must not interfere with work commitments.

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- j. Workforce members should remember the internet is not anonymous. Everything written on the web can be very easily traced back to its author, even if deleted or removed. Information is backed up often; posts in one forum are usually replicated in others through trace-backs, reposts, or references.

B. Property Rights and Confidentiality

- a. **All information created, transmitted, acquired, downloaded, or uploaded via the organization’s network and internet or intranet is the property of MSDH.**
- b. Internal and external email messages are considered business records and may be subject to discovery in the event of litigation. All electronic communications produced through the utilization of MSDH tools or internet access, including internal and external emails, may be subject to disclosure to a third party.
- c. Email is not guaranteed to be private or confidential. All electronic communications are MSDH’s property. Therefore, MSDH reserves the right at any time to examine, monitor, and regulate email messages, directories and files, as well as internet usage.

C. For additional information related to social media policies and practices, workforce members should review the following policies:

- a. Workstation Use Policy
- b. Email Security Policy
- c. Remote Access Policy
- d. Portable Devices Policy
- e. VPN Policy
- f. Cell Phone and Smartphone Policy
- g. General Agency Manual, Section 7.22 “Social Media”

Responsibilities:

All individuals, groups, and organizations identified in the scope of this policy are responsible for ensuring compliance with this policy. Further, all workforce members are obligated to report suspected violations of this policy to their Office Director/Supervisor, the ITSO, OHIT Director and the Office of Communications.

The ITSO, OHIT Director, and the Communications Director are responsible for ensuring all workforce members understand and follow this policy and associated controls.

If an activity by an individual is seen as in conflict with the content and intent of this policy, the Communications Director, with the assistance of the individual’s Office Director/Supervisor, ITSO, and/or OHIT Director, upon investigation and confirmation of such conflict, will evaluate options including cessation of the identified activity, loss of internet availability or initiating the Sanction Policy, up to and including dismissal.

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11.6 ACCESS

11.6.1 Access Control Policy

Purpose:

The purpose is to implement technical policies and procedures for electronic information systems that maintain confidential information to allow access only to those persons or software programs that have been granted access rights as specified by regulation or business process.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

In addition, some third parties such as contractors or vendors may be required to abide by parts of this policy if required by MSDH in a Business Associate Agreement (BAA) or another agreement.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will control access to its information assets and systems. Only individuals that have been formally authorized to view or change confidential information will be granted access to that information.

Procedure(s):

- A. To ensure that access to all servers, workstations, and other systems that access, transmit, receive, or store ePHI is appropriately secure, MSDH has instituted the following access control policies:
 - a. Unique User Identification Policy
 - b. Password Management Policy
 - c. Encryption and Decryption Policy
 - d. Wireless Access Policy
 - e. Remote Access Policy
 - f. Automatic Logoff Policy
- B. The implementation of the aforementioned policies will ensure that access to ePHI and its associated applications, systems, and networks are appropriately secured and controlled.
- C. MSDH will control access to its information assets and systems. Only individuals that have been formally authorized to view or change confidential information will be granted access to that information.
- D. Everyone that accesses confidential information via computer at MSDH will be granted some form of unique user identification, such as a login ID. At no time will any workforce member allow

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anyone else to use their unique ID. Likewise, at no time will any workforce member use anyone else's ID.

- E. MSDH will establish an Emergency Access Procedure for gaining access to confidential information during an emergency. Extraordinary care in safeguarding and documenting the use of the information will be exercised during this procedure.
- F. Access to confidential information will be granted based on job roles or functions that the individual performs within the organization.
- G. MSDH will maintain procedures for automatic logoff of systems that contain confidential information after a period of inactivity. See Automatic Logoff Policy. The length of time that a user can stay logged on while idle will depend on the sensitivity of the information that can be accessed from that computer and the relative security of the environment that the computer is located.
- H. MSDH will evaluate and implement encryption and decryption solutions as an additional form of access control, where deemed reasonable and appropriate.
- I. MSDH will evaluate and implement additional procedural and technical control solutions as additional forms of access control, where deemed reasonable and appropriate according to MSDH's policies.

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Ensuring no other individual uses their unique ID
- Never using another individual's unique ID
- Abiding by the terms of this policy

The MSDH ITSO is responsible for:

- With the Office Directors/Supervisors and OHIT Director, ensuring workforce members have access to only the confidential information they need to do their jobs.
- With the OHIT Director, creating and maintaining role-based access control based on the roles and functions workforce members perform in the organization.
- With Office Directors/Supervisors and OHIT Director, ensuring each workforce member has a unique user ID for access systems that contain confidential information.
- Maintaining Emergency Access Procedures.
- With the OHIT Director, maintaining Automatic Logoff Procedures.
- With the OHIT Director, evaluating and implementing (when reasonable and appropriate) encryption and decryption solutions as a form of access control.

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11.6.2 Authorization and/or Supervision Policy

Purpose:

The purpose is to implement procedures for the authorization and/or supervision of workforce members who work with confidential information (such as protected health information (PHI)) or in locations where it may be accessed.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will implement security safeguards to ensure that all members of the workforce who have access to confidential information, including operations and maintenance employees, are authorized and supervised appropriately.

Procedure(s):

MSDH will implement security safeguards to ensure that all members of the workforce who have access to confidential information, including operations and maintenance employees:

- Need the access they have;
- Have the access they need;
- Understand the limits of access to confidential information, and
- Understand how to authenticate themselves to the system or application.

The criterion for determining authorization must comply with the requirements of the Information Access Management Policy.

Office Directors/Supervisors will provide input as to what members of their workforce shall have access to what confidential information in accordance with their workforce members' respective job duties. However, the ITSO and OHIT Director must approve all access requests.

- A. Office Directors/Supervisors will request appropriate system level access to ePHI and/or other confidential information based on job function using a Form 907. The ITSO and OHIT Director must review all requests and must give approval to grant access.
- B. Office Directors/Supervisors will require all new workforce members to complete the necessary training required by the agency to utilize MSDH IT resources.
- C. The ITSO and OHIT Director may restrict access to ePHI or areas that contain PHI, until access is deemed necessary.
- D. Upon approval of access by the ITSO and OHIT Director, OHIT Staff will grant access in accordance with the level approved by the ITSO and OHIT Director.

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Responsibilities:

The ITSO and OHIT Director, with the assistance of the Office Directors/Supervisors, are responsible for ensuring the implementation of requirements related to the Authorization and/or Supervision Policy. The activities may include:

- Supervision of some members of the workforce
- Proper access authorizations based on job roles or functions
- Clearance procedures
- Maintenance of access authorization records

11.6.3 Information Access Management Policy

Purpose:

The purpose is to implement policies and procedures for authorizing access to confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH members of the workforce are granted access only to that confidential information to which they are authorized in order to perform their job role or associated job function.

Procedure(s):

All members of the workforce will be trained on appropriate access to confidential information and on information access controls.

Safeguards, such as role-based access control, context-based access control, mandatory access control or discretionary access control, will be used as appropriate to control access to confidential information.

Responsibilities:

All individuals identified in the scope of this policy are responsible for ensuring that they obtain only the type and amount of confidential information necessary to carry out their assigned job role or function.

The ITSO and OHIT Director are responsible for:

- With the assistance of OHIT Staff and Office Directors/Supervisors, determining and granting the appropriate access to confidential information.
- With the Data Governance Director, leading activities that bring MSDH into compliance with legislative and regulatory requirements.

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11.6.4 Access Authorization Policy

Purpose:

The purpose is to implement policies and procedures for granting access to confidential information – for example, authorization required to access a workstation, transaction, program, process or other mechanism.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information (including, but not limited to, PHI).

Policy:

MSDH shall implement policies and procedures for granting access to confidential information including authorization required to access a workstation, transaction, program, process or other mechanism.

Procedure(s):

- A. Each individual’s job description must be reviewed to determine their individual rights and the rights of group(s) that the individual belongs to.
- B. The principle of least privilege and separation of duties shall be factors that influence the access rights granted to an individual or an entity. The fundamental principle of “need to know” will be applied within MSDH to determine access privileges.
- C. Access rights to confidential information will be granted only if an individual has a legitimate business need for the information or a legal right to it.
- D. A workforce member’s Officer Director/Supervisor will ensure that access rights to ePHI and/or other confidential information is requested based on the role or job description of the workforce member. Access rights to ePHI and/or other confidential information must be approved by both the ITSO and OHIT Director.
- E. The ITSO and OHIT Director must review assigned access and recommend modifications as deemed appropriate.
- F. Only the ITSO and OHIT Director will have full access rights to agency files and systems.
- G. The ITSO and OHIT Director will ensure that the fewest number of workforce members possible are given administrator level access to agency files and systems.

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- H. The ITSO and OHIT Director will ensure that access control is in place for the diagnostic equipment that contains ePHI.
- I. The ITSO and OHIT Director will evaluate any new information systems or equipment that maintains, stores, creates or transmits ePHI and will develop passwords, user ID/log-on and system privilege codes if appropriate.
- J. The ITSO and OHIT Director will ensure that access always requires at least a user ID and password for system level privileges. Additional security measures may be implemented at the ITSO and OHIT Director’s discretion. The ITSO and OHIT Director will periodically review user access to verify security measures are in place and working appropriately.
- K. OHIT Staff will ensure that all workforce members maintain the antivirus software and security patches by not allowing the user to disable the automatic update feature.
- L. In accordance with agency Privacy Policies, each MSDH workforce member shall agree to and sign a Confidentiality Agreement, Business Associate Agreement, and/or Data Use Agreement, as applicable, with respect to PHI.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring the implementation of this Access Authorization Policy.
- With the assistance of Office Directors/Supervisors, reviewing and approving the access rights of individuals to ascertain that they are aligned with the individual’s job role or function.

11.6.5 Access Establishment and Modification Policy

Purpose:

The purpose is to implement policies and procedures that, based upon MSDH access authorization policies, establish, document, review, and modify a user’s right of access to a workstation, transaction, program, dataset and/or process.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store or transmit confidential information.

This policy does NOT apply to access card/badge privileges.

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Policy:

MSDH will create and maintain access control lists (ACLs) and other access control-related capabilities to ensure that access is limited to approved rights.

Procedure(s):

Based upon the Mandatory Access Control (MAC) methodology chosen by MSDH, access shall be:

- Granted according to documented procedures;
 - Limited to that access which is required to perform the assigned job function;
 - Thoroughly documented;
 - Periodically reviewed by assigned data owners; and
 - Modified as required by role change or business need.
- A. ACLs and other access control-related capabilities shall be utilized to ensure that status changes, such as termination or change in job role, are reflected in rights granted or removed for individuals or entities.
- B. In most cases, modification or deletion of user access can only be done with appropriate authorization from the ITSO and OHIT Director. Requests to modify or delete user access must be initiated by the user's Officer Director or Supervisor. If modification or deletion of user access must be done in an emergency situation to avoid harm to another or unlawful release of confidential information, the CHDOR, Senior Deputy, or State Health Officer may authorize the change in access rights.
- C. In order to delete/modify network and/or phone access, the Supervisor/Office Director must inform OHIT (Terminations/Transfer Form (Form 866) and/or an Information Resource Access Request (Form 907E)) of any MSDH staff member (or former staff member) that is separated from employment or undergoing another applicable circumstance requiring deletion or modification of access. Any modifications or deletions of access must be approved by the ITSO and OHIT Director. If the change results in new, reduced or increased access, OHIT Staff will modify the password and system privileges for the appropriate applications and data.
- D. The ITSO and OHIT Director, with the assistance of Office Directors/Supervisors, will periodically review system access and make recommendations for modifying or deleting access or disabling inactive accounts. The periodic review is to ensure that access rights for each individual or entity are consistent with established policies and job roles and functions.
- E. Reasons for approved modifications or removal of access rights must be documented.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring the implementation of this Access Establishment and Modification Policy.
- With the assistance of Office Directors/Supervisors, reviewing the access rights of individuals to ascertain that they are aligned with the individual's job role or function.

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11.6.6 Person or Entity Authentication Policy

Purpose:

The purpose is to implement procedures to verify that the person or entity seeking access to confidential information is the one claimed.

This policy sets a minimum acceptable level of authentication for users or entities at MSDH.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will evaluate authentication mechanisms to verify that a person, system, or process is who they claim to be.

Procedure(s):

- A. MSDH recognizes that the use of passwords as an authentication method is inherently insecure and intends to use strong authentication solutions for workforce members that have access to confidential information where reasonable and appropriate. Strong authentication solutions use a combination of two or more factors (described below) when granting or denying access:
 - a. something you have (such as a smartcard)
 - b. something you know (such as a PIN)
 - c. something you are (such as a fingerprint)
- B. Every MSDH workforce member will be required to at least have a unique user ID and password for authentication when accessing assigned agency hardware, networks, systems, devices, etc.
- C. The ITSO and OHIT Director shall continually evaluate both hardware and software authentication mechanisms such as tokens, key fobs, smart cards or biometrics.
- D. The ITSO and OHIT Director will implement an appropriate technology that is:
 - d. Technically sound and useable,
 - e. Financially reasonable, and
 - f. Meets business objectives.
- E. MSDH will give strong authentication preference to users that pose a higher risk to the organization. High risk users include (but are not limited to):

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- a. Users that have administrator rights to systems that contain confidential information
 - b. Users that connect to the network remotely
 - c. Users that have portable computing devices, such as laptops, that may be carried off the premises
- F. All workforce members that use passwords must make efforts to keep those passwords safe and secure.
- G. If a password is suspected to have been compromised (or if anyone requests or demands a password), it shall be treated as a security incident and reported to the ITSO, Privacy Officer, and any other individuals designated by MSDH in the Security Incident and Breach Procedures Policy.

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Using, as instructed, any authentication method required by the ITSO.
- Abiding by all requirements set forth for the protection of passwords at MSDH.

The ITSO and OHIT Director are responsible for:

- Evaluating and implementing strong (two-factor) authentication solutions when appropriate, while giving preference to high-risk users as described.
- Ensuring the password administration options of all software packages are set to reflect the password requirements outlined in the Password Management Policy.
- Monitoring compliance of the workforce with this policy and responding to any security incidents which may arise from it.

11.6.7 Electronic Signatures

Purpose:

The purpose is to establish a standard for the proper use of electronic signatures by MSDH workforce members when signing electronic records or documents in lieu of a physical signature on a physical record or document.

Policy: MSDH workforce members will be allowed to utilize electronic signatures to officially sign agreements, forms, records and other documents as long as proper methods are in place to provide unique electronic signatures to each applicable workforce member, and workforce members are provided a mechanism to securely sign electronic records and documents with electronic signatures.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data. This policy governs all uses of electronic signatures utilized to conduct the official business of MSDH. Such business shall include, but not be limited to, electronic communications, transactions, contracts, grant applications and other official purposes.

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Definitions:

1. Electronic signature: symbols or other data in digital form attached to an electronically transmitted document as verification of the signatory's intent to sign the document.
2. Electronic record: a record created, generated, sent, communicated, received, or stored by electronic means.

Procedure(s):

- A. The signatory must be uniquely identified and linked to the signature. Authentication of user names and secure passwords is accomplished by policies and procedures outlined in Section 6.6, Person or Entity Authentication Policy.
- B. The signatory must have sole control of the private key that was used to create the electronic signature.
- C. The signatory must be capable of identifying if accompanying data has been tampered with after the message was signed.
- D. In the event that the accompanying data has been changed, the signature must be invalidated .
- E. Signature required by policy
 - a. Where an MSDH policy requires that a record or document have the signature of a responsible person, that requirement is met when the electronic record or document has associated with it an electronic signature using an approved electronic signature method.
 - b. Where an MSDH policy requires a written record or document, that requirement is met when an electronic record or document has associated with it an electronic signature using an approved electronic signature method.
- F. Signature required by law
 - a. Where there is a legal requirement, beyond MSDH policy, that a record or document has the signature of a responsible person, that signature requirement is met when the electronic record or document has associated with it an electronic signature using an approved electronic signature method.
 - b. Where a legal requirement, beyond MSDH policy, requires a written record or document, that requirement is met when an electronic record or document has associated with it an electronic signature using an approved electronic signature using an approved electronic signature method.
- G. The signing of a record or document using an approved electronic signature method does not mean that the record or document has been signed by a person authorized to sign or approve that record or

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document. Appropriate procedures must be used to confirm that the person signing the record or document has the appropriate authority.

H. OHIT will ensure the provision of a mechanism for MSDH workforce members to securely apply electronic signatures to electronic records and documents.

Responsibilities:

All workforce members with signing privileges are responsible for understanding and following this policy and the procedures associated with it.

OHIT is responsible for providing a secure mechanism to allow for the use of electronic signatures in accordance with this policy and procedures associated with it.

11.6.8 Unique User Identification Policy

Purpose:

The purpose is to assign a unique name and/or number for identifying and tracking user identity.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will ensure that everyone who accesses confidential information, such as ePHI, at MSDH will be granted some form of unique user identification, such as a login ID.

Procedure(s):

- A. OHIT Staff will assign a unique user ID and temporary password after receiving a request from the Office Director or Supervisor. The workforce member given the new user ID will be tasked with developing a new password in accordance with the Password Management Policy.
- B. At no time will any workforce member allow anyone else to use their unique ID. Likewise, at no time will any workforce member use anyone else's ID.
- C. MSDH will develop a standard convention for assigning unique user identifiers.
- D. MSDH will maintain a secure record of unique user identifiers assigned.
- E. MSDH will seek to create unique, individual accounts for privileged access with similar access rights so that activities may be tied to a single individual.

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- F. It may be necessary to modify a user’s ID due to duplicate names with the naming convention in place. OHIT Staff will handle this on an as-needed basis.
- G. Upon a legal name change, it will be up to the discretion of OHIT Staff to modify the ID.
- H. MSDH workforce members must only use agency-approved mechanisms for access to ePHI and a separate ID and password may be required to access ePHI.
- I. The vendor that supplies access to ePHI may utilize a single sign-on system, if MSDH deems it appropriate for use.
- J. MSDH access to vendor ePHI shall be role-based with a system of roles agreed to by the ITSO, OHIT Director, Office Director and vendor staff.
- K. MSDH will track individual activities and record events as required by policies such as the Audit Controls Policy.
- L. MSDH will minimize the use of generic accounts.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of the requirements of this Unique User Identification Policy.

11.6.9 Password Management Policy

Purpose:

The purpose is to implement procedures for creating, changing and safeguarding passwords.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH will implement procedures and training to ensure that all members of the workforce, including privileged users and IT administrators, create secure, complex passwords, modify those passwords on a periodic and regular schedule, and safeguard their passwords appropriately.

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Procedure(s):

- A. MSDH workforce members are ultimately responsible for safeguarding their own passwords. Any actions taken by a user logged in with the MSDH workforce member's login ID are considered to be actions that the MSDH workforce member either performed or authorized the performance of on their behalf.
- B. MSDH staff must not disclose their passwords to anyone including other staff members (MSDH staff must not tape their passwords to their computer screens, laptops, or the bottom of their keyboards). This is considered a breach of security.
- C. The ITSO and OHIT Director will ensure that password protection is in place on all equipment used by MSDH.
- D. As necessary, OHIT Staff will assign every workforce member a unique user ID and temporary password that must be changed at the first log-in.
- E. In most situations, passwords will be required to be changed every sixty (60) days for all MSDH workforce members unless otherwise directed more or less frequently (e.g., BYOD Policy) or a waiver is granted by the ITSO. All administrator passwords will be changed annually and/or when a workforce member with administrative password knowledge has left or been terminated.
- F. In case of termination or Office transfer, OHIT Staff will reset the user's password.
- G. If a workforce member does disclose, either on purpose or by accident, their password to anyone, it is the workforce member's responsibility to immediately change their password to something sufficiently different so as to prevent someone else's actions being attributed to the staff member (i.e. someone else uses the staff member's login ID). An OHIT Staff person also has the right to change the password if he/she becomes aware of the unauthorized password disclosure before the original workforce member changes the password themselves.
- H. The ITSO and OHIT Director will require strong password policy to be enabled at all levels of network access at MSDH.
- I. Each of the following requirements must be met for any password created by/for an MSDH workforce member to protect an application, software, profile, workstation, account, data and/or other tool utilized for work purposes:
 - a. Be at least eight (8) characters long, but no longer than fifteen (15).
 - b. Letters (both uppercase and lowercase).
 - c. Numerals.
 - d. Symbols (all characters not defined as letters or numerals)! @ # \$ % ^ & .
 - e. Be significantly different from prior passwords.
 - f. Not contain 4 consecutive characters used from the previous password
 - g. Not contain your name or user ID, or agency name.

