

IMPORTANT INFORMATION ON CHANGES IN THE RYAN WHITE ACT.

The following information is regarding the protections for emergency medical personnel that were removed in the last re-authorization of the Ryan White Act.

Below is the actual text that was eliminated, followed by a document that is the issue brief put out by the National Association of State EMS Officials on the topic.

This re-authorization inadvertently omitted the legal process to notify responders in the eventuality of a needle stick. This will not be revisited for a few years. What this means is that the hospitals are no longer legally required to notify first responders if they have been exposed to an infectious disease by a victim of an emergency who was transported to a medical facility as a result of the emergency, and if the employee attended, treated, assisted, or transported the victim pursuant to the emergency.

øSEC. 2682. ROUTINE NOTIFICATIONS WITH RESPECT TO AIRBORNE INFECTIOUS DISEASES IN VICTIMS ASSISTED.

(a) ROUTINE NOTIFICATION OF DESIGNATED OFFICER.— (1) DETERMINATION BY TREATING FACILITY.— If a victim of an emergency is transported by emergency response employees to a medical facility and the medical facility makes a determination that the victim has an airborne infectious disease, the medical facility shall notify the designated officer of the emergency response employees who transported the victim to the medical facility of the determination.

(2) DETERMINATION BY FACILITY ASCERTAINING CAUSE OF DEATH.— If a victim of an emergency is transported by emergency response employees to a medical facility and the victim dies at or before reaching the medical facility, the medical facility ascertaining the cause of death shall notify the designated officer of the emergency response employees who transported the victim to the initial medical facility of any determination by the medical facility that the victim had an airborne infectious disease.

(b) REQUIREMENT OF PROMPT NOTIFICATION.— With respect to a determination described in paragraph (1) or (2), the notification required in each of such paragraphs shall be made as soon as is practicable, but not later than 48 hours after the determination is made.

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SEC. 2683. REQUEST FOR NOTIFICATIONS WITH RESPECT TO VICTIMS ASSISTED.

(a) INITIATION OF PROCESS BY EMPLOYEE.— If an emergency response employee believes that the employee may have been exposed to an infectious disease by a victim of an emergency who was transported to a medical facility as a result of the emergency, and if the employee attended, treated, assisted, or transported the victim pursuant to the emergency, then the designated officer of the employee shall, upon the request of the employee, carry out the duties described in subsection (b) regarding a determination of whether the employee may have been exposed to an infectious disease by the victim.

(b) INITIAL DETERMINATION BY DESIGNATED OFFICER.— The duties referred to in subsection (a) are that—

(1) the designated officer involved collect the facts relating to the circumstances under which, for purposes of subsection (a), the employee involved may have been exposed to an infectious disease; and

(2) the designated officer evaluate such facts and make a determination of whether, if the victim involved had any infectious disease included on the list issued under paragraph (1) of section 2681(a), the employee would have been exposed to the disease under such facts, as indicated by the guidelines issued under paragraph (2) of such section.

(c) SUBMISSION OF REQUEST TO MEDICAL FACILITY.—

(1) IN GENERAL. — If a designated officer makes a determination under subsection (b)(2) that an emergency response employee may have been exposed to an infectious disease, the designated officer shall submit to the medical facility to which the victim involved was transported a request for a response under subsection (d) regarding the victim of the emergency involved.

(2) FORM OF REQUEST. — A request under paragraph (1) shall be in writing and be signed by the designated officer involved, and shall contain a statement of the facts collected pursuant to subsection (b)(1).

(d) EVALUATION AND RESPONSE REGARDING REQUEST TO MEDICAL FACILITY. —

(1) IN GENERAL. — If a medical facility receives a request under subsection (c), the medical facility shall evaluate the facts submitted in the request and make a determination of whether, on the basis of the medical information possessed by the facility regarding the victim involved, the emergency response employee was exposed to an infectious disease included on the list issued under paragraph (1) of section 2681(a), as indicated by the guidelines issued under paragraph (2) of such section.

