

Ryan White Notification

LAW REPEALED

THE DELETION OF EMERGENCY- RESPONSE PROVISIONS DEMANDS ATTENTION

>> BY JAMES R. CROSS, JD

Emergency responders are protected by a number of laws and standards of care regarding occupational exposure to communicable diseases. Since 1994, the emergency-response provisions of the Ryan White CARE Act (Public Law 101-381) provided such protection. However, in a recent action that went unnoticed in the emergency-response community, Congress removed these provisions in the latest reauthorization of this law (Public Law 109-415).

This development is bad news for emergency responders—and must be addressed by all of us immediately.

CAUSE FOR ALARM

Why do we need this law? Some will say the bloodborne pathogens standard of the Occupational Safety and Health Administration (OSHA) is sufficient. This isn't true, because 1) OSHA does not have jurisdiction over state and local governments in about half of the states; 2) the bloodborne pathogens standard does not pro-

vide a clearly stated post-exposure procedure to be followed and does not give clear time frames for testing and notification; and 3) OSHA does not provide the clear coverage of volunteers that the Ryan White Law provided.

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 required 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. In other words, if you had non-intact skin that was exposed to a patient's blood, your agency's infection control officer was responsible for contacting the hospital and obtaining the patient's disease status.

This legislation has been extremely important for emergency responders because it forced hospitals to cooperate with them in post-exposure treatment. The medical facility had the obligation to provide those results as soon as possible and no later than 48 hours of the request. This 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. 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.

Having this law gave designated infection control officers some legal clout in dealing with hospitals. It often happens that hospitals don't cooperate fully or quickly in post-exposure management of emergency responders, and this provision in the Ryan White law gave emergency-response employers the right to contact the Centers for Disease Control and Prevention (CDC) and request that they intervene with non-

compliant hospitals. Another provision allowed for an injunction to be slapped onto non-compliant hospitals, which would mean a stop to federal money going to that facility. There have been many instances when the CDC's official intervention on behalf of emergency responders has made a difference. No injunctions were issued, but the existence of that provision made a hospital think twice about not complying with the law.

For example, hospitals throughout the country were interpreting the privacy provisions of HIPAA (the Health Insurance Portability and Accountability Act) as preventing them from releasing the results of source-patient testing. The CDC assisted in this matter by providing an official interpretation that it was not a HIPAA violation to make such disclosures. Chances are this battle would have gone on much longer if the emergency-response provisions of the Ryan White law had not been in existence.

In addition, the "ASAP/no later than 48 hours" standard for obtaining source-patient disease status makes a huge difference. Rapid tests are now available that can give us the disease status of a source patient within a few hours. We have rapid testing for HIV, hepatitis C, tuberculosis and meningitis, and current CDC guidelines instruct labs to conduct testing in this manner. However, a designated infection control officer needs to be involved in the process to ensure this is occurring.

Having the "clout" to manage the post-exposure situation enabled the designated infection control officer to set up meetings with the medical facilities and establish the ground rules and process. Hospital laboratories need to understand they must meet the testing requirements. Most laboratories are contracted services to the hospitals, and the hospitals need to be on board to get the labs to comply.

Without the results of rapid testing, there will be more instances in which emergency responders are unnecessarily given prophylactic HIV medication post-exposure because the HIV status of the source patient isn't known. Having that information as soon as an hour after an exposure means, in most cases, there's no need for this toxic medication to be administered. Side effects are significant, and this can be avoided. It's also beneficial for the employer when these drugs aren't administered, because of substantial cost savings.

CALL TO ACTION

So how could Congress remove these provisions? How could a law that provides important benefits to emergency responders just vanish? The answer to these questions highlights why the emergency-response community must remain vigilant in its efforts to protect and advance its interests in Washington.

In the legislation to reauthorize the Ryan White law (H.R. 6143) that was passed in late December 2006, the emergency-response provisions were struck by the congressional staff members representing the key members of the committees with jurisdiction. According to one of these staffers, none of the staffers participating in the reauthorization discussions understood the purpose of the emergency-response provisions of the law. Because the primary purpose of the Ryan White Law is to provide funding for HIV programs in the country, the staffers therefore decided to delete these provisions from the reauthorization bill.

What do we do now? To start, the national associations representing emergency responders must be tasked with the responsibility of rectifying this reckless action on the part of a small group of congressional staffers.

Efforts are also under way in Congress to address this situation. Congressman Henry Waxman (D-Calif.) was the sponsor of the original legislation in 1990. His staff was unaware that the emergency-response provisions of the law had been deleted from the reauthorization legislation and has been involved in discussions on how to proceed at this point.

On a positive note, the emergency-response community has the opportunity to revise, update and, in many ways, improve the original legislation. For example, hepatitis C was not addressed in the original legislation and could now be formally added. Clarification language on rapid testing could also be added.

So now is the time for you—emergency responders throughout the country—to contact your associations and congressional representatives and request they take appropriate action. Your health and safety is on the line. [JEMS](#)

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