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- h. Not be a common name/word.
- i. Example of a strong password using an acronym and symbols: “April showers bring May flowers in 2005” = !AsbMfN2005\$

J. MSDH requires that:

- a. All Administrator-level passwords must be part of the global password management database.
- b. User accounts that have system-level privileges must have a unique password from all other accounts held by that user.
- c. Passwords must not be inserted into email messages or other forms of electronic communication.

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Not sharing their passwords with anyone, including administrative assistants or secretaries.
- Treating all passwords as confidential information.

The ITSO and OHIT Director are responsible for:

- Ensuring the implementation of this Password Management Policy.
- At their discretion, authorizing periodic password cracking or guessing and requiring any identified passwords to be changed by the user.

11.6.10 Log-In Monitoring Policy

Purpose:

The purpose is to implement procedures for monitoring log-in attempts and reporting discrepancies.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH will configure all critical components that process, store, maintain, or transmit confidential information to record log-in attempts – both successful and unsuccessful – as well as when automatic lock-outs occur after so many unsuccessful log-in attempts.

Procedure(s):

A. The ITSO and OHIT Director will enable all applicable log-in monitoring systems.

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- B. The ITSO and OHIT Director will enable intruder lock-out after five (5) unsuccessful log-in attempts due to incorrect ID or password. Administrative accounts will lock-out after three (3) unsuccessful log-in attempts.
- C. OHIT Staff will review successful log-in by workforce members during non-business hours. Suspicious activity must be reported to the ITSO and OHIT Director. The information provided must address the steps for checking last log-in information.
- D. OHIT Staff must report log-in attempts by terminated workforce members to the OHIT Director and ITSO via the Security Incident policies and procedures.

Responsibilities:

The ITSO and OHIT Director are responsible for:

- Ensuring the implementation of this Log-in Monitoring Policy
- Identifying all critical systems that will record log-in attempts – both successes and failures
- Ensuring the regular monitoring of these logs by authorized individuals

11.6.11 Automatic Logoff Policy

Purpose:

The purpose is to implement electronic procedures that terminate an electronic session after a predetermined time of inactivity.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will maintain procedures for Automatic Logoff of systems that contain confidential information after a period of inactivity.

MSDH will configure systems that support automatic logoff to require logoff after a predetermined period of time.

Procedure(s):

- A. OHIT will activate an automatic logoff policy due to inactivity or idle time.
- B. The OHIT Director and ITSO shall test applications to ensure data integrity to all systems to prevent corruption of files or systems due to the automatic logoff procedure.

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- C. The length of time that a user may stay logged on while idle will be dependent upon the sensitivity of the information that can be accessed from that computer, the function of the activity, and the relative security of the environment that the system is located.
- a. Remote access will automatically log users off after two (2) hours of inactivity or idle time.
 - b. Local access will automatically log users off after six (6) hours of inactivity or idle time
- D. If systems do not support automatic logoff capabilities, MSDH will request those capabilities from the appropriate vendor and document all vendor responses in writing.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of this policy.

11.6.12 Workstation Use Policy

Purpose:

The purpose is to implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstation that can access confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

In addition, this policy applies to all workstations and other computing devices owned or operated by MSDH and any computing device allowed to connect to MSDH's internal network.

Policy:

MSDH will ensure that workstations and other computing devices with access to confidential information are being used for work-related purposes only.

All MSDH workstations will be utilized in a secure, approved manner, by authorized personnel only, and in such a way that the confidentiality, integrity, and availability of ePHI are not jeopardized.

MSDH will ensure that access is not permitted to MSDH workstations by individuals that are not authorized members of the MSDH workforce.

Procedure(s):

- A. Every MSDH workforce member will be held accountable for reviewing these workstation policies. MSDH may revoke the access rights of any individual at any time in order to protect or secure the confidentiality, integrity, and availability of confidential information or to preserve the functionality of electronic information systems.

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- B. To ensure those workstations and other computer systems that may be used to send, receive, store, or access ePHI are only used in a secure and legitimate manner, workforce members who use workstations and other computer systems to send, receive, store and access ePHI must comply with applicable MSDH policies.
- C. Workforce members who use MSDH information systems and workstation assets must have no expectation to privacy. To appropriately manage its information system assets and enforce appropriate security measures, MSDH may log, review, or monitor any data stored or transmitted on its information system assets.
- D. MSDH may remove or deactivate any workforce member's user privileges, including but not limited to:
- a. User access accounts
 - b. Access to secured areas
 - c. Any means necessary to preserve the integrity, confidentiality, and availability of its facilities, user services and data
- E. MSDH workforce members must be aware of the legal implications of their computer use.
- a. The Internet enables users to disseminate material worldwide. Thus, the impact of dissemination on the internet is often far broader than that of a statement made on paper or in routine conversation. MSDH workforce members must keep in mind that a larger audience means a greater likelihood that someone may object with or without legal basis.
 - b. Much of what appears on the internet is protected by copyright law regardless of whether the copyright is expressly noted. Users must generally assume that material is copyrighted unless they know otherwise and must not copy or disseminate copyrighted material without permission. Copyright protection also applies to much software, which is often licensed to MSDH with specific limitations on its use. Both individual users and MSDH may, in some circumstances, be held legally responsible for violations of copyright.
- F. Electronic mail will adhere to the same standards of conduct as any other form of mail. Agency workforce members must respect others they contact electronically by avoiding distasteful, inflammatory, harassing, or otherwise unacceptable comments. Distribution of unsolicited mail is inappropriate.
- G. While MSDH encourages respect for the rights and sensibilities of others, it cannot protect individuals against the existence or receipt of materials that may be offensive to them. Those who make use of electronic communications may come across or be recipients of material they find offensive or simply annoying.
- H. MSDH makes internet resources available to its workforce to assist in MSDH workforce member's educational, research, medical, service and related missions. These resources are generally available

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only for MSDH-related activities. MSDH does monitor the content of web pages and electronic communications. Under certain circumstances MSDH will take legal action against any workforce member who uses MSDH resources for personal gain or unlawful activities. Workforce members are responsible for all activity generated from his/her assigned property and will practice due diligence in protecting access rights to the property assigned to them.

- I. Network storage is available to its workforce to assist MSDH workforce member's storage needs. MSDH workforce must only store MSDH related files on the network. Back up will only be performed on network storage. Periodically, OHIT or the ITSO may scan the network for inappropriate files and remove them as needed without warning to the owner. Abuse of network storage may result in disciplinary action.
- J. **Whenever possible, confidential information must be stored in a secure virtual space, rather than on a hard drive or portable device or media. Hard drives or portable devices or media containing confidential information must be properly encrypted by OHIT.**
- K. Attempting to monitor or tamper with either the MSDH or another user's electronic communications, or reading, copying, changing, or deleting another user's files or software is prohibited. No workforce member shall place any device (software or hardware) on any MSDH electronic equipment that has the ability to intercept, copy, manipulate, or transmit information from one computer or system to another without the expressed permission of the ITSO. This includes and is not limited to disk copy utilities, key loggers, a Trojan horse, or any other form or method which will monitor or tamper with hardware, software, folders, files, or data. OHIT Staff shall be exempt from this while performing maintenance, diagnostic, or repair to MSDH equipment.
- L. MSDH will implement reasonable and appropriate measures to secure its computing devices that could be used to access confidential information. These measures will include, but are not limited to the following:
 - a. All user and administrator accounts must be protected by some form of authentication.
 - b. All users accessing MSDH's computing devices must have and use a unique user ID.
 - c. Procedures must be maintained that implement security updates and software patches in a timely manner.
 - d. Procedures must be maintained that keep anti-virus software on MSDH devices and machines up to date.
 - e. All unnecessary and unused services (or ports) must be disabled.
 - f. Measures must be taken to physically protect computers that are located in public areas and portable computers, such as laptops and smartphones, that could be removed from the premises.
 - g. Computers located in public areas will be situated as to block unauthorized viewing and/or will have screen savers that black out the screen. These computers will also have screen savers that automatically activate following a brief period of inactivity.

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M. Unless authorized to do so, workforce members are not allowed to procure or purchase hardware, software, applications, electronic media, and/or devices for the agency. This policy applies even if the workforce member uses his/her own funds without expectation of reimbursement.

Responsibilities:

The ITSO and OHIT Director will be responsible for ensuring the implementation of this policy.

11.6.13 Workstation Security Policy

Purpose:

The purpose is to implement physical safeguards for all workstations that access confidential information and to restrict access to authorized users.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

In addition, this policy applies to all workstations and other computing devices owned or operated by MSDH and any computing device allowed connecting to MSDH’s internal network.

Policy:

MSDH will implement physical safeguards for all workstations that access confidential information to restrict access to authorized users only.

Procedure(s):

All members of the workforce will be trained on the appropriate and authorized use of workstations as part of the security awareness training.

A. The ITSO shall be responsible for the assertion and retention of the “Warning” notice to pop-up during the boot-up session of every computer used in the agency. This warning notice shall state in whole or in part: “You are accessing a Mississippi State Department of Health (MSDH) computer System and/or Website. All activity on this System and/or Website may be monitored. All actions performed are subject to the MSDH Acceptable Use Policy, the State of Mississippi Enterprise Computer Security Policy, and all applicable federal, state, and local laws, rules, and regulations. Violations of any of the above referenced items may cause the offender to be subject to disciplinary action per the Mississippi State Personnel Board Policy and/or appropriate civil and legal action. By clicking OK to continue you accept these terms and conditions.”

B. Users must not store or post password information on the workstation or in an accessible location anywhere in its vicinity.

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- C. OHIT Staff shall employ a BIOS (hardware level) boot password on every computer. This can be set through the hardware setup utilities. Once defined, the machine will then require that password (which is not transmitted on any network) before the machine will boot.
- D. OHIT Staff upon initial setup shall, whenever possible, place all workstations to avoid unauthorized viewing from visitors or other workforce members. Office Directors and Supervisors will maintain this process for future moves and remodels. Workforce members should sit directly in front of the monitor and be able to see visitors as they approach. Workforce members shall turn off their monitor or minimize applications if their screen contains ePHI or other confidential information while addressing visitors. When leaving the workstation unattended for any period of time, MSDH workforce members must lock the workstation. During initial setup, the workstation will be labeled to identify function and location and assist with compliance with access control procedures.
- E. OHIT Staff will maintain all software updates and deploy them when testing has been completed. It is recommended that an update or patch management server be configured to track all systems and their current level of protection.
- F. OHIT Staff will enable computer policy that will automatically lock a user's workstation if idle or left unattended more than ten (10) minutes. All screen savers will be password protected.
- G. OHIT Staff will disable all unnecessary network or workstation services before deploying any computer to the MSDH workforce.
- H. Visitors, technicians, or maintenance personnel must be supervised while accessing any MSDH computer systems and must not be given unauthorized access to any ePHI or other confidential information. Supervision is not necessary if a contract stating so is in place with the visitor, technician, or maintenance personnel and/or the entity they are employed by.

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Using MSDH computing devices only for work-related purposes only.
- Following all procedures implemented by the ITSO related to this policy.

The MSDH ITSO and OHIT Director are responsible for:

- Maintaining procedures required to support this policy, and
- Supporting and ensuring compliance by workforce member

11.6.14 Workforce Security Policy

Purpose:

The purpose of this policy is to implement policies and procedures to ensure that all members of the workforce have appropriate access to confidential information and to prevent those workforce members who should not have access from obtaining access to confidential information.

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Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH shall ensure that members of the workforce as well as contractors and others are only accessing those systems and information to which they are authorized.

Procedure:

- A. Members of the workforce as well as contractors and others shall access only those systems and information to which they are authorized.
- B. Access will be provided in accordance with the Information Access Management Policy.
- C. The termination of any member of the workforce will result in the implementation of the activities identified in the Termination/Modification Procedures.
- D. All members of the workforce will be appropriately trained so they understand MSDH's policies related to accessing authorized information only.
- E. MSDH will continually assess potential risks and vulnerabilities to confidential information in its possession and develop, implement, and maintain appropriate security measures so that access is only provided to authorized members of the workforce and all such information access is restricted to the minimum necessary to accomplish their job role or function.

Responsibilities:

The ITSO, with the assistance of the OHIT Director, is responsible for determining the appropriate classification of information, such as confidential information, and maintains a list that details the type of access for each individual.

11.6.15 Workforce Clearance Procedure

Purpose:

The purpose is to implement procedures to determine that the access of a workforce member to confidential information is appropriate.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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Policy:

MSDH shall require that effective personnel screening processes be applied to allow a range of implementation, from minimal procedures to more stringent procedures, based on the results of the risk analysis performed.

Procedure(s):

- A. MSDH requires that effective personnel screening processes are applied, from minimal procedures to more stringent procedures, based on the job role of the individual and the results of the risk analysis performed.
- B. Application and résumé information must be validated. This includes validation of information such as:
 - a. Whether the individual is restricted from working with PHI by the United States Office of the Inspector General (OIG);
 - b. Whether the applicant actually worked for the entities listed in his/her résumé during the time periods provided;
 - c. Whether the applicant has the academic credentials they claim to have; and
 - d. Whether the applicant has received the recognition/awards they claim to have received.
- C. Additional screening must be performed, including:
 - a. Criminal background checks; and
 - b. Credit checks, where applicable and relevant for the position.
- D. All procedures will be consistent and in coordination with policies of the Office of Human Resources.

Responsibilities:

The HR Director and ITSO are responsible for ensuring the implementation of the requirements of the Workforce Clearance Procedure.

11.6.16 Facility Security Plan

Purpose:

The purpose is to implement policies and procedures to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

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Policy:

MSDH will develop a Facility Security Plan to safeguard facilities and premises from unauthorized physical access, tampering or theft including the equipment present in all such facilities.

All equipment that collects, stores, maintains, processes, or transmits ePHI will always be protected from unauthorized access.

Procedure(s):

A. Facility Security Plan will:

- a. Define the security perimeter of all buildings and sites.
- b. Ensure that all external doors are adequately secured against unauthorized access by installing locks, alarms, or other access control devices.
- c. Be reviewed (and, if necessary, updated) at least annually.

B. Facility access will be maintained and operational to all staff during normal business hours; access otherwise will be permitted on an as-needed basis.

C. Door locks, access systems, and alarms are kept in working order with minimal down time.

D. The OHIT Director will maintain a detailed database of all individuals with badges/cards to MSDH facilities, and to which facilities they have them. The ITSO and HR will have access to this database for review.

E. MSDH will ensure that adequate fire protection exists for all facilities.

F. Alarm codes must be changed routinely but no less than annually.

G. Every member of the DRT will have access to the Disaster Recovery Site. The ITSO and OHIT Director will have access to Disaster Recovery Site for periodic maintenance and testing.

H. Building Security

- a. Internally, within buildings and facilities, whenever possible, offices containing confidential information must be locked by default.
- b. Intrusion detection capabilities must be evaluated to secure privileged internal areas.
- c. Whenever feasible, physical barriers should be in place from the floor to the ceiling.
- d. Controls need to be deployed to protect against theft, as well guard against fire, water or other damage. To the extent possible, power and communications cabling must be located underground.

I. Report Damages to IT Assets

- a. Immediately report any break-ins, thefts, or tampering—suspected or actual—that affect IT assets or confidential information to:
 - a. Central Campus: Director of Facilities and Property Management, who then notifies the Chief Administrative Officer, who then notifies the Office of the State Health Officer (OSHO)

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- b. County Facilities: Regional Management, who then notifies the Field Services Director, who then notifies OSHO
- c. WIC Facilities: WIC Program Director, who then notifies the Health Services Director, who then notifies OSHO
- b. OSHO notifies the ITSO and OHIT Director, and, as a standing agenda item on its monthly meetings, the Information Security Management Council (ISMC).
- c. Report to law enforcement, if necessary.
- d. The ITSO investigates the matter and reports his/her findings to the ISMC.
- e. The ISMC makes recommendations for improvements with follow-up required.

J. Access to OHIT Offices and Data Centers

- a. Only authorized individuals have access to the OHIT offices and data centers.
- b. OHIT Staff is responsible for securing access to all network equipment and offices.
- c. Doors to certain designated OHIT offices are always locked, even when OHIT Staff members are present.
- d. LAN rooms, wiring closets, access control system, and alarm controls will be kept behind locked doors whenever possible.
- e. Equipment available for check-out will be kept in locked cabinets while not in use.

Responsibilities:

In consultation with MSDH senior management, HR, OHIT and the ITSO will be responsible for ensuring the implementation of the requirements of the Facility Security Plan as well as reviewing and updating the plan as necessary.

11.6.17 Facility Access Controls Policy

Purpose:

The purpose is to implement policies and procedures to limit physical access to MSDH's electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will conduct activities to ensure compliance with the Facility Access Control standard and its associated implementation specifications: Contingency Operations, Facility Security Plan, Access Control and Validation Procedures, and Maintenance Records.

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MSDH will limit physical access to all facilities, systems, and devices that collect, store, maintain, process, or transmit confidential information to only those members of the workforce who have authorization to access them.

Procedure(s):

- A. MSDH will safeguard facilities and equipment from unauthorized physical access, tampering and theft.
- B. MSDH will continually assess potential risks and vulnerabilities to confidential information and develop, implement, and maintain appropriate safeguards to ensure compliance with the requirements of the impacted regulation.
- C. All repairs and modifications to the physical components of the facility shall be documented and maintained by the ITSO, Property Management Office, and/or OHIT.
- D. All repairs and maintenance, including installation, of hardware and software will be documented and maintained by the ITSO, Property Management Office, and/or OHIT.
- E. The Facility Security Plan shall be reviewed and updated (as needed) at least once every quarter.
- F. Maintenance of all hardware and software will be reviewed on an annual basis.
- G. The security attributes of all hardware and software must be tested on an annual basis.

Responsibilities:

The ITSO, with Property Management and/or OHIT, will be responsible for ensuring the implementation of the requirements of the Facility Access Control standard and its associated implementation specifications: Contingency Operations, Facility Security Plan, Access Control and Validation Procedures, and Maintenance Records.

11.6.18 Access Control and Validation Procedures

Purpose:

The purpose is to implement procedures to control and validate a person’s access to facilities based on their role or function, including visitor control, and control access to software programs for testing and revision.

To ensure that workforce members can access the information that is appropriate and required in their positions and that all other office and patient information remains confidential.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will configure facility access controls to validate all access by members of the workforce to facilities and systems. Access controls will be enforced to ensure that the only access to confidential information is by authorized members of the workforce.

Procedure(s):

- A. Facility access to MSDH offices by workforce members shall be managed by HR and controlled by a card/badge access system. OHIT will manage the card/badge database and enable/limit each agency workforce member's access through the card/badge system as needed.
- B. With consultation from their respective Office Directors/Supervisors, badge/card access rights will be granted by HR to MSDH workforce members based on their respective job functions. The ITSO and OHIT must approve decisions on badge/card access rights if it concerns access to electronic confidential information. OHIT shall maintain a database of these individuals and issue badges/cards as needed. The ITSO and HR must have access to this database.
- C. Regional Office access will be controlled by the supervisor of each office. The supervisor, through HR, will distribute keys/badges as needed and OHIT will maintain a database of which individuals have keys to the facility. The ITSO and HR must have access to this database. The ITSO and OHIT must approve decisions on badge/card access rights for regional offices if it concerns access to electronic confidential information.
- D. When a workforce member's job responsibilities change and such a change involves access to electronic confidential information, HR, OHIT, and the ITSO, with the assistance of a workforce member's Office Director/Supervisor, will determine if such will require a modification in facility access rights. If so, the workforce member's badge/card will be modified to fit his/her new job responsibilities.
- E. No visitor will be given unrestricted access to any facility or computer system operated or occupied by MSDH.
 - a. All visitors must sign-in and establish their identity before access to any part of MSDH offices and must be escorted to and from their destination.
 - b. Unless a contract is in place saying otherwise, all repair personnel must be supervised and escorted throughout the facilities for the duration of repairs. Once all work has been completed, an integrity check of the completed work must be performed.
 - c. The visitor's identity must be verified by checking a government issued-photo ID card.
 - d. The visitor must be given a badge/label that clearly identifies the individual as a visitor.
- F. This policy will be implemented in conjunction with the Computer, Network, System and Device Maintenance Records Policy, as applicable.