(2) NOTIFICATION OF EXPOSURE. — If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has been exposed to an infectious disease, the medical facility shall, in writing, notify the designated officer who submitted the request under subsection (c) of the determination.

(3) FINDING OF NO EXPOSURE. — If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has not been exposed to an infectious disease, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the determination.

(4) INSUFFICIENT INFORMATION. — (A) If a medical facility finds in evaluating facts for purposes of paragraph (1) that the facts are insufficient to make the determination described in such paragraph, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of the facts.

(B)(i) If a medical facility finds in making a determination under paragraph (1) that the facility possesses no information on whether the victim involved has an infectious disease included on the list under section 2681(a), the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of such medical information.

(ii) If after making a response under clause (i) a medical facility determines that the victim involved has an infectious disease, the medical facility shall make the determination described in paragraph (1) and provide the applicable response specified in this subsection.

(e) TIME FOR MAKING RESPONSE. — After receiving a request under subsection (c) (including any such request resubmitted under subsection (g)(2)), a medical facility shall make the applicable response specified in subsection (d) as soon as is practicable, but not later than 48 hours after receiving the request.

Continue for the brief put out by the National Association of State EMS Officials



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NASEMSO Issue Brief on the Repeal of Emergency-Response Provisions Contained in the Ryan White Care Act

Issue

During the recent reauthorization of the Ryan White Care Act in 2006, the emergency-response provisions were struck by Congressional staff members representing the key members of the committee with jurisdiction. Because the primary purpose of the Ryan White Law is to provide funding for HIV programs in the country and none of the staffers participating in the reauthorization discussions understood the purpose of the emergency-response provisions of the law, the emergency response provisions were deleted from the reauthorization bill.

NASEMSO Position

The National Association of State EMS Officials supports the efforts of Congressman Henry Waxman and others to reauthorize the emergency response provisions contained in the original Ryan White Care Act (P.L. 101-381) that mandates that source patient test results be provided to the designated infection control officer (DICO) of the emergency response employee involved in an exposure incident and encourages revised language to include provisions for hepatitis C, pandemic influenza, and clarifying language on rapid testing.

Rationale and Background

Ryan White was a 13 year-old hemophiliac from Indiana when he was inadvertently infected with HIV/AIDS during a blood transfusion in the 1980's. Shortly after his death in 1990, Congress passed the Ryan White Care Act, intended to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. The Act was reauthorized in 1996, 2000, and 2006 and remains an active piece of legislation today. The Ryan White programs also funds and provides technical assistance to local and state primary medical care providers, support services, healthcare provider and training programs.

Workers in many different occupations are at risk of exposure to bloodborne pathogens, including Hepatitis B, Hepatitis C, and HIV/AIDS. Emergency medical services (EMS) personnel are healthcare providers who may be at risk of exposure to blood and other body fluids when caring for victims of trauma but also in the handling of used needles and syringes, secretions, and other body fluids while caring for all types of patients. In 1991, OSHA issued the Bloodborne Pathogens Standard ([29 CFR 1910.1030](http://www.federalregister.gov)) to enhance worker protection from this risk.

When emergency response personnel are exposed to potentially infectious body fluids, a key provision of the Ryan White Care Act mandates that source patient test results be provided to the designated infection control officer (DICO) of the emergency response employee involved in an exposure incident. The medical facility to which the source patient involved in the exposure was transported HAD the legal obligation under this law to provide source patient test results following notification of the exposure by the DICO. The DICO then has the obligation to inform the exposed employee of the source patient test results.

The OSHA Bloodborne Pathogens Standard provides that the employer of an employee involved in an exposure incident must obtain the results of the source individual's testing and make this information available to the exposed employee. However, the Ryan White Law provided the legal provisions necessary to force hospitals to comply with the request for testing and release test results to the designated officer. The provision in the Ryan White Law also gave emergency-response employers the right to contact the Centers for Disease Control and Prevention (CDC) and request that they intervene when hospitals refused to comply with the law.