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Responsibilities:

The ITSO, OHIT Director, HR, and Property Management will be responsible for ensuring the implementation of the requirements of the Access Control and Validation Procedures.

11.6.19 Termination/Modification Procedures

Purpose:

The purpose is to implement procedures for quickly, securely and completely terminating or modifying access to confidential information when the employment of a workforce member or other arrangement ends or rights of access are altered.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH must terminate or modify, as necessary, access to systems and facilities when any member of the workforce or entity MSDH has other arrangements with has been terminated, no longer requires access to information or facilities in order to perform their assigned job role, or needs their access rights modified to perform new or additional responsibilities.

Procedure(s):

- A. The Office Director, Supervisor, and/or HR will review the circumstance(s) requiring termination to assess whether the workforce member should be terminated or job responsibilities officially changed.
- B. When a workforce member is terminated or official job duties modified, HR and the applicable Office Director/Supervisor are responsible for initiating the removal of the staff member (or former staff member) from all physical and technical access to MSDH depending on the termination or modification. This includes, but may not be limited to, submitting a Terminations/Transfer Form (Form 866) and/or an Information Resource Access Request (Form 907E). Upon approval from the OHIT Director and ITSO, OHIT Staff should immediately remove or modify the workforce member's user ID, passwords, and system privileges, and document actions taken. If the termination/modification is of an urgent concern, HR, the Chief of Health Data, Operations and Research (CHDOR), Senior Deputy or State Health Officer can contact OHIT Staff for necessary procedures to be implemented.
- C. In the case of a need for an immediate termination to protect data and/or other property of the agency at risk, the CHDOR or ITSO may immediately change the access badge and/or security alarm access code and notify all existing workforce members of the new access code.
- D. If an access badge system is used, OHIT Staff must delete or modify the access badge access as necessary. Upon termination, the terminated workforce member must be required to return all keys

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in their possession to MSDH property. If access is modified, the workforce member must return or retain keys in their possession as directed.

- E. OHIT Staff will provide feedback to HR, the ITSO and OHIT Director on the success or failure of access termination/modification. Termination/modification of access must be verified, and segregation of duties must be applied to ensure immediate termination/modification of all applicable access rights including electronic and physical.
- F. If a workforce member's agency-provided items cannot be returned to MSDH for any reason, compensatory controls must be implemented.
- G. HR must remind the departing/transferring workforce member of his/her continuing responsibility to protect confidential information with which he/she has come in contact during his/her time in their prior position.
- H. HR and OHIT must update the job responsibility with respect to logs that are maintained of workforce members and their access. The ITSO and OHIT will work with HR, Office Directors and Supervisors to update the workforce member access matrix as required.
- I. HR, the ITSO, OHIT, Office Directors and Supervisors must work together to ensure all necessary procedures are followed to successfully complete termination or modification of a workforce member.
- J. Upon completion of termination procedures, the former workforce member is not provided any access to their desk or office or, if provided, the access is limited and carefully supervised.

See Human Resources policies for further policies and procedures related to termination/modification of duties.

Responsibilities:

The ITSO, OHIT Director, Officer Directors, Supervisors, and HR are responsible for ensuring that all activities identified in this Termination/Modification Procedure policy occur.

11.6.20 Emergency Access Procedure

Purpose:

The purpose is to establish and implement as necessary authorized access to confidential information during an emergency.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH will establish an Emergency Access Procedure for gaining properly authorized access to confidential information, such as ePHI, during an emergency.

Procedure(s):

- A. MSDH will identify the necessary confidential information that would need to be obtained during an emergency. Such information will be consistent with that identified under Contingency Operations Policy.
- B. In the event a user has lost his/her authentication method, OHIT Staff will work with the user to grant access to the network.
- C. OHIT Staff will make every attempt possible to verify a user's identity before granting access to any system during an emergency.
- D. If in the event a user has lost his/her authentication method for accessing ePHI, the user shall contact their Office Director/Supervisor or OHIT Staff for assistance.
- E. If access is not available due to a disaster or temporary outage, the ITSO will activate the DRT with CHDOR approval. If necessary, the Disaster Recovery Plan or Contingency Operation Procedures will be activated.
- F. The configuration of emergency access controls will be consistent with approved authorizations.
- G. MSDH must test the emergency access controls to ensure availability and the appropriate restrictions.
- H. In the event of an emergency, a record will be maintained of systems accessed by unique individuals.

Responsibilities:

The ITSO will be responsible for ensuring the implementation of Emergency Access Procedure.

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11.7 SECURITY INCIDENTS & REPORTING\

11.7.1 Security Incident and Breach Procedures

Purpose:

The purpose is to thoroughly address security incidents, including breaches.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH must create processes for the identification, reporting, and timely response to real or potential violations of information security or a material breach of any part of MSDH’s security policy.

Procedures:

- A. MSDH must maintain procedures for identifying security incidents. A security incident, according to the HIPAA Security Rule, is an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- B. Under the HIPAA Breach Notification Rule, a breach is defined as the unauthorized acquisition, access, use, or disclosure of protected health information in a manner not permitted under HIPAA or any other federal or state law, which compromises the security or privacy of such information. A breach is a type of security incident.
- C. Incidents will be designated as “serious” or “non-serious.” **Non-serious incidents** generally have the following characteristics:
 - a. It is determined that there was no malicious intent (or the attack was not directed specifically at MSDH); and
 - b. It is determined that no confidential information was used, disclosed, or damaged in an unauthorized manner.
- D. **Serious incidents** generally have the following characteristics:
 - a. It is determined that there was malicious intent and/or an attack directed specifically at MSDH
 - b. It is determined that confidential information, including ePHI, may or has been used, disclosed, or damaged in an unauthorized manner or that this incident may constitute a data breach.
- E. As soon as possible, workforce members of MSDH must report any suspected security incident to their respective Supervisors, the Privacy Officer (PO), and the ITSO. An email will also be sent to

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the PO, ITSO, and IT.Security@msdh.ms.gov to memorialize the report. (NOTE: Suspicious emails must NEVER be forwarded or responded to.)

- F. Workforce members will not disclose the incident information to anyone other than their Supervisor, the ITSO, PO, and any other individuals designated by MSDH, and will not disclose any information about the incident to anyone or in any place outside of MSDH.
- G. MSDH will maintain procedures for responding to security incidents in order to prevent the escalation of the incident and to prevent future incidents of a similar nature.
- H. Incidents characterized as serious by the ITSO and PO will be responded to immediately and reported to all upper-level management.
- I. MSDH will attempt to mitigate any harmful effects, when possible, of security incidents and breaches that affect patient information.

Responsibilities:

All individuals, groups, and organizations identified in the scope of this policy are responsible for:

- Staying aware of and identifying potential security incidents
- Reporting any suspected security incident to their Supervisor, the ITSO, the PO, and any other individuals designated by MSDH
- Assisting the ITSO in ending the security incident and mitigating its harmful effects, if possible

The ITSO and PO are responsible for:

- Maintaining all security incident-related policies and procedures
- Characterizing all reported security incidents as “serious” or “non-serious” as per the guidelines outlined above. The ITSO and PO may take into account their professional expertise and experiences when making these characterizations.
- Maintaining procedures for responding to security incidents.
- Documenting all reported security incidents and their outcomes.
- With the assistance of the Data Governance Director, leading activities that bring MSDH into compliance with regulatory requirements.

The ITSO and other members of management are jointly responsible for:

- Mitigating, to the extent possible, any harmful effects of security incidents
- Deciding when it is appropriate to contact law enforcement officials about a security incident that has been characterized as serious

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11.7.2 Security Incident Response and Reporting Policy

Purpose:

The purpose is to identify and respond to suspected or known security incidents (including breaches); mitigate, to the extent practicable, harmful effects of security incidents that are known to MSDH; and document security incidents and their outcomes.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will:

- Identify, research, and respond to any suspected security incidents, including breaches;
- Mitigate, to the extent practicable, any harmful effects of any suspected or actual security incidents; and
- Maintain appropriate documentation for all security incidents.

Procedures:

If the security incident constitutes a breach of ePHI, immediately follow the instructions in the Data Breach Discovery Policy.

This Response and Reporting policy addresses the following seven steps:

1. Prepare for a Security Incident
2. Detect and Report Security Incidents
3. Assemble the Incident Response Team
4. Limit Further Damage
5. Gather Evidence
6. Fix the Damage
7. Analyze the Incident

Step 1: Prepare for a Security Incident

Every network may at some point be a victim of a computer security incident. System and network administrators must be prepared for security incidents and be able to respond quickly to minimize and repair the damage. Some critical steps that must be addressed are:

- Identify the Incident Response Team (IRT).
- Acquire specialized security training.
- Verify the deployment of Intrusion Detection Systems (IDS).
- Verify Data Backup Plan and its implementation.

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The key is to be prepared so that in the event of a security incident the response is swift and comprehensive in resolving the damage.

Step 2: Detect and Report Security Incidents

- MSDH workforce members will report suspected, attempted, or actual security violations, both physical and technical, to their Supervisor, the ITSO, Privacy Officer, and any other individuals designated by MSDH. An email will also be sent to the Privacy Officer, ITSO and IT.Security@msdh.ms.gov to memorialize the report. (NOTE: Suspicious emails must NEVER be forwarded or responded to.)
- The ITSO will review any incident report the same day of receipt.
- The ITSO, with the assistance of other staff with relevant expertise, will activate the contingency planning procedure, the sanction procedures, or other relevant procedures.
- All workforce members will be made aware of the procedure for reporting security incidents and should be required to report such incidents as quickly as possible.
- Suitable feedback processes should be implemented to ensure that those reporting incidents are notified of results after the incident has been dealt with and closed.
- These incidents can be used in user awareness training as examples of what could happen, how to respond to such incidents, and how to avoid them in the future.
- All users of information services should be trained to note and report any observed or suspected security weaknesses in, or threats to, systems or services. Users should be informed that they must not, in any circumstances, attempt to prove a suspected weakness. This is for their own protection, as testing weaknesses might be interpreted as a potential misuse of the system.
- Procedures will also be established for reporting malfunctions such as those related to software, hardware or any other type.

Step 3: Assemble the Incident Response Team (IRT)

The IRT must include at a minimum:

- ITSO – Chairman
- Privacy Officer – Vice Chairman (takes lead if ITSO is unavailable or if incident does not involve ePHI or other electronic confidential information)
- Senior Deputy
- Chief of Health Data, Operations and Research
- Director of Data Governance
- Director of OHIT
- Director of Policy Evaluation
- Director of Communications
- Legal representative

Whenever an incident is reported, the IRT will promptly investigate the incident and lead all efforts to mitigate further damage, gather evidence, and take measures to limit the risk of further incidents.

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Step 4: Limit Further Damage

Once the initial data has been collected, immediate steps need to be taken to minimize the spread of the damage. These steps may include:

- Disable Internet access.
- Disable file servers, email servers, communication devices and other systems.
- Isolate impacted workstation(s), if possible, and stopping their use.
- Users must not attempt to remove the suspected software unless authorized to do so.
- If equipment is to be examined, disconnect it from any organizational networks before being examined. Portable media must not be transferred to other workstations and systems must not be powered off unless absolutely necessary.
- In the event a violation has occurred, all data will be restored and integrity checked, if applicable.

- The OHIT Director, ITSO, PO and Data Governance Director will update all procedures, software and hardware to ensure that security measures are enhanced to prohibit future violations, as needed.

At a minimum, if the violation involves the release of electronic confidential information, the ITSO, with assistance from the OHIT Director and PO if available, must immediately consider a response that includes:

- Disconnecting the affected system from the network (should not remove power from the system)
- Determining if the incident is accidental or intentional
- Identifying all system-related information such as:
 - Hardware address
 - System name
 - IP address
 - Confidential data processed by the system
 - Applications installed on the system
 - Location of the system

Step 5: Gather Evidence

The IRT must gather all possible evidence to fully understand the type of attack and its scope. The team needs to address questions such as:

- How many systems are impacted?
- What levels of privileges were accessed?
- How widespread is the vulnerability?
- How far into the internal systems did the intruder get?
- Which systems have been compromised?
- Any risk to confidential information stored by systems?

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All the information collected must be thoroughly documented and reported. Dedicated systems should be used for incident analysis and forensics. The involved personnel should be trained in the use of such applications.

Step 6: Fix the Damage

Having gathered all the evidence, the IRT must lead eradication efforts.

- Appropriately trained and experienced staff authorized by the IRT should carry out recovery activities.
- Malicious files should be deleted, removed or replaced.
- User accounts and associated passwords may need to be modified or re-created – if there was any evidence of unauthorized access.
- Data may need to be restored from trusted backups.
- After the impacted systems are cleaned and protected, they may be brought back online.
- The team must monitor these systems and their infrastructure for other similar, subsequent incidents.

Step 7: Analyze the Incident

- The IRT should regroup to do a post-event debriefing.
- The objective of the debriefing is to assess the incident, the response, and identify any specific areas of concern. The team must have a full and complete understanding of the incident and how to prevent such incidents from occurring in the future.
- The team will conduct a review of mechanisms in place to enable the types, volumes and costs of incidents and malfunctions to be quantified and monitored. This information will be used to identify recurring or high impact incidents or malfunctions. This may indicate the need for enhanced or additional controls to limit the frequency, damage and cost of future occurrences, or to be considered in the security policy review process.
- Finally, there must be a formal disciplinary process for workforce members who have violated organizational security policies and procedures. Such a process can act as a deterrent to workforce members who might otherwise be inclined to disregard security procedures.

Responsibilities:

All individuals identified in the scope of this policy are responsible for:

- Immediately reporting any and all suspected violations of information security to their Supervisor, the ITSO, Privacy Officer, and any other individuals designated by MSDH. All incident reporting and response activities must be conducted strictly on a need-to-know basis.

The ITSO is responsible for:

- With the assistance of the PO, OHIT Director, and Data Governance Director, training all members of the workforce on appropriate reporting of security violations.
- With the PO and the rest of the IRT, determining the appropriate level of response to a security incident. All such responses must be in accordance with established policies and procedures.

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- With the PO and rest of the IRT, completing a Security Incident Report for each security incident with as much information as possible about the following:
 - Contact information of the person reporting the incident (name, phone, address, email)
 - Date and time of the incident
 - Detailed description of the incident
 - Any further information, such as unusual activities or individuals associated with the incident
 - Efforts to rectify damage caused by the incident

11.7.3 Data Breach Discovery and Response Policy and Procedures

Purpose:

The purpose is to assist workforce members of MSDH in identifying and responding to potential security breaches of protected information, such as Protected Health Information (PHI), personal information or other confidential information. Through proper education and preparedness, MSDH can better protect all of its confidential information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Definitions:

Breach: the acquisition, access, use, or disclosure of protected health information in a manner not permitted in a manner not permitted under HIPAA or any other federal or state law which compromises the security or privacy of the protected health information.

Unsecured Protected Health Information: PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of HHS in guidance.

Policy:

MSDH must employ policies, technology, and education to identify and respond to breaches.

Procedures:

- A. A breach shall be treated as discovered by MSDH on the first day the breach is known to MSDH or, by exercising reasonable diligence, should have been known to MSDH.
- B. If a breach of confidential information is discovered the person making the discovery will notify their Supervisor, the ITSO, Privacy Officer, and any other individuals designated by MSDH immediately. An email must also be sent to the Privacy Officer, ITSO, and IT.Security@msdh.ms.gov to memorialize the report. (NOTE: Suspicious emails must NEVER be forwarded or responded to.)

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- C. If a data breach is discovered at MSDH, the following steps will be followed in order to prevent further damage, assess the severity of the breach, and manage all associated breach-related activities.
- a. Once a breach has been identified, the ITSO will:
 - i. With the Privacy Officer, assemble the Incident Response Team (IRT) according to Security Incident and Breach Procedures Policy and agency Privacy Policies;
 - ii. The IRT will conduct a risk assessment. The assessment will consider at least the following factors:
 1. the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
 2. the unauthorized person who used the protected health information or to whom the disclosure was made;
 3. whether the protected health information was actually acquired or viewed; and
 4. the extent to which the risk to the protected health information has been mitigated.
 - iii. Develop a response according to the Security Incident Response and Reporting Policy and agency Privacy Policies;
 - iv. Review the breach details and develop an appropriate response to prevent further data leakage, and
 - v. Assess the details of the breach.
 - b. The ITSO, PO, and the IRT will manage all phases of the process once a breach has been identified.
 - c. The ITSO, PO, and the IRT will keep MSDH leadership apprised of the situation.
 - d. Priorities of the ITSO, PO, and the IRT will be:
 - i. Stopping the data leakage
 - ii. Mitigation of the weakness that was exploited
 - iii. Restoration of normal business
 - iv. Notification of persons and businesses impacted as deemed appropriate
 - e. The ITSO, PO and IRT will work with MSDH Legal and Data Governance to determine applicable state and federal laws that may be applicable to the incident, including but not limited to HIPAA, HITECH, and state breach notification laws.
 - f. Forensic analysis of the breach is to begin immediately upon determination of the breach, unless the ITSO deems a delay is appropriate, or additional forensic support is required.
 - g. All meeting minutes, technical documentation, and hand-written notes of the breach are to be compiled by the ITSO, PO or a designee within 72 hours of the closure of the breach.
 - h. Any systems that were compromised or targeted as part of an incident resulting in an investigation may be quarantined as determined by the ITSO and IRT.
 - i. Based upon the scope of the perceived threat, the ITSO, PO and IRT will notify local law enforcement, the FBI Jackson Field Office, or the FBI Internet Crime Complaint Center (IC3).
 - i. FBI Jackson Field Office: 601-948-5000
 - ii. FBI Internet Crime Complaint Center (IC3): <http://www.ic3.gov/default.aspx>.
 - j. All documentation related to the breach investigation, including the risk assessment, must be retained for a minimum of six (6) years.

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Responsibilities:

The Incident Response Team (IRT) is responsible for the proper management of the agency’s response to a security incident. When the incident involves electronic confidential information, the ITSO will lead the IRT response. If the incident does not involve electronic confidential information, the PO will lead the IRT response.

All workforce members are responsible for understanding and following all policies and procedures related to data and security breaches.

11.7.4 Data Breach Notification

Purpose:

The purpose is to provide guidance on the notification actions required following the discovery of a breach of protected information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data. More specifically, this policy applies to workforce members of MSDH that are responsible for the security of protected information.

Policy:

MSDH will notify persons and organizations that have been impacted by a data breach. Breach notification is necessary in all situations except those in which the covered entity or business associate, as applicable, demonstrates, through a risk assessment, that there is a low probability that the PHI has been compromised (or one of the other exceptions to the definition of breach applies).

Procedure(s):

- A. MSDH will notify persons and organizations that have been impacted by a data breach in accordance with HIPAA and HITECH standards as applicable, unless state law or regulations set more rigorous requirements.
- B. The ITSO and PO will work with MSDH Legal and Data Governance to determine state and federal laws that may be applicable to the incident; including but not limited to HIPAA, HITECH, and state breach notification regulations
- C. MSDH has the burden of proof for showing why breach notification was not required. Accordingly, MSDH must document why the impermissible use or disclosure falls under one of the exceptions under 45 CFR §164.402.
- D. The ITSO and PO will notify the MSDH Office of Communications prior to any public notices.

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- E. Notifications are to occur according to the requirements of HITECH Act for breaches of protected health information (no later than sixty (60) calendar days from the discovery of the breach) and applicable state breach laws.
- a. The time period for breach notification begins when the incident is first known, not when the investigation of the incident is complete, even if it is initially unclear whether the incident constitutes a breach as defined in the rule.
- F. Notifications may be delayed at the request of law enforcement agencies as part of their investigation process
- G. Notifications may be delayed to determine the scope of the breach and to restore the reasonable integrity, security and confidentiality of the impacted systems
- H. Notifications will be made at no charge to the impacted patients or organizations
- I. Method(s) of notification may vary according to the type of breach, severity of breach, and applicable laws and regulations
- J. For all breach notifications:
- a. Patients whose unsecured information has been breached must be notified within sixty (60) days of discovery, regardless of the number of records breached.
 - b. If participants need to be notified of any lost/stolen or compromised PHI, the Privacy Officer will ensure all affected individuals receive a notification letter. Written notification must be made to affected patients by mail. If MSDH determines notification requires urgency because of possible imminent misuse of unsecured PHI, notification may be provided by phone or other means, as appropriate, in addition to the methods already stated herein. Patients can receive notification by e-mail if they have agreed to it.
 - c. Business associates must notify covered entities about breaches.
 - d. If there is insufficient or out-of-date contact information that precludes written or electronic notification, a substitute form of notice reasonably calculated to reach the patient shall be provided. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then the substitute notice may be provided by an alternative form of written notice, by phone, or by other means. If there is insufficient or out-of-date contact information for ten (10) or more individuals, then the substitute notice shall be in the form of either a conspicuous posting for a period of ninety (90) days on the homepage of MSDH's website, or a conspicuous notice in major print or broadcast media in the geographic areas where the individuals affected by the breach likely reside. The notice shall include a toll-free number that remains active for at least ninety (90) days where an individual can learn whether his or her PHI may be included in the breach.

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- e. Breaches of over 500 affected MSDH patients must be reported to the Secretary of Health and Human Services (HHS).
- f. Breaches of less than 500 affected MSDH patients must be submitted as part of an annual breach log to the Secretary of HHS.
- g. In the event the breach affects more than 500 residents of a state, prominent media outlets serving the state and regional area will be notified without unreasonable delay and in no case later than sixty (60) calendar days after the discovery of the breach. The notice shall be provided in the form of a press release.

Responsibilities:

All workforce members are responsible for understanding and following all policies and procedures related to data breaches.

The ITSO and PO will work together with the IRT to ensure the agency fulfills its duties regarding breach notifications.

11.7.5 Data Breach Notification to the Secretary of HHS

Purpose:

The purpose is to provide guidance on when and how to notify the Department of Health and Human Services (HHS) following a breach of protected information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

More specifically, this policy applies to workforce members of MSDH that are responsible for the security of protected information.

Policy:

MSDH will notify persons and organizations that have been impacted by a data breach and require notification as determined by all applicable Data Breach Notification Policies and the agency Privacy Policies. This policy will serve as guidance to determine if, when and how the HHS Secretary is to be notified.

Procedure(s):

- A. To determine the time period in which the Secretary of HHS must be notified of the breach, the following must be considered:

Were more than 500 persons impacted by the breach?

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- a. YES: Notice to the Secretary of HHS will be provided at the same time notice is made to the affected individuals. These notices are given without regard to whether the breach involved more than 500 residents of a particular State or jurisdiction.
 - b. NO: Covered entity must maintain a log of any such breach occurring and annually submit such a log to the Secretary of HHS no later than sixty (60) days after the end of each calendar year.
 - c. IN ALL SITUATIONS, MSDH must maintain the internal log or other documentation for six (6) years and must make such information available to the Secretary upon request for compliance and enforcement purposes.
- B. If HHS must be informed, the following steps will be taken:
- a. The ITSO will work with the PO and the rest of the Incident Response Team (IRT) to develop and coordinate all communications to HHS.
 - b. HHS Office of Civil Rights (OCR) may be notified in the following ways:
 - i. For breaches affecting 500 or more individuals:
 - Online: https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true
 - Phone: 1-800-368-1019
 - TDD: 1-800-537-7697
 - ii. For breaches affecting 500 or fewer individuals:
 - Online: https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true
 - Phone: 1-800-368-1019
 - TDD: 1-800-537-7697

Responsibilities:

All workforce members involved in the breach notification process are responsible for understanding and following all policies and procedures related to data breaches.

The ITSO, PO, OHIT Director, and Data Governance Director are responsible for ensuring all workforce members understand and follow all policies and procedures related to data breaches.

11.7.6 Data Breach Notification to Individuals

Purpose:

The purpose is to provide guidance on when and how to notify the impacted patient(s) following a breach of protected information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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More specifically, this policy applies to workforce members of MSDH that are responsible for the security of protected information.

Policy:

MSDH will notify persons that have been impacted by a data breach in accordance with all applicable Data Breach Notification Policies and the agency Privacy Policies.

This policy will assist in determining if, when and how impacted patients are to be notified.

Procedure(s):

- A. The following steps will be taken to notify impacted patients following a breach of protected information:
 - a. How soon to notify: MSDH will notify impacted patients without unreasonable delay and in no case later than sixty (60) days after the discovery of the breach, or sooner if required by state law or regulation.
 - b. Who will notify: The ITSO and PO will work with the Incident Response Team (IRT) to develop and coordinate all communications.
- B. Methods of Notification
 - a. Letter via first class mail (or email if specified as preferred by the individual), to individual's last known address using MSDH's standard breach notification letter (if available).
 - b. If patient is deceased, then the above applies to their next of kin or personal representative.
 - c. Multiple notifications may be necessary as information becomes available.
 - d. If MSDH does not have sufficient contact information for some or all of the affected individuals, or if some notices are returned as undeliverable, such a situation requires a covered entity to provide substitute notice for the unreachable individuals.
 - e. The substitute form of notice will be reasonably calculated to reach the individuals for whom it is being provided.
 - i. If there are fewer than ten (10) individuals for whom MSDH has insufficient or out-of-date contact information to provide the notice, MSDH will provide substitute notice to such individuals through an alternative form of written notice, by telephone, or other means.
 - ii. If MSDH has insufficient or out-of-date contact information for ten (10) or more individuals, MSDH will provide substitute notice through either a conspicuous posting for a period of ninety (90) days on the home page of its web site or a conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.
 - iii. For either method involving ten (10) or more individuals, MSDH is also required to have a toll-free phone number, active for ninety (90) days, where an individual can learn whether the individual's unsecured PHI may be included in the breach and to include the number in the notice.

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- f. MSDH, with out-of-date or insufficient contact information for some individuals, can attempt to update the contact information so that they can provide direct written notification, in order to limit the number of individuals for whom substitute notice is required.
 - g. Where the individual affected by a breach is a minor or otherwise lacks legal capacity due to a physical or mental condition, notice to the parent or other person who is the personal representative of the individual would satisfy the requirements.
- C. All notifications to Individuals must contain the following items:
- a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
 - b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, disability code, or other types of information were involved).
 - c. Any steps affected individuals should take to protect themselves from potential harm resulting from the breach.
 - d. A brief description of what MSDH is doing to investigate the breach, to mitigate the harm, and to protect against any further breaches.
 - e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, Web site, and/or postal address.

Responsibilities:

All workforce members who are involved in the breach notification process are responsible for understanding and following all policies and procedures related to data breaches.

The ITSO, PO, OHIT Director and Data Governance Director are responsible for ensuring all workforce members understand and follow all policies and procedures related to data breaches.

11.7.7 Data Breach Notification to Media

Purpose:

The purpose is to provide specific guidance on when and how to notify the media following a breach of protected information.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

More specifically, this policy applies to workforce members of MSDH that are responsible for the security of protected information.

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Policy:

MSDH will notify persons that have been impacted by a data breach in accordance with all applicable Data Breach Notification Policies and the agency Privacy Policies. This policy will provide guidance in determining if, when and how the media is to be notified.

MSDH will notify the Media when required by and in accordance with state and federal regulations.

Procedure(s):

A. The following steps will be taken to determine if and how to notify the media following a breach of protected information:

Were more than 500 residents of a state or jurisdiction impacted by the breach?

- a. YES: Notice to prominent media outlets must be provided without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.
- b. NO: Notice to prominent media outlets is not required

B. If the media must be notified, the following steps will be taken:

- a. The ITSO and PO will work with the Incident Response Team (IRT) to develop and coordinate all communications.
- b. The media will be notified in the form of a press release.

C. All notifications to prominent media outlets must contain the following items:

- a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
- b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, disability code, or other types of information were involved).
- c. Any steps affected individuals should take to protect themselves from potential harm resulting from the breach.
- d. A brief description of what MSDH is doing to investigate the breach, to mitigate the harm, and to protect against any further breaches.
- e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, Web site, and/or postal address.

Responsibilities:

All workforce members involved in the breach notification process are responsible for understanding and following all policies and procedures related to data breaches.

The ITSO, PO, OHIT Director and Data Governance Director are responsible for ensuring all workforce members understand and follow all policies and procedures related to data breaches

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11.8 CONTINGENCY & EMERGENCIES

11.8.1 Applications and Data Criticality Analysis

Purpose:

The purpose is to assess the relative criticality of specific applications and data in support of other contingency plan components.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH shall assess the relative criticality of applications and data in support of the contingency and disaster recovery plans.

The relative criticality shall be documented and approved by executive management in order to establish the priority of recovery capabilities and activities.

Procedure(s):

- A. MSDH will identify critical applications and data via the risk analysis.
- B. "Critical" areas of the agency include:
 - a. Critical business functions
 - b. Critical infrastructure
 - c. Critical information or records
- C. The specific components of applications and data criticality analysis must include:
 - a. Network architecture diagrams and system flowcharts that show current structure, equipment addresses, communication providers and system interdependencies.
 - b. Identification and analysis of critical business processes surrounding confidential information.
 - c. Identification and analysis of key applications and systems used to support critical business processes.
 - d. A prioritized list of key applications and systems and their recovery time objectives.
 - e. Documented results of an analysis of the internal and external interfaces with key applications and systems.
 - f. Adequate redundancies within the network infrastructure to reduce or eliminate single points of failure.
 - g. Mitigating controls or work-around procedures in place and tested for single points of failure that are unable to be eliminated.

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- D. Upon identification, each application and data shall be prioritized and planned for recovery in the Disaster Recovery Plan.
- E. The ITSO, with the assistance of OHIT, will inventory necessary software and hardware for a planned recovery to ensure business continuity.

Responsibilities:

The ITSO will be responsible for ensuring the implementation of the requirements of Applications and Data Criticality Analysis.

11.8.2 Contingency Operations Policy

Purpose:

The purpose is to establish and implement as needed procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications, as well as all facilities, which process, store, maintain, or transmit confidential information.

Policy:

MSDH must ensure that protocols are in place to allow access to data in facilities by designated MSDH workforce members in the event of an emergency.

Procedure(s):

- A. MSDH must develop contingency operation procedures to address emergency response. Contingency Operations will be addressed in the Disaster Recovery Plan.

These procedures will include (but not be limited to):

- Notification
- Facility access
- Evacuation
- Equipment tests
- Training
- System shutdown

For example, the area of emergency notification procedures would include activities such as:

- Contacting the Emergency Response Team (ERT) Leader
- Contacting Department Managers as required

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- Evacuate the building if required
- Conduct a damage assessment
- Create damage assessment report and communicate to senior management
- Determine if the damaged site can be repaired and used
- Establish time objectives for activities

Responsibilities:

The ITSO will be responsible for ensuring the implementation of the requirements of this Contingency Operations Policy.

11.8.3 Contingency Plan Policy

Purpose:

The purpose is to establish and implement, as needed, policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain confidential information. Policies and procedures include ensuring uninterrupted computer system access in the case of an electrical failure.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH will develop, maintain, and test a contingency plan. The plan shall be routinely updated and include activities for responding to a system emergency including performing backups, preparing critical facilities, and appropriately detailed migration plans that can be used to facilitate continuity of operations in the event of an emergency and recovering from a disaster.

It is the policy of MSDH that the computer system be attached to a backup power source such as an emergency generator and/or uninterruptible power supply (UPS) in case of an electrical failure.

System configuration at MSDH's facility must be installed and attached to an adequately sized UPS (uninterruptible power supply).

Procedure(s):

MSDH will develop contingency plan documents and procedures to identify core activities in the areas of:

- Data Backup Plan;
- Disaster Recovery Plan;

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- Testing and Revision; and
- Applications and Data Criticality Analysis.

MSDH will develop and implement a contingency plan to ensure the confidentiality, integrity, and availability of confidential information during and after an emergency. The core objectives of contingency planning include the capability to:

- Restore operations at an alternate site (if necessary)
- Recover operations using alternate equipment (if necessary)
- Perform some or all of the affected business processes using other means

The contingency plan will be developed for the entire enterprise. The contingency plan must address IT system components such as:

- Local, wide area and wireless networks including Internet access (if critical to the operation of the business)
- Server systems such as file, application, print and database
- Web sites
- Security systems such as firewalls, authentication servers, and intrusion detection
- Desktop, laptop, end-user systems

MSDH will follow the recommendations of the National Institute of Standards and Technology (NIST) in the area of contingency planning. The NIST recommends following seven key steps to address the requirements of contingency planning:

1. Develop the contingency policy objective statement;
2. Conduct a Business Impact Analysis (BIA);
3. Identify preventive controls;
4. Develop recovery strategies;
5. Create the contingency plan;
6. Conduct testing and training; and
7. Review and maintenance.

MSDH will follow the following steps to meet contingency planning requirements.

Step 1: Contingency Policy Objective Statement

The first step in addressing the requirements associated with contingency planning is to very clearly define the contingency planning policy. The core objective of the policy statement is to establish the organizational framework and responsibilities for contingency planning. NIST recommends that the contingency policy address the following topics:

- Roles and responsibilities
- Scope of policy with respect to systems/platforms and organizations functions subject to contingency planning
- Resource requirements
- Training requirements
- Exercise and testing schedules

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- Plan maintenance schedule
- Frequency of backups and storage of backup media

Step 2: Business Impact Analysis (BIA)

One of the critical steps in contingency planning is Business Impact Analysis (BIA). BIA helps to identify and prioritize critical Information Technology (IT) systems and components. IT systems may have numerous components, interfaces and processes. BIA enables a complete characterization of:

- System requirements
- Processes
- Interdependencies

As part of the BIA process, information is collected, analyzed and interpreted. The information provides the basis for defining contingency requirements and priorities.

The objective is to understand the impact of a threat on the business. The impact of the threat may be economical, operational or both. Questionnaires or survey tools may be used to collect the information.

BIA is performed at the beginning of disaster recovery and continuity planning to specifically identify the areas that would suffer the greatest financial or operational loss in the event of a disaster or disruption.

Two key objectives are to:

- Identify all critical systems that are required for the continuity of the business and
- Determine the time it would take to recover such systems in the event of a loss.

The critical steps for BIA include:

- Identify critical business functions
- Identify disruption impacts and allowable outage times
- Develop recovery priorities

The BIA should be periodically reviewed for accuracy and updated to ensure the levels of impact have not changed.

Step 3: Preventive Controls

The BIA provides vital information regarding system availability and recovery requirements. It may be possible to mitigate some outage impacts identified in the BIA through preventive controls. The objective of preventive controls is to deter, detect, and/or reduce impacts to the system. Wherever possible, preventive controls are preferable to actions to recover the system after a disruption.

Step 4: Recovery Strategies

- The objective of recovery strategies is to restore IT operations quickly and effectively following a disruption. A critical focus is to provide access to all confidential information. Several factors will influence recovery strategy including cost, allowable outage time, security and integration with larger organizational-level contingency plans.

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- The choice for the recovery approach would depend on the incident, type of system and its operational requirements. Technologies such as Redundant Arrays of Independent Disks (RAID), automatic fail-over, Uninterruptible Power Supply (UPS), and mirrored systems should be considered when developing a system recovery strategy.

Step 5: Development of Contingency Plan

The contingency plan contains detailed roles, responsibilities, teams, and procedures associated with restoring critical systems following a disruption. The contingency plan will document technical capabilities designed to support contingency operations. The contingency plan will be tailored to the organization and its requirements.

Plans need to balance detail with flexibility; usually the more detailed the plan is, the less scalable and versatile the approach. The NIST identifies five main components of the contingency plan. They are:

- Supporting Information
- Notification/Activation Phase
- Recovery Phase
- Reconstitution Phase
- Plan Appendices

Step 6: Testing and Training

Testing of the plan is a critical element of a viable contingency capability. Testing enables plan deficiencies to be identified and addressed. Testing also helps evaluate the ability of the recovery Staff to implement the plan quickly and effectively. Each IT contingency plan element should be tested to confirm the accuracy of individual recovery procedures and the overall effectiveness of the plan. The following areas must be addressed in a contingency test:

- System recovery on an alternate platform from backup media
- Coordination among recovery teams
- Internal and external connectivity
- System performance using alternate equipment
- Restoration of normal operations
- Notification procedures.

Step 7: Review and Maintenance

To be effective, the plan must be maintained in a ready state that accurately reflects system requirements, procedures, organizational structure, and policies. IT systems undergo frequent changes because of shifting business needs, technology upgrades, or new internal or external policies. Therefore, it is essential that the contingency plan be reviewed and updated regularly, as part of the organization's change management process, to ensure new information is documented and contingency measures are revised if required. As a rule, the plan should be reviewed for accuracy and completeness at least annually or whenever significant changes occur to any element of the plan.

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Responsibilities:

The ITSO is responsible for leading activities that bring MSDH into compliance with regulatory requirements in contingency planning and in adhering to this policy.

11.8.4 Data Backup Plan

Purpose:

The purpose is to establish and implement procedures to create and maintain retrievable exact copies of confidential information in the event of equipment failure or damage.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH will create and maintain exact, retrievable copies of confidential information.

MSDH will ensure that confidential data is backed up on a regular basis to minimize the loss of data in the event of an incident or disaster.

MSDH will ensure that backup media is periodically tested to ensure suitable quality and reliable data restoration.

Procedure(s):

A backup schedule must include incremental backups each weekday, at different times of the day; full backups on weekends, and replication to the alternative operating facility.

- A. Backups of all MSDH data must be retained such that all systems are fully recoverable. This may be achieved using a combination of image copies, incremental backups, differential backups, transaction logs, or other techniques.
- B. The frequency of backups is determined by the volatility of data. The retention of backup copies is determined by criticality of the data. At a minimum, backups must be retained for 180 days.
- C. At a minimum, one fully recoverable version of all critical data must be stored in a secure, off-site location.
- D. All MSDH work related documents should be placed on networked file server drives to allow for backup. All mobile workstations or devices should copy work related documents to the network as

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soon as possible. Users will be responsible for removing ePHI from MSDH equipment after copying documents to the network.

- E. Backup documentation includes identification of all critical data, programs, documentation, and support items that would be necessary to perform essential tasks during a recovery period.
- F. Documentation of the restoration process must include procedures for the recovery from single-system or application failures, as well as for a total data center disaster scenario.
- G. Backup and recovery documentation will be reviewed and updated regularly to account for new technology, business changes, and migration of applications to alternative platforms.
- H. Recovery procedures must be tested on an annual basis.
- I. File restores will be tested on a monthly basis before the monthly tape is shipped for storage. Documentation will be kept as to file location, size before restore, after restore, and if file was able to be successfully accessed.
- J. OHIT Staff will maintain a backup for every day on individual media, properly labeled and easily identifiable
- K. OHIT Staff should perform the following backup procedures on the following schedule:
 - a. Monday = Differential
 - b. Tuesday = Differential
 - c. Wednesday = Cumulative
 - d. Thursday = Differential
 - e. Friday = Differential
 - f. Sunday = Full
 - g. Monthly = Full

Responsibilities:

The ITSO and OHIT Director will be responsible for implementing the requirements of the data backup plan.

11.8.5 Disaster Recovery Plan

Purpose:

The purpose is to establish and implement as needed procedures to restore any loss of data.

The Disaster Recovery Plan (DRP) applies to major, usually catastrophic, events that deny access to the normal facility for an extended period. A disaster recovery plan refers to an IT-focused plan designed to restore operability of the target system, application, or computer facility at an alternate site after an emergency.

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A disaster recovery plan provides a blueprint to continue business operations if a catastrophe occurs. The disaster recovery plan must include contingencies for the period of the disaster and until the recovery plan can be completely implemented. The price for not developing a disaster recovery plan is that MSDH may find it difficult to continue operations to the detriment of those the agency serves.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

This policy also applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH must develop and maintain a Disaster Recovery Plan. The ITSO will ensure the development of a Disaster Recovery Plan document.