Key Questions and Answers

What are the risks for EMS personnel for exposure to infectious materials in the workplace?

Virtually every patient encounter contains the risk of exposure to infectious materials for EMS personnel. While advances have been made to protect workers from blood and other body fluids, the prehospital environment is frequently chaotic and inadvertent exposure can occur when blood and other materials splash or splatter onto EMS workers and are inadvertently ingested, absorbed, or inhaled. Exposure can also occur when blood from the source patient seeps into any cut that rescue workers may sustain during vehicle extrication or inadvertent "needle stick" if a patient becomes combative during invasive medical procedures or a needle is accidentally dropped or lost in clothing, bedding, or otherwise. There are also reports of EMS personnel being "stuck" when dirty needles puncture the plastic receptacles intended to protect them from harm.

Isn't OSHA's Bloodborne Pathogens Standard sufficient to protect emergency response workers from exposure to infectious materials?

No. OSHA does not have jurisdiction over state and local governments in about half of the states. In addition, the bloodborne pathogens standard does not provide a clearly stated post-exposure procedure to be followed and does not give clear timeframes for testing and notification. Finally, OSHA does not provide the clear coverage of volunteers that the Ryan White law provided.

What other provisions of the Ryan White law are important to EMS personnel?

The Ryan White law also requires mandatory training/education and mandatory infection control safety programs at the agency/employer level.

Why are the emergency-response provisions of the Ryan White law so critical to the safety of EMS personnel?

The emergency-response section of the Ryan White law put emergency responders in charge of post-exposure management instead of medical facilities. The Ryan White law requires all emergency response employers—fire departments, police departments, and EMS agencies in the country to have a "designated infection control officer." The law stated that if an exposure to communicable diseases

occurred, the infection control officer of the employer of the exposed emergency responder must contact the medical facility to which the source patient in the exposure was transported and request their disease status. It forced hospitals to cooperate with emergency response agencies in post-exposure treatment.

Couldn't an emergency responder find other legal means to obtain a source patient's disease status following an exposure?

It would be enormously difficult for an individual emergency responder to request this type of information from a medical facility. The Health Insurance Portability and Accountability Act (HIPAA) has made it virtually impossible to obtain any patient information without the patient's consent—even if, in a worst case scenario, the source patient knows they are infected with a serious disease and knowingly tries to infect an emergency responder by biting, spitting, or other means. Under the Ryan White law, the medical facility had the obligation to provide results as soon as possible and no later than 48 hours of the request. This rapid testing and quick turnaround of disease-status information has been critical in effective post-exposure medical management. It also allowed department personnel to be tested if needed and treated outside of the emergency department, which served to lower costs and increase proper care and counseling.

Were there any other mandates supported by the emergency response provisions?

The law also provided that medical facilities were required to contact the designated infection control officer of any emergency response employer that transported a patient with pulmonary tuberculosis as soon as possible and no later than 48 hours of making that medical determination.

Another provision allowed for an injunction to be imposed onto non-compliant hospitals, which could mean a stop to federal money going to that facility. Although that provision never needed to be used, the threat of an injunction was sufficient to encourage compliance.

Why is clarification needed to support "rapid testing" by medical facilities?

Rapid tests are now available that can give us the disease status (such as HIV) of source patients within a few hours and current CDC guidelines instruct labs to conduct testing in this manner. Rapid testing reduces the need to provide emergency responders with prophylactic medication that is expensive and contains a risk of toxic side effects.

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NASEMSO gratefully acknowledges the Journal of Emergency Medical Services (JEMS) for content included in this informational reference:

Cross JR (2008) Emergency Response Provisions of Ryan White Law Repealed. J Emer Med Serv. Mar; 33(3): 136-137.