Procedure(s):

- A. MSDH must develop a comprehensive Disaster Recovery Plan and establish a team to handle coordination of duties during a disaster. Team members will be individually identified in the Disaster Recovery Plan.
- B. The ITSO is to ensure the development of a Disaster Recovery Plan document. This document typically includes the following sections:
 - a. Purpose: a statement describing the goal of the disaster recovery plan.
 - b. Scope: identifies the specific locations/sites and critical systems that are a part of the disaster recovery plan.
 - c. Assumptions: identifies the foundation that the plan is based on.
 - d. Team: identifies the Team lead for the activity as well as members of the IT organization and others that will be involved in the disaster recovery process.
 - e. Notification: establishes the formal communication required to contact members to alert them of the situation.
 - f. Damage Assessment and Reporting: describes the process of analyzing the extent of damage to systems and sites and includes reports that identify recommendations for management.
 - g. Activation: describes the process to start disaster recovery activities.
 - h. Recovery Operations: describes the steps to recover critical systems and applications at the recovery site. This section would include information on data recovery based on the backed-up data.
 - i. Return to Normal Operations: describes the procedures for the full recovery of all data and a complete return to normal processing of all business functions.
- C. In the event of a disaster, the ITSO, CHDOR, State Health Officer and/or other designated MSDH Staff will coordinate duties with the Disaster Recovery Team (DRT) and assist in enacting the Disaster Recovery Plan.

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- D. The DRT members will store a copy of this Disaster Recovery Plan in a secure location. Failure to secure this document will constitute a breach in security. The Disaster Recovery Plan will be retained off-site in hard-copy form in a secure location, for immediate access. Another version may be retained off-site in Word format and PDF.
- E. At least once each year, the ITSO, with assistance from OHIT, must restore the full system backup on the Disaster Recovery equipment. The ITSO and OHIT must test and verify the validity of the restored network operating system and data. Additionally, the DRT will test the contingency plan in its entirety including the ability to locate key personnel, maintain communications locate and retrieve back up data and obtain alternate site access.
- F. In the event of a disaster or other situation requiring activating the Disaster Recovery Plan, the DRT will begin by assessing the circumstances. The ITSO, CHDOR, State Health Officer and/or other designated MSDH Staff shall activate the DRT if necessary. The assessment will determine if the situation is:
- a. A computer or information system failure that is temporary.
 - b. A computer or information system failure that will require an emergency mode operation.
 - c. A hazard or event that is temporary.
 - d. A hazard or event that will require an emergency mode operation

Responsibilities:

The ITSO will be responsible for implementing the requirements of the Disaster Recovery Plan.

11.8.6 Emergency Mode Operation Plan

Purpose:

The purpose is to establish and implement as needed procedures to enable continuation of critical business processes for protection of the security of confidential information while operating in an emergency mode, as defined below.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Further, the policy applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH ITSO must identify the levels of emergencies and associated responses. The ITSO must develop specific components of the Emergency Mode Operation Plan, maintain those components, and periodically test the plan.

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Procedure(s):

- A. Disaster Recovery Plan will document Emergency Mode Operation.

- B. The ITSO must identify the levels of emergencies and associated responses. This may be based on the magnitude of the incident or disaster. For example:
 - a. Level 1 Emergency may relate to a loss of business function or a specific part of a location/site.
 - b. Level 2 Emergency may be based on an incident impacting multiple business functions or multiple locations/sites.
 - c. Level 3 Emergency may be based on a significant disruption to several business functions or substantial damage at one or more locations/sites.

- C. The specific components of an emergency mode operation plan must include:
 - a. Identification of crisis management team members throughout the organization who will address strategic response of the organization in an emergency.
 - b. Identification of support team members who will address tactical response of the organization in an emergency.
 - c. Identification of a command center or other specifically designated facility to be utilized during emergency mode operation.
 - d. Process for acquisition of additional human resources with applicable skill sets if current human resources are geographically restricted.
 - e. Procedures and checklists to provide for the orderly transition and restoration of normal business operations (e.g., moving from the impacted site to the alternate site).
 - f. Coordination of available critical facilities for alternate processing and business workspace for continuing operations in the event of an emergency.
 - g. Communication plan for internal workforce members as well as external business partners, business associates, and other stakeholders that addresses essential issues (e.g., Human Resources, Business Status and Financial concerns).
 - h. Procedures to ensure that health and safety issues are addressed.

Responsibilities:

The ITSO will be responsible for implementing the requirements of the Emergency Mode Operation Plan.

11.8.7 Testing and Revision Procedures

Purpose:

The purpose is to implement procedures for periodic testing and revision of contingency plans.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

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This policy also applies to all systems, networks, and applications that process, store, maintain, or transmit confidential information.

Policy:

MSDH must ensure that all contingency and disaster recovery plans are tested and revised, as necessary, on a periodic basis, not to exceed annually.

Procedure(s):

- A. MSDH must periodically activate the Contingency and Disaster Recovery plans. Testing should have minimal impact on users. However, it may be necessary to shut down the main network and bring up the Disaster Recovery site. This should be done after-hours, on weekends, or on holidays, whenever possible.
- B. At least once each year, the ITSO, with assistance from OHIT, must restore the full system backup on the Disaster Recovery equipment. The ITSO and OHIT must test and verify the validity of the restored network operating system and data. Additionally, the DRT will test the contingency plan in its entirety including the ability to locate key personnel, maintain communications locate and retrieve backup data and obtain alternate site access.
- C. The ITSO will make any notes of problems or areas of improvement for the Contingency and Disaster Recovery Plans

Responsibilities:

The ITSO will be responsible for implementing the requirements of Testing and Revision Procedures.

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11.9 TRAINING

11.9.1 Security Awareness and Training Policy

Purpose:

The purpose is to implement a security awareness and training program for all members of MSDH's workforce, including management.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH understands that people, not necessarily technology, are often the largest threat to the security of confidential information in the organization.

MSDH will ensure that all workforce members have been trained in, and fully understand, the pertinent security policies and procedures of MSDH and the Mississippi Department of Information Technology Services (ITS). In addition, all workforce members will be trained in how to identify, prevent and report potential security incidents.

Procedure(s):

- A. Security training will be an ongoing and mandatory activity at MSDH. Topics covered will include (but not be limited to):
 - a. Log-in monitoring,
 - b. Password management
 - c. Antivirus updates
 - d. Workstation security
 - e. Identification of phishing and other potential sources of malware
 - f. Physical security
 - g. PHI and security
 - h. Breach notification

- B. All MSDH workforce members must complete a basic IT security awareness training on at least an annual basis along with occasional topic-specific trainings assigned to workforce members by the ITSO and/or designated training coordinator based on their respective duties.

- C. A representative from HR will provide the names of new workforce members to the ITSO or another designated training coordinator to register the new workforce members for the required training(s). The basic IT security awareness training course must be completed by new workforce members within 48 hours of receiving access to the course.

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D. At least annually, workforce members must be refreshed on applicable security, privacy and data breach agency policies.

Responsibilities:

All individuals identified in the scope of this policy are responsible for understanding and following all pertinent security-related policies and procedures

The ITSO, Data Governance Director and PO are responsible for:

- Ensuring all workforce members understand and follow security-related policies and procedures
- Maintaining an ongoing security awareness training program at MSDH
- Ensuring the content of the training is up-to-date and adequately informs MSDH workforce members on IT security matters relevant to their work

11.9.2 Security Reminders Policy

Purpose:

The purpose is to implement and ensure that periodic security reminders are distributed to all members of the workforce.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will periodically send out security reminders to all members of the workforce.

Procedure(s):

- A. The ITSO will periodically meet with the State Health Officer, Senior Deputy, CHDOR, Data Governance Director, PO and/or other management periodically to ensure their awareness and adherence to these procedures.
- B. The ITSO and OHIT Director will review the risk analysis and determine which security reminders should be implemented.
- C. The ITSO, OHIT Director, PO, and Data Governance Director will review alerts or news items from the press, technology vendors and other sources. The ITSO, OHIT Director, PO, and Data Governance Director will assess these alerts and develop a corrective action plan and take appropriate actions to protect the MSDH resources. Security memorandums will be distributed alerting workforce members of current threats that may affect MSDH resources.

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- D. Periodically, the ITSO and OHIT Director will also use these memorandums to remind workforce members about this organization’s other security policies and procedures, especially after an incident or breach.

- E. The security reminders shall reflect security awareness concerns and issues that have the potential to compromise the confidentiality, integrity or availability of confidential information. The security reminders may also communicate new or on-going security activities and initiatives.

Responsibilities:

The ITSO, with the assistance of the PO, OHIT Director, and Data Governance Director, is responsible for periodically sending out security reminders to all members of the workforce.

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11.10 DATA AGREEMENTS

11.10.1 Data Agreements Policy

Purpose:

The purpose is to obtain satisfactory assurances that the business associate and/or other party will appropriately safeguard all confidential information in accordance with applicable regulations.

Scope:

This policy applies to MSDH and impacts those business associates and/or other parties that:

- process or handle MSDH confidential information on behalf of the agency;
- process or handle MSDH confidential information provided by the agency; and/or
- enter into an agreement with MSDH to process or handle confidential information

Definitions:

Business Associate: A business associate includes an entity that “creates, receives, maintains, or transmits” PHI on behalf of a covered entity. Entities that maintain or store PHI on behalf of a covered entity are business associates, even if they do not actually view the PHI.

Examples of business associates are:

- Patient Safety Organizations
- Health Information Organizations
- Federal, state, or local government entities
- Healthcare Providers
- Vendors of Personal Health Records that require routine access to PHI
- Persons who facilitate data transmission
- Data storage company that has access to PHI (whether digital or hard copy), even if the entity does not view the information
- Subcontractors that create, receive, maintain, or transmit PHI on behalf of the business associate

Sub-contractor: A person who acts on behalf of a business associate, other than in the capacity of a member of the workforce of such business associate. The covered entity is not required to have a contract with the subcontractor. *The business associate is required to obtain satisfactory assurances from the subcontractor in the form of a written contract or other arrangement that a subcontractor will appropriately safeguard PHI.*

Policy:

MSDH will identify all organizations that process or handle confidential information from, on behalf of, or with MSDH as well as all organizations for which MSDH collects, processes, or transmits confidential information. All such arrangements will require the implementation of a Business Associate Agreement(s) (BAA) and/or other agreements (e.g. Data Use Agreement (DUA)) executed by MSDH.

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MSDH will execute a BAA with all Business Associates of MSDH and will further require any subsequent Business Associates to execute a similar agreement.

Procedure(s):

- A. Each organization that provides data transmission of PHI to MSDH (or its business associate) and that requires access on a routine basis to such PHI, such as a Health Information Exchange Organization, Regional Health Information Organization, E-prescribing Gateway, or each vendor that contracts with an MSDH entity to allow MSDH to offer a personal health record to patients as part of its electronic health record, is required to enter into a BAA and/or DUA with MSDH, as deemed appropriate by Legal, the PO, or the Data Governance Director.
- B. MSDH must enter into a memorandum of understanding (MOU) with business associates that are federal, state, or local government entities.
- C. All BAAs, DUAs and other similar legal agreements must be tracked and logged by MSDH. They must be retained at least six (6) years.
- D. MSDH will have appropriate BAAs, DUAs and/or other applicable agreements signed by vendors, suppliers, providers and any other organization with which trade of services or data occurs, as deemed appropriate by Legal, the PO, or the Data Governance Director.
- E. Annually, BAAs and other agreements should be reviewed and modified as required. This review includes revisions for compliance with impacted regulations.
- F. MSDH will establish the flow of confidential information to all outside entities and identify how such information is transmitted, and the requirements for processing confidential information at the business associate site.
- G. The termination of an agreement with a business associate or other party must result in return or destruction of all confidential information by the business associate or other party.
- H. Business associates or other parties with which MSDH handles and processes confidential data must train all members of their workforce that process or encounter confidential information. This training must include awareness of the requirements of the appropriate regulation as well as information about the business associate or other party's security policies and procedures.
- I. MSDH must have the right to audit the business associate or other contracting party in the event of violations related to its confidential information.
- J. If the business associate or other contracting party intends to process or transmit MSDH confidential information outside the United States of America, then MSDH will be informed of specific details related to such processing or transmission and reserves the right to not authorize any such flow of confidential information.

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- K. Business associates and/or other contracting parties must comply with all applicable HIPAA standards and HITECH Act regulations.
- L. Business associates and/or other contracting parties shall notify their MSDH Point-of-Contact, the PO, and ITSO **without unreasonable delay, and no later than five (5) days after discovery by telephone and in writing** upon the discovery of an actual or suspected breach of unsecured PHI or PII in electronic media or in any other media. Business associates and/or other contracting parties must also notify their MSDH Point-of-Contact, the PO, and ITSO **without unreasonable delay, and no later than five (5) days after discovery by telephone and in writing** of any actual or suspected security incident affecting their agreement with MSDH, including but not limited to an actual or suspected security incident that involves data provided to MSDH by the Social Security Administration.
- M. Except as allowed by law, a business associate or other contracting party may not receive compensation in exchange for any PHI without authorization from patient.
- N. As required by law, MSDH will account for their own disclosures of patient information and then provide the name and contact info of the business associate or other contracting party for additional disclosure details. If requested by the patient, the business associate or other contracting party must account for their disclosures under a separate cover.

Responsibilities:

The Office of Legal Counsel, with the assistance of the ITSO, PO, and Data Governance Director, will review all BAAs, DUAs, and/or other similar agreements and modify them as necessary to ensure compliance with this standard.

The ITSO, PO, Data Governance Director, and OHIT Director will review the flow of confidential information to identify all possible organizations that access confidential information and may be required to execute a BAA, DUA or other legal agreement to ensure compliance with the applicable regulations.

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11.11 SANCTIONS

11.11.1 Sanction Policy

Purpose:

The purpose of this policy is to apply appropriate sanctions against workforce members who fail to comply with the security policies or procedures of MSDH.

Scope:

This policy applies to all MSDH workforce members including, but not limited to, full-time employees, part-time employees, trainees, interns, volunteers, contractors, and temporary workers granted access to MSDH assets, resources, and/or confidential data.

Policy:

MSDH will ensure all members of its workforce comply with these security policies of the organization as well as state and federal regulations such as HIPAA and the HITECH Act by applying sanction and disciplinary actions appropriate for the breach of policy.

Procedure(s):

- A. MSDH will appropriately discipline employees and other workforce members for any violation of security policy or procedure to a degree appropriate for the gravity of the violation. Possible sanctions include, but are not limited to, re-training, verbal and written warnings, or immediate dismissal from employment.
- B. All new workforce members must be informed about this policy by HR at orientation and annually in refresher IT security training.
- C. All sanctions in this policy will be consistent with Office of Human Resources, Privacy Policies, and/or other applicable MSDH policies.
- D. The ITSO will work with the Office of Human Resources to apply sanctions to any member of the workforce who breaches security policy. The Office of Human Resources will document the sanction applied and the outcome in the personnel file of the workforce member.
- E. Workforce members who knowingly and willfully violate state or federal law for improper use or disclosure of a patient's information are subject to criminal investigation and prosecution or civil monetary penalties.
- F. In the event of a malicious action by a present or former workforce member or an outside individual the ITSO will immediately meet with the CHDOR, and together they will seek their attorney's advice for further actions. They will also contact the OHIT Director to secure any security vulnerabilities. If the breach or violation involves inappropriate disclosure of PHI, the Privacy Officer (PO) will be contacted.

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G. MSDH and its workforce members will not intimidate or retaliate against any workforce member or client that reports the incident.

Responsibilities:

All individuals identified in the scope of this policy are responsible for compliance with any sanction that is applied to them under this policy.

The ITSO is responsible for reviewing reported security incidents and violations of security policy and, with HR, levying, based on the gravity of the breach, appropriate sanctions upon the workforce member.

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Federal, state, and local statutes and regulations affect pharmacy practice. Federal controls include those of the Food and Drug Administration (FDA), Drug Enforcement Administration (DEA), Federal Trade Commission (FTC), and the Health Resources and Services Administration's (HRSA) Office of Pharmacy Affairs (OPA). State controls include those of the Pharmacy Practice Act and state controlled substance laws. Local requirements include business licensing and permit laws. The Mississippi State Department of Health (MSDH) Pharmacy is also subject to agency policies.

12.1 340B Drug Pricing

Many programs within the MSDH purchase medications at 340B pricing. The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services (www.hrsa.gov).

HRSA and manufacturers have the authority to audit covered entities regarding their compliance with diversion of drugs and duplicate discounts associated with the 340B Program. Audits will require documentation of procurement of 340B priced drugs, prescription and/or medication orders, distribution, dispensing, and administration records.

12.2 Pharmacy and Therapeutics Committee and Pharmacy Formulary

The MSDH Pharmacy and Therapeutics Committee (P&T Committee) is responsible for managing the MSDH formulary and formulary system. The formulary, a list of pharmaceutical products which the agency routinely stocks for use, is usually revised on a biennial basis. Management of the formulary system includes review and approval of policies related to the medication use process.

The MSDH P&T Committee:

1. serves as an advisory group to the MSDH and its medical staff pertaining to the choice of available medications;
2. maintains a formulary of drugs approved for use by the public health clinics;
3. reviews medication use processes proposed by central office program directors that impact pharmacy and clinic services;



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4. monitors and evaluates the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);
5. directs the MSDH Pharmacy to determine, by public health district, appropriate monitoring indicators and analysis for:
 - a. prescribing/ordering medications;
 - b. preparing and dispensing medications;
 - c. administering medications;
 - d. monitoring the effects of medication; and
6. directs the MSDH Pharmacy to provide routine summaries of the above analyses and recommend process improvements when opportunities are identified.

The P&T Committee of the MSDH is comprised of physicians, nurses, nurse practitioners, pharmacists, and administrators and has a chairperson and a secretary. Additional subject matter experts may participate in P&T Committee meetings as necessary. The committee meets quarterly and as needed.

The Pharmacy Formulary is located on the MSDH intranet under *Documents>Program Areas>Pharmacy Formulary*. Medications are approved for use by health programs (e.g., Family Planning, Tuberculosis) and may not be used in a non-approved program. The Formulary is organized by the health program for which each drug is approved, followed by a list of emergency medications, items dispensed only by authorization of the Office of Epidemiology, and clinic stock medical supplies. For quick reference, all drugs are listed alphabetically in the back of the Formulary.

The manner in which a product is considered for approval by the P&T Committee is as follows:

1. A physician forwards a completed *Application for Changes in Formulary* (Form 94) to the MSDH Pharmacy. Information included in the *Application* should take into account pharmacogenetic and pharmacogenomic considerations for the requested drug as well as differences in effectiveness related to culturally informed dietary habits.
2. The MSDH Pharmacy prepares a drug monograph review, comparing the drug to existing formulary products and providing cost information. The drug monograph review shall include pharmacogenetic and pharmacogenomic considerations for drug selection as well as considerations of differences related to culturally informed dietary habits.
3. The MSDH Pharmacy inquires of the appropriate program director of sufficient money in the budget to cover the expense.
4. All information (application, drug monograph, cost, and availability of funding) is brought before the P&T Committee for discussion and evaluation. Products approved are usually those necessary for direct support of public health programs. Since approved products are usually program specific, patients should meet program criteria.



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12.3 Emergency Medication Supplies

Emergency medications stored at county health departments are listed in the Pharmacy Formulary and in the MSDH Public Health Nurse’s (PHN) Manual. The PHN Manual is reviewed and routed for agency approval annually. Emergency medications should be stored in sealed containers in an area that prevents unauthorized access. The exterior of the container should be clearly labeled “Emergency Medications” and marked with an expiration date of the earliest expiration date of any drug in the container. Emergency medications should be inspected routinely for expiration dates, proper storage, and security.

12.4 Distribution of Drugs and Biologicals

For distribution purposes, drugs and biologicals are divided into two groups:

1. Those products employed in the management of chronic conditions. Group One includes products such as those necessary for the management of tuberculosis or treatment of HIV. The Pharmacy will only supply these drugs by submission of a valid prescription order.
2. Those products needed immediately by the clinic. Group Two includes products furnished by the Immunization and Sexually Transmitted Disease programs and supplied by the Pharmacy upon receipt of a requisition. This category also includes some drugs and biologicals furnished by the Maternal and Child Health (MCH) and Family Planning programs.

12.5 Control of Medication Inventory Outside the Pharmacy

Because the MSDH is subject to audits on 340B drugs by HRSA’s Office of Pharmacy Affairs, inventory control at all levels of the agency is imperative.

County health department documentation of inventory received from the pharmacy, added or removed from stock, and physical count is done using the *Monthly Medication Inventory Log* (Form 68). If medications are received at district offices, use of a similar tracking system is recommended.

Medications at district offices and county health departments should be stored in areas of proper sanitation, temperature, light, ventilation, and moisture control. Further, the area where medications are stored should be capable of being locked to prevent unauthorized access. Each district and county health department should assign access to few staff; a list of those authorized access should be maintained by the county health department and the list reviewed and updated every six (6) months.

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12.6 Tamper-Resistant Prescription Pads

As of April 1, 2008, all prescriptions for Medicaid recipients must be written on a tamper-resistant prescription blank. Medicaid has spelled out the type of blank they require in their regulations and the MSDH Pharmacy has consulted with representatives from specialty companies that provide such materials. Serially numbered prescription pads are ordered, distributed, and tracked to all District Offices. Those entities, in turn, have distributed and tracked the prescription pads to the county health department level. *Prescription blank* (Form 250) has a general format and should be used for writing all prescriptions except for Family Planning products. District Offices may reorder pads from the Pharmacy whenever their supplies become depleted and the Pharmacy will attempt to keep re-supply quantities on hand. However, it is still advisable to allow a month's lead time in case a vendor supply problem should develop.

12.7 Prescriptions Including Scheduled Products

Prescription drugs are dispensed only pursuant to a valid prescription or a valid order. A prescription/order may be accepted by a pharmacist in written form, orally, or electronically, unless the order is for a Schedule II controlled substance. If transmitted orally, the prescription drug order is transcribed onto paper of a permanent quality by the pharmacist and maintained as the original prescription.

There is no statutory provision for "rubber-stamped" signatures. Prescriptions must be signed by the prescriber in the same manner as that individual signs any other legal document (e.g., one's paycheck). Prescriptions received which are "rubber-stamped" cannot be accepted and will be returned.

Most prescription blanks have two lines available for the physician's signature. A signature on one line indicates that the generic substitution is permissible, while an entry on the other line indicates a desire for the prescription to be dispensed as written. In the latter case, the Pharmacy may be unable to comply with the physician's directive due to the unavailability of the particular brand of drug. When this occurs, the prescription is returned to the appropriate clinic with an explanation of why it cannot be filled.

A prescription may not be refilled without authorization. A prescription will not be refilled after twelve months from the date of issuance.

The most stringently regulated drugs are those which are classed as controlled substances. One Schedule III item is provided for HIV/AIDS patients. Products found in Schedules III-V may be filled once and, if indicated, refilled up to five times, or for six months, whichever is first. Schedule II products are not refillable under any circumstances, even if authorized (there are no Schedule II items on the MSDH formulary).



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12.8 Clinic Supplies

Those products which are available as clinic supplies are furnished by the MSDH Pharmacy upon receipt of a requisition. Requests for district or program personnel approval of requisitions will be honored, but will delay county receipt of the supplies.

The size of a given medication package is determined by the MSDH P&T committee with input from the county health departments. Should an individual need a dose which varies from that which is normally supplied, the need can be accommodated by forwarding a prescription which has been written for that patient (e.g., metronidazole).

12.9 Offer to Counsel and Patient Education Materials

Congress passed the Omnibus Budget Reconciliation Act, also known as OBRA'90, which included several provisions impacting the practice of pharmacy. One such provision was for pharmacists to counsel, or offer to counsel, with patients regarding their medications (patients have the option to refuse the offer), so that the public may be better advised on the drugs they take. The thought is that this will make patients more compliant and affect treatment outcome in a positive manner. The MSDH Pharmacy met this responsibility by dedicating an area of the Pharmacy facility for that purpose. However, many patients never frequent the MSDH Pharmacy since they live a considerable distance away and usually pick up their medications at the county health departments. For those patients, the Pharmacy has installed a toll-free number so that individuals may telephone the Pharmacy staff at their discretion. Since county health department personnel usually place medications in a bag before giving them to the patient, special bags are printed to advise patients of this offer and the toll-free number. The number is 1-800-264-6635 and is to be used only for counseling on medications obtained from the local health departments. For non-English speaking clients, the MSDH Pharmacy will coordinate within the Mississippi State Department of Health for medication education services.

English and Spanish patient education materials for clinic stock items have been developed and approved by the P&T Committee and are located on the MSDH intranet under *Documents>Program Areas>Patient Education Materials*. Also, a patient education leaflet is printed for each dispensed prescription medication. The pharmacy software system is capable of printing patient education leaflets in many languages.

12.10 Recipient/Representative Documentation of Receipt of Medication

Note: This is only applicable to those patients where the MSDH Pharmacy bills third party prescription insurance.

The MSDH Pharmacy is able to bill third party prescription insurance for medications dispensed. A *Recipient/Representative Signature Form for Medications Billed to Third Party Prescription*



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Insurance (Form 254) accompanies patient medication when sent from the MSDH Pharmacy to a county health department and the recipient/representative signature is to be obtained by the healthcare provider when the medication is picked up at the county health department. A separate signature must be obtained for each medication listed on the form. Form 254 is then faxed back to the MSDH Pharmacy with the original sent to the MSDH Pharmacy via mail/courier. Form 254 will be used by the MSDH Pharmacy during prescription audits from third party insurance companies to document medications filled for/received by patients and billed to third party prescription insurance.

For family planning products, capturing a signature documenting receipt of product is accomplished using the *Medication Record* (Form 66) which will be maintained in the patient record.

12.11 Expired Drugs and Returned Goods

Pharmaceutical products are shipped to the county health departments for use in patient treatment. Should the pharmaceutical products not be used within a reasonable period of time, they should be returned to the Pharmacy for redistribution or for return to the manufacturer for credit. Frequently, products are returned to the Pharmacy early enough that they can be worked through a high-volume county health department prior to reaching the expiration date. If they are not discovered until after the expiration date is reached, they should still be returned to the Pharmacy as some companies allow the agency a one-year grace period after the expiration date before the deadline is reached. No product should be discarded at the county level. Products returned to the Pharmacy with words such as “expired”, “outdated”, or “return” written indelibly on the package render the products unreturnable. Should it be found necessary to provide a reminder, it should be done with a stick-on note. Do not write on the manufacturer’s package.

Clinic stock and prescription medications should be returned to the MSDH Pharmacy using the *Medication Return Form* (Form 67).

12.12 Drug Recalls

Information about drug recalls will be coordinated between the MSDH Pharmacy and Field Services. If the medication recalled is within our inventory, Field Services will notify appropriate district and county health department staff and provide details about the drug recall. A memo will be prepared for mail out to all patients who could have received the drug providing patient instructions for disposal of the medication, obtaining alternate product, and follow up of medical care, if necessary.

12.13 Prescription Programs

Maintenance programs for which prescriptions are required include cystic fibrosis, neurology, hypertension, diabetes (insulin), phenylketonuria, family planning, cancer, tuberculosis, AIDS, and those items provided through intravenous admixture. Also included are some items found in the Maternal and Child Health (MCH) Program. A brief discussion of operational procedures for each



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of these areas follows. Also included are special notes for each program which will help shorten the “turn around” time for obtaining medications and thus assist in providing better services to the recipient.

STD

This section describes the ordering procedures for the county health departments and details the procedures for both the requisitioning and the return of STD medications. Each county should anticipate its needs at least one week in advance. A *Supply Order* (Form 54) is utilized for ordering all STD medications. These are forwarded through the district Disease Intervention Specialist or Epidemiology Nurse and then to the Pharmacy, where they are processed. The quantity ordered should be predicated on utilized amounts and the amounts on hand. All products should be monitored closely for expiration dates and rotated for use.

Every effort should be made to rotate all STD medications appropriately and to use on a first- in, first-out basis to avoid losses due to any abbreviated expiration dates.

Immunization

Each county must anticipate its vaccine needs at least two weeks in advance and order accordingly. Orders are entered by either county health department or district staff in the Mississippi Immunizations Information eXchange (MIIX) system for subsequent approval by the Immunization Program or the MSDH Pharmacy (Refer to the Immunizations Manual for more information on the MIIX system). Orders for adult and travel vaccine are shipped from the MSDH Pharmacy; orders for pediatric vaccine are shipped from McKesson.

Upon approval of the order in MIIX, Pharmacy personnel will ship all adult and travel vaccines on Mondays through Thursdays. All vaccines are shipped in red, insulated containers with cold packs.

VFC vaccines are returned to McKesson through United Parcel Service, Inc (UPS). UPS shipping labels can be obtained by the Immunization Program at Central Office. Vaccines returned to the Pharmacy for any reason must be approved by the District Immunization representative. Two copies of a *Vaccine Return & Wastage Form* (Form 131) must be completed and signed. One copy should be sent to the Immunization Program personnel and one copy included with the returned product. Vaccines should never be discarded locally.

Cystic Fibrosis

Patients approved for the Cystic Fibrosis Program through the Children’s Medical Program (CMP) may receive prescribed medications and supplies from the MSDH Pharmacy. County health departments may verify patient eligibility by telephoning the CMP. CMP intake assessments must remain current and updated annually. Products supplied by the Cystic Fibrosis Program will be provided by the MSDH Pharmacy following the receipt of a prescription from a physician. The life of the prescription cannot exceed one year from the original date of the document. Telephoned prescriptions are acceptable.



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County health department staff and or CMP staff will need to provide prescription insurance information for patients with private insurance. A copy of the prescription insurance card, front and back, may be faxed to the MSDH Pharmacy (601-364-2670).

Patients with Medicaid eligibility should have prescriptions filled at their local pharmacies using their Medicaid benefits for payment. However, Medicaid will not reimburse for over-the-counter products such as vitamins, and these may be obtained from the MSDH Pharmacy as long as they are formulary items. Should any patient exhaust his/her monthly allotment of five prescriptions, the MSDH Pharmacy will attempt to furnish prescribed formulary items only for that month. The MSDH Pharmacy can and will invoice Medicaid for injectables (e.g., Tobramycin, Ceftazidime, or Colymycin) when the patient is unable to obtain them from their local pharmacy. Medicaid numbers, if known, should always be provided along with any other insurance information.

All prescriptions and refill requests received before 1:00 p.m. will usually be shipped by the Pharmacy on the same day. Items requiring refrigeration will not be shipped on Fridays unless special arrangements are made in advance for someone to receive and accommodate such items on Saturday mornings at the county health department. Intravenous medications will be shipped in a cooler pack. High density plastic bags will be inside the cooler pack for transport of the IV medications by the patient. The cooler pack must be returned to the MSDH Pharmacy. A pharmacist will notify and coordinate with county health department personnel for shipment of intravenous medications.

Remaining refills may be ordered from the Pharmacy by returning the reorder label and accompanying original, signed *Recipient/Representative Signature Form for Medications Billed to Third Party Prescription Insurance* (Form 254) shipped with the previous prescription issue.

Neurology

Neurology patients should be enrolled in the CMP. Patients must complete CMP intake assessments each year and remain current within the program to receive medication. All new CMP patients must be 21 years of age or less and must not be eligible for Medicaid or have an alternate pay source. All prescriptions forwarded to the Pharmacy should have the patient's name, address, and Social Security number. If the patient is being enrolled for the first time (new patient), the enrollment form must also contain the patient's date of birth, drug allergies, and the name of both the county health department and the clinic at which the patient wishes to receive medications.

Once the prescription is received, it is filled by the MSDH pharmacists and returned to the appropriate county health department. Prescriptions are filled for a one-month supply and refills are exactly as indicated by the physician. When refills are not specifically noted on the prescription, it is assumed that no refills are authorized and the prescription will be valid for only one issue. Should the strength or dosage of a prescription be changed, a new prescription will be required.



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Remaining refills may be ordered from the Pharmacy by returning the reorder label and accompanying original, signed *Recipient/Representative Signature Form for Medications Billed to Third Party Prescription Insurance* (Form 254) shipped with the previous prescription issue.

Genetic Services

Application to determine eligibility of a patient is made through the CMP. Although the formula itself is an over-the-counter item, the Pharmacy uses the prescription to generate the initial order of formula. A prescription is also needed to satisfy Medicaid and CHIP regulations.

Family Planning

The MSDH Pharmacy provides Family Planning products through an electronic prescription record. Information entered into the PIMS system, obtained from the *Patient Encounter Form* (Form 142), will stand as the electronic prescription record for the provision of Depo Provera, Micronor, Ortho-Cyclen, Ortho-Tri Cyclen, Ortho-Tri Cyclen Lo, Otho-Evra Patches NuvaRing, and Nexplanon. Failure to comply with this PIMS entry for said products will result in no product re-supply to the clinic. Pharmacists employed by the MSDH will run a PIMS report daily and enter medications administered into the pharmacy system (*patient specific*) for dispensing. These Family Planning products will be shipped to each clinic twice a month with a shipping report, documenting each client's name and the product sent. The Pharmacy ships orders on the first and the fifteenth of each month unless there is an emergency. Refill slips will no longer be sent from the Pharmacy for the above mentioned contraceptive methods.

Clinics must submit paper prescriptions daily, through the MSDH mail system, for the following contraceptive methods: Mirena and ParaGard T380A. IUD prescriptions should be submitted daily by all health department clinics. To expedite the return process, send these prescriptions in a separate envelope clearly marked "IUDs". These prescriptions will be processed by the Pharmacy and returned in approximately two days. Every effort should be made to ensure the insertion goes as planned. The clients should be called and reminded of pending appointments and instructed to arrive in a timely manner to ensure insertion. In the event the procedure does not take place within one month, return the device to the Pharmacy.

Cancer

Cancer patients should be enrolled in the MSDH Cancer Program. Once a patient is approved within the MSDH Cancer Program, prescriptions are forwarded to the Pharmacy with a copy of the application. The pharmacist verifies patient data with the county health department and notifies the staff of forthcoming prescription fill and delivery. Remaining refills may be ordered from the Pharmacy by returning the reorder label that was shipped with the previous prescription issue. New prescriptions may also be submitted from MSDH personnel to the Pharmacy for approved patients.

HIV/AIDS Drug Program

The AIDS Drug Assistance Program (ADAP) is a federally funded program which provides selected medications to patients who qualify. The Office of STD/HIV, Care and Services Division, ADAP



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Branch, will mail application packets to medical providers or caregivers requesting patient information for the purpose of applying for assistance through ADAP. The patient's primary medical provider is responsible for filling out and signing the Patient Information Form and the *MSDH Ryan White Services Form* (Form 256). The MSDH Ryan White Services Form (Form 256) also serves as written prescriptions for the patient. The patient is responsible for completing and signing the *Financial Status* (Form 15) along with providing current verification of income to the ADAP office every six months. Once the patient has been approved, a copy of the MSDH Ryan White Services form (Form 256) will be sent to the county health department and prescriptions will be sent to the pharmacy for processing. The MSDH Ryan White Services Form is to be placed in the patient's file, as this form allows the nurse to release medications to the patient. Any subsequent changes or renewals of medications will require a new MSDH Ryan White Services Form to be filled out and forwarded to ADAP. The MSDH Ryan White Services form is valid for **6 months** from the date signed by the attending physician unless there is a change.

The Pharmacy will prepare a one-month supply of the medication. The patient's medication will be bagged with the reorder label on the front of the bag. **As soon as the patient picks up the medication, the reorder label should be returned to the Pharmacy, regardless of the refill status.** Prompt return of prescription labels to pharmacy will assure that the prescriptions will be refilled on a timely basis. Refills for the ADAP program can be processed 20 days from the date of last fill. Refill slips showing zero (0) refills should be returned to the Pharmacy. This allows the Pharmacy not only to document that medications were picked up by the patient, but also request new prescriptions for the patient through their medical provider. Once new prescriptions are received, Pharmacy will fill and ship to the appropriate health department. Patients are considered noncompliant if they have not picked up medications in a 45-day time frame from the date of last fill.

MSDH Ryan White Services forms (Form 256) are valid for **one** year from the date signed by the physician unless there is a change. Prescriptions are valid for a one-month supply and up to **five refills** for the ADAP program only; after which, new prescriptions will be requested from the attending physician.

The patient **will not qualify** for the program if he/she has Medicaid. Individuals with Medicare Part D may be eligible for co-pay assistance or gap coverage assistance and should contact ADAP for enrollment guidelines.

Tuberculosis

Tuberculosis (TB) prescriptions are placed in one of three categories, as are the types of patients:

1. Preventive – includes contacts or other at risk individuals who require treatment with one or more antituberculosis drugs.
2. Suspect – patients usually managed with three or more antituberculosis drugs, pending a definite diagnosis.



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3. Case – a diagnosis has been confirmed and the patients are managed with two or more antituberculosis drugs.

Although TB prescriptions are usually processed with high priority, those for TB suspects and cases are some of the highest. All new prescriptions must contain the following information: legible name of patient, patient’s date of birth, weight, drug allergies, Social Security number, county health department for shipping, prescription insurance information, name and strength of medication, quantity, directions to patient, refill instructions, physician’s signature, complete enrollment information on back of prescription, an indication that patient is on directly observed therapy (DOT), if that is the case. Medications used in the treatment of TB have many drug interactions. A list of all medications the patient is currently taking should also be submitted with the prescription.

The dose of ethambutol should be checked according to standard dosing procedures. Prescriptions are prepared for only a one-month supply of ethambutol at the time.

Baseline testing for red-green color discrimination (Ishihara tests) and visual acuity must be performed on all patients who are to receive ethambutol. A Snellen eye chart should be used for establishing visual acuity. On initial orders (prescriptions) where visual acuity is found to be equal to or greater than 20/50, authorization by an ophthalmologist is required and should be included with the prescription. This authorization should clearly state the physicians “approval to start ethambutol” and any time-constraints concerning length of treatment. The local consultant can provide a written order to start ethambutol while ophthalmic examination is pending, regardless of visual acuity. This order should be on the written prescription or in the MD notes section of the ERS.

Question patients monthly regarding changes in vision. Subjective visual symptoms may occur prior to objective changes. Monthly monitoring with visual acuity, red-green color differentiation and weight must be performed on all patients on ethambutol. These results must be provided to the Mississippi State Department of Health Pharmacy before the patient can be given another supply of ethambutol. Since ethambutol is prescribed on a weight basis, it is essential to weigh patients monthly and adjust dosage as necessary.

Note: A two or more-line change in visual acuity or an impairment of color vision while receiving ethambutol requires discontinuation of therapy followed by an appropriate evaluation. On refill requests where the patient has undergone a two-line or greater change in visual acuity, an authorization by an ophthalmologist must be included

Listed below are special notes which may be useful to county health department personnel:

1. The District TB Coordinator telephones the Pharmacy and relays the physician’s orders for a given patient before he/she is discharged from the hospital and is being referred to a county health department. The prescriptions are filled for a one-month supply and shipped to the appropriate county. Hard copies of the prescriptions are forwarded to the Pharmacy. Refills are predicated on the aforementioned hard copies.



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2. As with other programs, when the refill balance on the reorder slip (label) reads “0”, no refills remain and a new prescription will be required for that patient before more medication can be dispensed.
3. Refill orders and new prescriptions for previously prescribed drugs should be sent at reasonable time intervals.
4. As with ethambutol, cycloserine, PAS and injectables (e.g., capreomycin, streptomycin) are only shipped in a one-month supply.
5. Cycloserine will decompose in the presence of moisture, so dry conditions are required for storage.
6. Prescriptions for antituberculosis medications, both new and refill requests, must contain the current weight of the patient. Patient weight should also be entered or updated in the Electronic Record System (ERS). If a dosage change of a TB drug is indicated based on a weight increase or decrease, the nurse should notify the Pharmacy by phone or in writing by recording the patient’s weight change on a patient reorder label, a generic prescription blank (Form 250), or other supporting documentation. The Pharmacy must be notified of the following:
 - a. five-pound weight change in infants up to 40 pounds; or
 - b. ten-pound weight change in patients who weigh more than 40 pounds.
7. Sterile water for use with injectable TB drugs is carried by the Pharmacy and will be supplied upon request.
8. Isoniazid (INH) syrup is intended for children three years of age and under, unless the physician has prescribed it for an older person because of a special condition. INH tablets may also be crushed for administration in applesauce or feeding formulas and is the method of choice because of the bitter taste of the syrup.
9. INH syrup may not be therapeutically efficacious if mixed with sugar.
10. Rifampin suspension is not commonly used because it is only stable for four weeks. In cases where it must be used, refills are ordered after the third week.
11. Ethambutol and PZA dosage is according to the Dosing Guidelines for Antituberculosis Drugs as per the American Journal of Respiratory and Critical Care Medicine, vol. 167, 2003.
12. Pyridoxine may be ordered for clinic stock.



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13. When mixed with water, streptomycin will turn orange in color after sitting overnight, but is still good for four weeks when stored at room temperature.
14. TB should be treated without delay when discovered during pregnancy. However, streptomycin is toxic to the fetus and is not recommended at this time.
15. Drugs which are not recommended for children are PAS, kanamycin, cycloserine, and capreomycin.
16. Streptomycin and PAS should never be used alone when treating M. Tuberculosis as resistance develops rapidly.
17. Daily therapy of INH, rifampin, and PZA are usually filled in a one-month supply.
18. Daily directly observed therapy (DOT) will usually continue for two to eight weeks before converting to biweekly therapy.

Miscellaneous Information

Only sickle cell, genetic related disorders, cystic fibrosis, cancer, and intravenous admixture patients are permitted to pick up their own medications at the MSDH Pharmacy in Jackson.



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District and Local Health Departments

The budget office of the Division of Finance and Accounts and the Internal Auditor's office will be available to assist districts with the business management activities of the district and local health departments. This will include transactions concerning budgeting, bookkeeping, receipts, and disbursements.

13.1 Budgeting

The funding of Mississippi county health departments is a combined federal, state, and local effort. The MSDH and county health departments prepare annual budgets to serve as guides in purchasing the essential services, commodities, and equipment that will enable them to carry out the duties assigned by governmental bodies.

The District Administrator will provide the MSDH budget information regarding the counties based on guidelines and forms provided by the Division of Finance and Accounts. The time for submitting data will be announced through the budget calendar. The District Administrator is responsible to the Chief Financial Officer for the preparation of the district budgets based on guidance by the Chief Financial Officer.

The Division of Finance and Accounts will conduct budget conferences with each district as necessary and provide proposed budgets for the district and county health departments for each new fiscal year. The adjusted county budgets will provide information to be used in the preparation of the local support request. Each District Administrator is expected to use the adjusted budget information, along with his/her knowledge and assessment of the local situation, to prepare a reasonable budget request of the local board of supervisors.

Budget revisions may be requested in writing from the Division of Finance and Accounts. Upon return of the approved budget revision, the District Administrator may authorize the expenditure of funds. No purchase or commitment for purchase shall be made prior to approval of the budget revision.

It will be the responsibility of the District Administrator to maintain and operate the health department in an acceptable manner within the amount of funds available.

13.2 County Financial Records

Bookkeeping

Financial records for county expenditures will be maintained by the bookkeepers at the District Office. Each county health department is authorized to maintain only one checking account that will serve as a clearing account prior to transferring funds to the State Treasury. All accounts



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outside the State Treasury, such as checking and savings accounts with a bank, require prior approval by the Department of Finance and Administration (DFA). Requests for bank accounts should be made through the Division of Finance and Accounts and not directly to DFA.

The Division of Finance and Accounts will provide instructions for the bookkeeper regarding financial reports, lists of authorized accounts, filing of invoices, and similar bookkeeping procedures. The classification of expenditure items is determined by the State Department of Finance and Administration.

County Receipts

The recipient will place a restrictive endorsement (For Deposit Only) on all checks when received and ensure they are deposited in the county health department's checking account without undue delay. All deposits slips will clearly identify the source of all receipts (i.e., county, city, special fees, etc.).

A receipt will be prepared for all cash received to provide documentation for cash deposited to the bank account. The office manager will ensure unused receipts are kept in a secure place and shall account for all receipts issued on a daily basis. The deposit slip will clearly identify the cash receipt numbers, which are included in the deposit.

Funds received for operating expenses and/or fees collected will be forwarded to the Division of Finance and Accounts weekly. A Cash Receipt document (VC) will be entered in the Statewide Automated Accounting System (MAGIC) for the amount of the deposit into the clearing account. A check in the same amount will be written from the clearing account to State Treasury Fund 330000000 and submitted to the Division of Finance and Accounts via nightly courier.

County and city appropriations will remain in the clearing account when received and will be transferred to the State Treasury monthly. The appropriations will be transferred at the end of each month to cover the following month's expenses. The Division of Finance and Accounts will submit a monthly reconciliation sheet to the District bookkeepers, which will include the estimated expenses for the following month, the amount expended the prior month and any balance that can be subtracted from the amount to be transferred.

When a patient's check is returned for non-sufficient funds and a copy of the bank debit memo is received, an entry must be made to remove the amount of the check from revenues. This is performed by entering a negative Cash Receipt transaction in MAGIC. When the check is re-deposited or when the patient redeems the check for cash, the revenue account will be credited again.

County Purchasing

All purchases must follow state purchasing laws and procedures. Items on state contract must be



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purchased from the identified contract vendor, purchase orders must be entered to encumber funds in accordance with DFA policies, and bids received when dollar limits are exceeded. The bookkeepers must enter a purchase order in MAGIC for all items requiring purchase orders.

Payments cannot be made for items until they have been received or until services have been delivered. The purchase order must be reviewed when goods are delivered to ensure items ordered were delivered. Payment for the items should not be processed from the delivery ticket or bill of lading. When an invoice is received for the items ordered, the invoice should be matched to the purchase order and the payment must reference the purchase order.

County Disbursements

The District Administrator will be responsible for reviewing and approving all expenditures. This should include reviewing and approving the Statewide Payroll and Human Resource System (SPAHRs) preliminary payroll summary and detail reports provided by the Division of Finance and Accounts, travel vouchers, payment requests (See Exhibit 1) and invoices. Approval of the invoices and other payments must be indicated on the face of each document. Payments must always be made from invoices in lieu of statements, bill of lading, receiving report or other document.

All payments must be entered into MAGIC once approved by the District Administrator. The system assigned transaction numbers must be written on the face of the supporting documentation, dated and initialed by the District bookkeeper. The original documentation must be forwarded to the Division of Finance and Accounts via courier the same day as it is entered into MAGIC. A copy of the documents should be retained in the District Office files.

The Division of Finance and Accounts will approve the transaction in MAGIC and electronically submit to DFA for processing. All warrants (payments) will be generated from MAGIC and returned to the Division of Finance and Accounts. Finance and Accounts will be responsible for mailing all warrants to the appropriate vendors.

The only checks written on the county bank accounts should be checks to transfer funds to the State Treasury for operating expenses or for revenue collected. No checks will be drawn payable to "Cash." All voided checks will be retained.

Salary and Fringe Benefits

The payroll will be prepared by the MSDH based upon information provided by the county health department on the Time and Attendance Report. All employees will be paid by a state warrant or will receive their salaries as a direct deposit from DFA in conformity with the State Personnel Board (SPB) policy and procedures.

Each county health department will transfer funds to cover salary expense in the same manner as

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operating expenses discussed in Section III. The bookkeeper shall review provided documentation to ensure that all charges are proper and accurate. The bookkeeper will contact the Budget Director in Finance and Accounts to attempt to resolve questions or discrepancies in the monthly reports.

No Health Officer, District Administrator or other official may employ an individual or authorize payment to any individual except by the procedures outlined in the Administrative Services Manual. When an employer-employee relationship is created, the employer becomes liable for Social Security taxes.

Travel

Travel payments are intended solely to reimburse MSDH employees for expenses incurred in the conduct of official agency business. Travel payments are not to be construed as a fringe benefit or a supplement to an employee's salary. Travel should be scheduled and planned in the most efficient and effective manner to accomplish the unit's objectives within the applicable budgeted constraints.

Travel vouchers shall be submitted monthly and shall be supported by appropriate documents. No payment for travel should be issued before supporting documents are completed and on file. County employees whose responsibilities necessitate travel in two or more counties shall prepare a separate travel voucher for each respective counties portion of the related travel expenses. Some travel benefiting counties are paid from state budgets. No travel benefiting one county should be paid from another county budget.

All travel vouchers will be reviewed for reasonableness and accuracy and initialed by the employee's immediate supervisor before being submitted to the bookkeeper. Reimbursement will be based upon the mileage allowance set by state law and the MSDH travel rules and regulations. The bookkeeper will review the voucher for accuracy and proper signatures prior to submitting the vouchers to the District Administrator for approval and signature. Any discrepancies noted on the travel vouchers should be reported to the District Administrator.

When the travel vouchers have been verified and approved for payment, they will be sent to the Division of Finance and Accounts for processing in SPAHRS. All travel reimbursements (and any advances) must be paid from SPAHRS. Employees will receive reimbursements in the same manner as they receive their payroll – either by paper warrant or as a direct deposit into the same account as they receive their salary payment.

Contracts for Professional Services

District Administrators and Health Officers are responsible for all contractual arrangements. Rules and Regulations of the SPB shall be followed in all contractual agreements. All service contracts will be processed by the Human Resources Unit of MSDH. Human Resources enter the contract



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into SPAHRS to obtain a contract number and obtain SPB approval. When a contract is approved, Human Resources will notify the District.

A Payment Request supported by a properly executed Professional Service Record (Form 16) or by an appropriate statement is required. The District Administrator will approve all contractual Payment Requests. Once approved all original documentation will be forwarded to the Division of Finance and Accounts via courier.

The Division of Finance and Accounts will process the payment request and submit to DFA for payment. All warrants (payments) will be generated from SPAHRS and returned to the Division of Finance and Accounts. Finance and Accounts will be responsible for mailing all warrants to the appropriate vendors.

County Financial Records

Each bookkeeper should be thoroughly familiar with the financial terms, sources of funds, account code structures, purchase regulations, categories of expenditures and state accounting procedures. The following sections are designed for orientation of new bookkeepers and as a quick reference for others.

Financial Records and Budget Categories

1. Bank Account - Serves as a clearing account for funds received. Payments are not made directly from checking accounts.
2. Cash on Hand - Represents the total of change funds and petty cash accounts in the health department.
3. Revenue Accounts - Detail of all health department revenues.
4. Expenditure Accounts - Specified by the Department of Finance and Administration; detail of all health department expenses.
5. Budget Accounts - to record authorized expenditure amounts. Budgetary revenue accounts may be used.
6. Cash Balance and Surplus - The "Fund Balance" account, in which the net excess of revenues over expenditures is shown. In a commercial business, this account is called "Owner's Equity."

Journal Entries

1. Journal entries will be used to make corrections of errors. Most journal entries are made merely to correct the coding of a revenue or expense item. Journal entries should be entered into MAGIC by the bookkeepers. Supporting documentation must be included as an attachment in



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MAGIC. When the 3 journal entry is processed in MAGIC by the bookkeeper, workflow is triggered in MAGIC. Finance and Accounts will then review the document online and approve.

2. If organizational budget amounts need to be changed, the bookkeeper should inform the Budget Office in the Division of Finance and Accounts. The Budget Office will make all budget entries.

Bank Reconciliations

Bank reconciliation determines that the bank account book balance (check register) is correct by reference to transactions which have occurred in the bank statement.

1. To reconcile the bank account, list the balance shown on the bank statement. Add all deposits shown in the check register that are not shown in the bank statement. Subtract all outstanding checks (all checks that have been issued, but did not clear in the bank statement).
2. If there have been no unrecorded service charges or no errors, the total will agree with the balance of the bank account.
3. Any unresolved reconciling items from the prior reconciliation, must also be included as a reconciling item. Errors should be corrected as soon as possible.

Imprest Cash Fund (Petty Cash)

A petty cash fund of a reasonable amount, as authorized by the District Administrator, may be maintained by each Office Manager who shall be responsible for the funds operation. The Office Manager will ensure the fund is locked in a secure place at all times. Receipts must be obtained and used as supporting documentation for the replenishment of the fund. Transactions of a personal nature (i.e., cashing checks, IOUs, loans, etc.) are not authorized. The fund should be reconciled and replenished at least monthly. A payment voucher made payable to the Office Manager, County Health Department must be entered for the total of all receipts written. When the check is issued it should be cashed to replenish the petty cash account. Discrepancies should be noted, investigated, and reported to the District Administrator.

Adjustments to the petty cash fund may be made as follows:

1. Shortages should be corrected by increasing the amount of the check to make up any differences between the receipts total plus the cash on hand and the total authorized amount of the fund. Shortages should be charged to 61690000-Fees and Services. Unsubstantiated shortages may be charged to the custodian of the fund.
2. Overages should be corrected by taking any cash in excess of the authorized amount and depositing it into the health department bank account crediting revenue code 43510000.



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Items purchased from petty cash should be small in amount, and purchased from local stores which do not issue invoices. All items purchased must be listed on a petty cash receipt and the receipt must be signed by the official receiving the cash. The items below are commonly purchased, or paid with petty cash. The list is not complete:

1. Ice, for mailing milk samples, specimens, etc.
2. Postage due, on incoming mail only.
3. Office and janitorial supplies (small quantities not on state contract).

The petty cash account for each county should be monitored by the District Administrator on a monthly basis and should be audited by the administrator, or designee (other than the office manager) on an annual basis.

Unauthorized Expenditures

Some expenditures cannot be authorized by health departments because they do not assist in achieving the purpose of the agency. A clarification of what could be authorized was requested of the State Attorney General. Each Office Manager should ensure that no unauthorized purchase is made. The District Administrator should be contacted prior to any questionable purchase.

Auditing

The Office of Internal Audit will conduct audits of the county health departments. Such audits will be for the purpose of evaluating compliance with MSDH regulations, policies, and procedures. The audit will be performed as efficiently and effectively as possible.

An audit exit conference will be conducted with the District Administrator, Branch Director, Bookkeeper, and Office Manager to inform them of the audit findings. This will allow an opportunity to discuss any audit recommendations or exceptions.

A copy of the audit report will be sent to the District Administrator and/or Health Officer. A letter indicating accomplishment of or compliance with all recommendations made by the auditor, or stating the reasons such compliance has not been accomplished, will be submitted to Internal Audit by the district administrator or health officer within 15 days after receipt of the report.

Although the list of areas (items) audited varies from time to time, most audits will include the following:

1. Bank account balances
2. Bank deposit procedures
3. Financial records
4. Leave records and reports
5. Patient billing/collections



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6. Purchasing procedures
7. Third Party billing
8. Travel vouchers

13.3 Fee Collection General

Fee collection for services rendered is essential for the overall operations of the Mississippi State Department of Health. It is imperative that all MSDH staff adhere to the policies and procedures outlined by this Agency.

The Mississippi State Department of Health is authorized to charge fees for services under Section 41-3-15 of the Mississippi Code of 1972, amended. All county health departments must bill and collect fees in a consistent and uniform process based on the following policies.

All MSDH staff will be supportive and knowledgeable about the importance of collecting fees and the proper procedure for handling fees. While certain staff members are responsible for the direct administration of assessing and collecting fees, it is expected that all employees understand the fee collection policy and participate in an active and positive manner to inform and educate clients on charges for services, operational needs for fees and expectations of client payment to clinics.

- The client will not be harassed and must be treated fairly and courteously, regardless of ability to pay based on the sliding fee scale.
- The client will not be pressured but asked to pay for services rendered, preferably the full amount.
- If the full amount cannot be collected, partial payments should be encouraged.
- Clients will not be denied services because of an inability to pay and will not be subjected to any variation in quality of services rendered.

Patient Registration

All clients must be registered using the Patient Information Management System (PIMS). The patient intake form (143) should be completed by all patients. Demographic data, income and pay sources are collected and entered into PIMS. (See PIMS Manual for instructions)

- It is essential that all demographic information is complete in PIMS as many state and federal funds are determined by data reported on clients served.
- Data are also used for billing purposes; therefore, if one required field has incorrect or incomplete data, PIMS may not generate a charge or charges may be rejected.

At registration, the client is informed if there will be fees charged for services provided that day and of any past due balances. Monies collected or amount billed and any past due balances are documented on the back of the Patient Encounter (Form 142C or 142I).



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- ./ Patient should initial Form 142C/142I to verify payment or non-payment for services rendered and/or any outstanding balance due.
- ./ Clerical Staff should initial Form 142C/142I to verify collection or non-collection of monies for services rendered and/or any outstanding balance due.

The status of Third Party coverage including Medicaid/Medicare eligibility must be checked at registration using HDX, Envision and/or Medicaid 1-800 number. Once the patient's Third Party coverage is verified, the effective date of eligibility or date of termination must be entered on the Guarantor Screen in PIMS and a new Form 15, Household Document/Financial Status, must be printed and signed by the patient.

- Medicare B eligible patients- the patient's Signature on File should be documented in PIMS. (See PIMS Manual, Revisions Section)

Household Size

Household size is determined by the number of people in a family residing at one address.

Family

A family is defined as a person living alone or a group of two or more persons related by birth, marriage, or adoption, who reside together and who are responsible for the support of the other person(s). Unborn children are included in family size.

One-Person Household

One adult living alone.

- An adult living with others who is financially responsible for their self and does not support the others
- A child in foster care

Household Group

Some examples of household groups living together are:

- Two persons married to each other
- One or both legal parents and their legal minor child/children
- Parent, managing conservator(s), or guardian(s) of disabled person(s) or person(s) unable to care for themselves (but not a minor)
- The managing conservator, minor child, the conservator's spouse and other legal minor children

Relationships

A child may be considered part of a household when living with someone other than the natural parents. If documentation can be provided, verify the relationship using birth certificates or other



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legal documents that demonstrate the relationship. An example of a family relationship would be a grandparent taking care of a grandchild. The grandparent provides the birth certificate of the child and the natural mother of the child that establishes relationship between the natural mother and the grandparent. Other relatives could include brother, sister, aunt, uncle, cousin, nephew, niece, stepmother, stepfather, stepbrother, and/or stepsister.

- If relationship of the child is other than the biological mother and father, document the relationship.
- Relatives that a minor child could live with, other than the natural parents, are the same as listed above.

Separate Families

One family may live with another family.

Examples of some separate families living together are as follows:

- Two or more unmarried adults living together
- A one-person family and a household group
- Two or more household groups
- One relative living with another relative

Income Assessment

An income assessment for sliding fee scale services is required each April or when a stated financial status change is reported.

Sliding fee scale charges are determined by household size and income using the Federal Poverty Guidelines published annually in April. The income guidelines determine if the percentage of charge will be either 100%, 75%, 50%, 25% or 0%.

Income

Income determination is established on gross income and based on earned income (related to employment) and unearned income (income or benefits received without performing work, i.e. child support). Unearned income does not include a one-time payment.

At registration, clerical staff view documents presented for assessment and indicate the type of documentation presented in PIMS. (See Patient Registration)

To establish the income category for sliding scale fee collections, determination of income, proof of residency, size of household and household income should be identified and documented. Zero income will not be entered at registration, except in extreme instances. Clients who indicate zero income will be assessed to determine an amount of income by reviewing any in-kind income provided to the individual or family. In-kind income is defined as any gain or benefit that is not in the form of money. Ask the client how they obtain food, shelter, clothing,



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medical care, etc. Document how the client meets their basic needs or the circumstances surrounding the unavailability of proof of income. Have the client sign documentation and place it in the medical record.

PIMS – Point of Service

PIMS generates charges and payments through the Point of Service. Charges are determined by the provider indicating on the Patient Encounter (Form 142C/142I) the type of visit, and the type of service(s) and/or procedure(s) received that day. Once the clerical staff receives the encounter form, the activity is entered into PIMS and charges are generated.

Payment for clinic charges is made through a third party provider or directly from the client, also referred to as a “guarantor”. For certain program services, guarantor charges are based

on a sliding fee scale determined by the client’s income using the Federal Poverty Guidelines. All clients who receive services will be made aware of the total amount adjusted and given the opportunity to make a payment, not only on today’s charges but on any past balance. Payments may be accepted during the entrance and/or exit processing.

- When charges are made, a copy of their bill should be printed that lists services provided and any discounts received.

At exit, the Patient Encounter (Form 142C/142I) is attached to client records; however, in order to expedite clinic flow, there are times when the client may be exited by sending the client to the exit clerk with the encounter form only. Client records that are not attached to the encounter form at exit will be returned to the exit clerk or the file room at the end of the day. Follow-up that is not completed on the day of service may be completed the following day by retrieving client records from the file room. No client records are kept overnight in offices.

Payment Method Policy

Acceptable methods of payment for services rendered:

1. Cash - Encourage client to pay past balances in addition to current charges.
2. Check -When a check is received for services:
 - Check is to be made payable to the health department
 - No two-party or payroll check shall be accepted
 - Check must be written for the correct amount
 - Identification must be presented
 - Verify that address and telephone numbers are current
 - Confirm that client does not have a history of bad checks
 - If client previously had two bad checks, request cash or other method
3. Debit / Credit Cards – VISA, MasterCard, Discover, American Express If the client does not have cash or a check to pay for services, ask if they would like to make a payment



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using a VISA, Master Card, Discover or American Express credit or debit card.

- Make sure the credit card is in the client's name
- Check expiration date
- Check identification

4. Returned Checks

- Make an attempt to redeposit or collect payment by calling or writing payor a letter requesting payment in cash or money order.
- If check is not redeemable, reverse the payment in PIMS.
- If unable to contact, hold returned check until client returns to clinic.
- If payment is received by cash or money order, return the check to the client.
- If check clears the bank or client comes in and pays for services, prepare a separate deposit slip and attach a statement to the bookkeeper that this is a redeposit. This statement is used as a reference on the monthly PIMS report.
- Enter payment into PIMS.

Deposits

Fees collected in the county health departments will be deposited daily into local bank accounts and are utilized to assist in meeting program operational costs.

- Office Managers are responsible for the daily cash balancing and deposit.
- When possible, fees shall be deposited into an interest bearing account.

Billing Guidelines

General Health Care Services Billing Guidelines

PIMS billing rates applied to the patient fee scale are the same rates that are applied to third party billing - Medicaid, Medicare, CHIP, Family Planning Waiver or Commercial Insurance. The current PIMS billing rates for county health department service delivery are established as follows and are reviewed annually.

- MD/NP provider encounters, EPSDT services, PHRM/ISS and Early Intervention case management billing rates are based on the annual agency cost report. These rates are typically revised in December or January of each year.
- The intra-agency sliding fee scale allows for standardized billing adjustments to individual clients and is updated annually based on the federal poverty guidelines.
- Select agency fee-for-service procedures such as laboratory tests are set at the allowable Blue Cross Blue Shield reimbursement rates. These rates will be reviewed and revised annually on approximately April 1st of each year. The



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PIMS system will do an automatic write-off upon receipt of payment when charges exceed the third party reimbursement amount.

- Refer to the current PIMS Transaction Fee List, by program services, for a list of services and the appropriate fees.

Early Intervention / First Steps Billing

For those infants with dual eligibility for PHRM/ISS and Early Intervention services, the PHRM/ISS program will provide intervention and case management services. Medicaid will be billed for PHRM/ISS case management until the end of the month of the first birthday. If PHRM/ISS services cannot be billed during any month, Early Interventions services may be billed if eligible. Transition to Early Intervention case management will take place beginning at age 13 months.



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13.4 Fee Collection

Flat Fees

Certain clinic fees/services are not based on income. These fees are referred to as Flat Fee Services and are generally listed under PIMS Transaction Codes as 93 (all Immunizations) and 99 (Single/Other Services codes i.e.; Urine Pregnancy Test, TB Skin Test, Interferon Gamma Release Assay (IGRA), Medical Record Copies, etc.)

Fees for these 99 services will be charged and collected at registration, with the exception of childhood immunizations and pregnancy test for patients less than 21 years of age.

Program Requirements

Child Health

Demographic data, income and pay sources (Medicaid/Medicare/CHIP) are collected and entered into PIMS for billing purposes at patient registration. (See Patient Registration) For children under the age of six, there is no charge for child health services except for immunization administration fees.

Diabetes Self-Management Education(DMSE)

Demographic data, income and pay sources (Medicaid, Medicare/Commercial Insurance) are collected and entered into PIMS for billing purposes. (See Patient Registration) Proof of income is requested but not required, a verbal statement is acceptable. Clients will not be denied services because of inability to pay.

Family Planning

Demographic data, income and pay sources (Medicaid/Medicare/CHIP) are collected and entered into PIMS for billing purposes at patient registration. All MSDH clients (including Family Planning) must be asked to provide proof of income. (See Patient Registration)

Appointments

Family Planning services are provided in confidence for all clients. (Parental consent is not needed.) Clients under 21 years of age are considered priority for appointment scheduling.

Family Planning Program Client Proof of Income Procedure

Proof of Income

All Family Planning clients must be asked to provide proof of income to receive services at no cost or a reduced rate according to the Intra-Agency Sliding Fee Scale.

- Clients under 21 years of age seeking services in confidence; household income will be based on the individual client's income.
- Services for married clients under 21 years of age are based on household income.
- Clients who have parental consent for services; household income will be based on the family household's income.



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- If the required income documentation is not provided; the client's self-declared income must be documented in PIMS and the patient will be advised to bring income documentation (*Income list in PIMS under Household Document Help Screen*) to the next visit and any fees assessed accordingly. Once the household document is printed, the client's signature is required.



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No Proof of Income

Document how the client meets their basic needs or the circumstances surrounding the unavailability of proof of income. Have the client sign documentation and place it in the medical record.

Fee Requirements:

- Clients 21 years of age or older, and do not have Medicaid coverage, will be assessed fees/charges according to their pay category prior to receiving services.
- Clients in P75 category or less may qualify and apply for the Medicaid Family Planning Waiver Program (*if they do not have private insurance coverage*).
- Clients applying for the Medicaid Family Planning Waiver Program at the initial/annual visit should not be charged personally for the visit.
- Clients are to make a minimum payment on their outstanding balances prior to receiving services according to their pay category below, or pay total bill if less than minimum payment.

Pay Category	Minimum Payment
P00	No Payment (No Charge)
P25	\$10
P50	\$15
P75	\$20
PCL	\$25

Note: Clients currently on Regular Medicaid or Medicaid Family Planning Waiver are Not required to pay a minimum, however, should be informed of any outstanding balances and asked to make a payment if possible.

Hardship Exemptions:

- Fees for family planning services may be waived for individuals whose family Income has been temporarily altered for extenuating circumstances (i.e. house destroyed by fire; catastrophic illnesses/injury; etc.) *This decision will be determined, in writing, by the District Administrator, Health Officer, or designee.*

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- Clients must not be denied services because of inability to pay current or past due amounts.

Family Planning Wavier –

- If the client’s household income is declared at 185% (P75) or less, clients may be eligible for the Medicaid Family Planning Waiver Program. *Clients should be educated as to the benefits of the Medicaid Family Planning Waiver Program and the significance to its participants and the services provided by MSDH.*
- Health Department staff will assist clients with submitting applications for the Medicaid Family Planning Waiver Program. *Proof of income and ID are not required to submit the FPW application. If the Division of Medicaid requires further information they will notify the client directly.*

Voluntary Donations: Consistent with the Title X Guidelines, Section 6.3 Financial Management; “voluntary donations from clients are permissible. However, clients must not be pressured to make donations, and donations must not be prerequisite to the provision of services or supplies. Donations from clients do not waive the billing/charging requirements set.

- All clients may be asked if they would like to make a donation for supplies or services.
- Clients will not be pressured to make donations, and donations must be a prerequisite to the provision of services or supplies.
- Donations from the clients do not waive billing and charging requirements set out in policy.

Family Planning Program Client Visits and Fees:

Initial / Annual Visit:

Individuals seeking Comprehensive Reproductive Health services must be informed of the Family Planning Waiver Program and assisted with application process prior to their appointment when possible. In the event the FPW eligible client has not applied prior to their visit, clinic staff should encourage client to apply and assist with submission of the application.

Clients applying for FPW should be scheduled for an appointment with the clinician in 8-12 weeks. If needed, the client can be seen by the nurse for a “Quick-Start” contraception method. If at subsequent visit client has not been approved for FPW client will be informed of estimated charges in accordance with the Intra-Agency Sliding Fee Scale

Self-Pay clients on sliding fee scale and desiring to pay for services directly should be informed of estimated charges in accordance with the Intra-Agency Sliding Fee Scale and have the option of seeing

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the provider that day or receive the Quick Start method if needed and be scheduled to see a clinician at the next available appointment.

Family Planning Client Resupply Visit

Clients without third part coverage should be advised of the FPW if eligible and assisted with submitting their application. Clients should be informed of their current pay category and minimum payment expected for their anticipated visit.

At the resupply visit, following the initial 3-month distribution, 10 months of contraception may be provided (*except for Depo-Provera, Patches and NuvaRing for which the client must return quarterly*).

Clients will be asked to make a minimum payment on their outstanding balances prior to receiving services according to their pay category, or pay total bill if less than the minimum payment.

Immunization

Demographic data, income and pay sources (Medicaid/Medicare/CHIP/Commercial Insurance/Family Planning Waiver) are collected and entered into PIMS for billing purposes. (See Patient Registration)

- Childhood and Adult Immunization fees are referred to as flat fee services.
- Childhood immunizations may be collected or billed at point of exit.
- Adult Immunizations will be charged and collected at registration.

Laboratory

Charges for Lab Specimens and PAP Smears that are rejected and/or unsatisfactory due to MSDH collection and/or submission errors; charges should be adjusted by the Office Manager using 230 ADJ code found in the PIMS Manual and documented on Patient Encounter Form 142C/142I. (See PIMS Manual/Office Manger Section)

STD (Sexually Transmitted Disease)

Demographic data, income and pay sources (Medicaid/Medicare/CHIP/Family Planning Waiver) are collected and entered into PIMS for billing purposes.

Tuberculosis (TB)

Demographic data, income and pay sources (Medicaid/Medicare/CHIP) are collected and entered into PIMS for billing purposes. (See Patient Registration)

SKIN TEST or Interferon Gamma Release Assay (IGRA) -

Skin Tests or (IGRA) that are job-related, a school requirement, or for nursing homes and personal care homes, immigration needs, etc., will be billed the current flat fee rate (see 99 Services under Flat Fees).



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- When administering the two-step TB test, a charge is associated with each test.
- Exceptions: There are no fees charged for TB Skin Test /IGRA for patients who are contacts to a documented TB Suspect or a TB Case. (The procedure code 97 should be used for TB contacts/cases.)

TB Fees- Adoptees, Immigrants, Refugees, Foreign Students, etc. Refer to the Billing Section of the TB Manual.

TB Drugs will be billed to the patient's Private Insurance, Medicaid, and/or Medicare through the MSDH Pharmacy.

- The patient must present his/her Private Insurance/Medicaid/Medicare Card(s) for verification of continued Private Insurance/Medicaid/Medicare eligibility or changes of Private Insurance Company by the Health Information Clerk and/or Public Health Nurse at each visit.
- The Public Health Nurse and/or Health Information Clerk must copy front and back of any and all insurance cards and submit to the Pharmacy with each TB Prescription ordered.
- Recipient/Representative Signature Form for Medications Billed to Third Party Prescription Insurance (Form 254) that accompanies medicine delivered from MSDH Pharmacy, must be signed and dated by patient/or designee. (Currently used by Pharmacy for CMP Program). Fax a copy of Form 254 to the Pharmacy when medicines are issued. Send the original Form 254 back to Pharmacy via courier mail.

Women, Infant, and Children (WIC)

There are no fees for WIC Services.

- Patient's must be registered in PIMS and demographics must be updated in PIMS prior to registration or update in the SPIRIT system.
- A patient's household assessment is done and proof of identification, residency, and income is required at each certification and re-certification for WIC eligibility.
- For newborns, the first certification is valid until the end of the month the child reaches one year of age
- After the child reaches 1yr of age, the certification period is for six months.



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Purpose

This policy is intended to promote health equity in all policies, practices, and processes within the MSDH. This policy will equip MSDH staff with the guidance needed to set priorities, take action and ensure policies, programs, services, and information are provided in an equitable and just manner for the state's residents and diverse communities. MSDH will collaborate with partners to identify health disparities and their root causes in an effort to promote evidence-based solutions that lend to an equitable system and focus on training, policy and program development, material review and development, staff recruitment, translation services, and community involvement. The MSDH utilizes the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as general guidelines in order to provide a uniform framework for developing and monitoring culturally and linguistically appropriate policies, plans, and services.

The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint to implement culturally and linguistically appropriate services. A blue print for advancing and sustaining the National CLAS Standards policies and practices can be found at: <http://www.integration.samhsa.gov/EnhancedCLASStandardsBlueprint.pdf>.

Definitions

Health Equity-Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions in health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.

Cultural Competence-A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective working in cross-cultural situations.

Health Disparities- the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.

Interpretation-The verbal rendering of information from one language into another. The act of interpretation occurs in instances of oral communication, such as medical exams, therapy sessions, wellness groups, and health education classes, etc.

Limited English Proficiency-(LEP) Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient.



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Translation- The written rendering of information from one language into another. The act of translation occurs when written text, such as policies, consent forms, patient education materials, etc., are converted into another language.

Linguistic Competency-The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency (LEP), those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

Health Literacy-Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.

Certified Interpreter-An individual certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training or have taken a screening test administered by an employing health organization, interpreter, or referral agency are **not** considered certified.

Health in All Policies (HIAP)-Health in all Policies is an approach to public policy across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity. It improves the accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policy on health systems, determinants of health and well-being.

Health in All Policies (HiAP) Standards

The Mississippi State Department of Health is committed to supporting a HiAP approach to address the social factors that influence health. MSDH's Health in All Policy Workgroup developed HiAP standards to assist employees in their work both internally and externally. The standards were developed utilizing nationally recognized sources such as the National CLAS Standards <https://www.thinkculturalhealth.hhs.gov/about>, *The Concept of Principles and Health Equity* by Margaret White Head, and *Health In All Policies Framework for State Health Leadership* <http://www.astho.org/HiAP/Framework/>. Staff should use these standards when making decisions that account for their services' and activities' health impacts.

1. **Overall Standards:** Promote the value of health and well-being for all Mississippians by providing effective, equitable, understandable, and respectful quality care and services to



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advance a broader movement that establishes health as a shared societal goal, a vital resource for everyday life, and a key factor for sustainable communities.

2. **Structural or Process Changes**: Establish internal processes that advance long-term policy and financial commitment for leadership development, and to recruit and retain a diverse skilled public health workforce able to address current and future public health needs.
3. **Collaboration**: Build alliances between government levels, science and academia, business, professionals, non-governmental organizations, and communities to promote a shared responsibility towards integrated sustainable policies, understanding that all government policies can have a negative and positive impact on health.
4. **Data**: Monitor, evaluate, and collect reliable data in order to assess activities addressing the social determinants of health related to core public health, and to promote continual quality improvement activities.
5. **Engage Stakeholders**: Engage Mississippians in the design, implementation, and evaluation of policies, practices, services and programs by intentionally sharing power and inclusion in the decision making process. This inclusive approach encourages wider social and cultural environments that allow for more meaningful participation in improving access to care, social determinants of health, and improved economic conditions.

Training

Training on cultural and linguistic competency, including population specific and skills-based training activities, is mandatory and is included in the Workforce Development Plan. Training will be provided either in person or electronically through the department's Learning Management System (LMS). The department will support staff attendance at seminars and conferences that promote health equity, health literacy and cultural competency. The department will also make reasonable efforts to identify further training opportunities in the community and share them with staff.

Staff Recruitment

MSDH managers and supervisors will recruit and hire a diverse workforce by using diversity in advertisements and interviewing, i.e., recruiting for bilingual staff and assessing for cultural and linguistic competency, as appropriate. Attention will be focused on recruiting a public health workforce with core competencies and skills to work effectively within communities in which inequities are a barrier. The recruitment and identification of bilingual staff who speak the language of the community being served will be a priority. For positions that require bilingual skills, the selected candidate must pass an appropriate language assessment that uses a validated tool.

Community Engagement



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MSDH is committed to engaging community organizations as a means for service enhancement and implementing best practices that provide culturally competent services to target audiences. MSDH staff will partner with the public health systems and communities to identify and address health problems through various forms of collaborative processes to include: information sharing, co-creating new projects or adopting shared goals, and participating in and creating coalitions which may include advisory councils designed to gain input and provide feedback to stakeholders for the purpose of addressing health inequalities and proposing solutions. MSDH staff will work with identified priority groups during the development of health promotion strategies and other strategic planning efforts in order to increase community impact.

MSDH staff will proactively consult with the diverse community groups when developing educational materials and messages to enhance the effectiveness of its outreach and to identify and address health inequalities. MSDH will provide or contract for language translation and interpretation services at a level that ensures sufficient capacity to meet our consumers' needs. The department will provide bilingual staff training and resources for maintenance of appropriate certifications and/or qualifications.

MSDH staff will conduct and assist in the community health improvement planning process to develop interventions and strategies that respond to the needs of the community as identified in the Community Health Assessment, including health disparities and inequalities, and to assess health care services capacity and access to care.

Policy and Program Development

Health Equity and Health in All Policies: Staff will review and approve policies and procedures, strategic plans, presentations, trainings, project proposals, educational material, and other documents as needed to assure racial, ethnic, cultural and linguistic, sexual orientation and gender identity, including non-English speaking populations and individuals with disabilities or any other marginalizing characteristic that attributes to social identity or affects health. In addition, staff will work across various sectors to assure health is addressed in all policies that could have an adverse health outcome.

Grant Opportunities: Program directors or other appropriate staff must supply Policy Evaluation with a copy of any Request for Proposals (RFP) or Program Announcement (PA) for which an application will be prepared as soon as the RFP or PA is received. Staff will review grant applications or cooperative agreement to ensure that opportunities for health equity and health in all policies are addressed. All progress reports submitted to the funding agency should follow the same process.

Requests for Proposals should, as appropriate, include a statement informing respondents that by responding to an RFP, they agree to follow federal law as it relates to nondiscriminatory practices and provide culturally competent services, including:



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- Demonstrating previous experience with providing services to the diverse ethnic, linguistic, sexual, or cultural population to be served.
- The current ability of the organization’s staff, volunteers, and board to provide these specific services solicited to the diverse, ethnic, linguistic, sexual, or cultural population to be served.
 - The specific outcome measures, qualitative and quantitative, which demonstrate that the program provides culturally and linguistically competent services.

Sub-grants, contracts, and other funding opportunities for MSDH partners will include a Health Equity Assurance Statement which reflects the language in the RFP in order to confirm the partners’ commitment to MSDH policy. The Health Equity Assurance statement, which requires a signature on behalf of the sub-grantee/contractor, will be included in the sub-grant and contract template.

HiAP-CLAS Policy Assessment, Form 115 will be used as a guide for policy review to assure that all programs and agency policies conform to Health in All Policies Standards whenever possible and to assure that National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare are included in all program and agency policies and procedures.

The MSDH will maintain reliable, comparable, and valid data that provides information about health inequalities, contributing factors or causes of health inequalities, and potential solutions, as feasible, to assist MSDH offices and programs when seeking funding opportunities that address groups or individuals at a higher health risk.

Material Review and Development

MSDH is committed to ensuring materials have been reviewed for cultural and linguistic competency and if appropriate, health equity considerations have been incorporated. In order to meet department requirements, the following must be implemented:

- Press releases or website /social media message targeting a specific community are published using the general and local ethnic outlets for reaching populations with disabilities, non or limited English speaking public, and other members of the public who require particular communication consideration as available.
- Information provided to the public is accurate, accessible, and actionable for the target populations, reflecting consideration of primary language spoken, Limited English Proficiency (LEP) levels, cultural competence, and health literacy.
- Test educational material during the development phase to ensure the target audience is able to understand the message, as needed and as possible.
- Use readability assessment tools test the material for literacy of a target audience.



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- Assure informational resources, such as brochures and posters, are made available in the appropriate languages for the respective communities consistent with program requirements.
- Assure MSDH website content is selectively adapted and tailored to meet the needs of different cultural and linguistic groups and assure decisions on what content to publish in which language(s) are made based on an analysis of the target audience’s needs and in response to emergency situations and crisis.
- Assure multilingual information in printable material, follows the standards of the American Translators Association (ATA) for certified translators.
- Assure textual information on the agency website (not including brochures, posters, or other prepared material) will be made available in other languages by automated online translation services, with appropriate notification concerning accuracy.

Translations of materials: Program staff in need of translation of printed materials will complete the Translation Request Form (1052) found on the agency intranet under Communications. A separate Form 1052 will be required for each document needing translation.

Health Equity Technical Assistance

Health Equity staff will provide technical assistance to program staff in writing, reviewing and approving policies and procedures, funding opportunities, sub-grants, memorandums of understanding, strategic plans, presentations, trainings, project proposals, educational material, request for proposals, and other documents as needed to ensure that health equity and health in all policies has been adequately addressed. MSDH staff should contact Health Equity staff in the Office of Policy Evaluation for any questions and issues with respect to implementing health equity within MSDH and in order to coordinate health equity efforts across all MSDH offices and programs.

