NYS DOH Attachment to April 18, 1994 "Dear Emergency Response Organization" Letter

IMPLEMENTATION OF RYAN WHITE CARE ACT PROVISIONS FOR EMERGENCY RESPONSE EMPLOYEES

GUIDELINES FOR DESIGNATED OFFICERS

I. APPOINTMENT AND ROLE OF DESIGNATED OFFICERS

Selection of the DO

Organizations whose employees or volunteers are trained to respond to emergency situations (ambulance services, fire departments, police) must have an individual who is responsible for carrying out the duties of a designated officer (DO), in accordance with the Ryan White CARE Act provisions for EREs. **Ideally, this person should have a medical or nursing backgrqund** that has prepared him/her to address clinical issues. The Department of Health has designated the chief executive officer (CEO) as the responsible individual. However, the CEO may appoint the person most qualified in the organization to assume this responsibility.

The identity of the DO should be readily known to EREs It is recommended that the name and phone or page number of the DO be visibly posted. The organization should notify all hospitals with which it routinely does business, of its DO, how to initiate contact (e.g., through the communications center), and update facilities when changes occur. In addition, EMS organizations may wish to consider stamping the name of its DO on PCR/ACR forms.

Duties of the DO

1. DOs are responsible for assuring that EREs employed by their organization receive appropriate exposure evaluation and information about the exposure.

2. DOs are the point of contact for receiving reports of possible exposure events from EREs and from hospitals that identify that an ERE transported a patient with an airborne or other high risk communicable disease.

3. DOs must assess available information to determine whether a possible exposure has occurred.

4. DOs must initiate a request for evaluation with the medical facility receiving the client and communicate directly with the facility and with the ERE to assure appropriate follow-up.

5. DOs may contact designated health officers as necessary to obtain expert counsel when information may be insufficient to determine whether exposure has occurred.

6. DOs must communicate the findings received from a facility resulting from a request for information and advise the ERE on the appropriate medical follow-up.

7. DOs must maintain the confidentiality of all information acquired directly or incidentally in the course of fulfilling their responsibility for occupational exposure management.

II. DETERMINING A POSSIBLE EXPOSURE TO AN ERE

BLOODBORNE PATHOGENS

Bloodborne pathogens (HIV, hepatitis B) may be transmitted when an infectious body fluid is able to bypass the skin and gain entry to the body. To determine the potential, the DO needs to find out: the **type of body substance involved and the type of injury or contact. The following are considered** significant exposures which require clinical follow-up.

A. The body substance was **blood, semen, vaginal secretions, an internal body fluid** (e.g., cerebrospinal, peritoneal, pericardial, pleural, amniotic, synovial or joint), or **other body fluid visibly contaminated with blood**. (Although breast milk is associated with HIV transmission to infants but is not considered a significant risk body fluid in the occupational environment);

OR

Exposure was to a body fluid during a circumstance where it was difficult or **impossible to differentiate the fluid type** involved and is therefore considered potentially hazardous;

AND

B. The type of injury or contact provided a portal of entry;

percutaneous exposure (e.g., a **penetrating injury** with a contaminated implement that went through the skin such as **needlestick** or **cut**),

mucous membrane contact (e.g., eyes or mouth),

non-intact skin contact (e.g., open dermatitis or abrasion).

Criteria in **both A and B must be met** for the exposure to be considered significant.

What if the exposure is to intact skin?

Blood or body fluid **exposure to intact skin** generally poses no risk of bloodborne disease transmission. However, if there has been prolonged contact with intact skin (e.g., maintaining pressure on a spurting vessel without gloves) and/or there is a massive blood exposure, it is prudent to initiate exposure follow-up.

Should bites be considered an exposure?

Human bites, if the skin is broken, may pose a risk for hepatitis B transmission. Post-exposure follow-up after a human bite generally is not indicated unless there has been blood-to-blood exposure (e.g., the person who did the biting was bleeding from the mouth and the bite punctured the skin).

What should a DO tell an ERE when the "exposure" does not meet these criteria?

DOs who determine that an EREs "exposure" does not meet these criteria should inform the ERE that it is unlikely that the incident would put him/her at risk for a bloodborne disease. If the ERE questions the determination, he/she should be referred to their health care provider for further follow-up.

TUBERCULOSIS

The chief mode of transmission for *Mycobacterium tuberculosis* is through the inhalation of infectious droplet nuclei that are disseminated when a person with active pulmonary or laryngeal tuberculosis coughs, sneezes, speaks, or sings. The opportunity for transmission is enhanced where there is prolonged contact with contaminated air.

Questions to ask:

Did the ERE ride in the ambulance with the patient?

Did the ERE spend any time in any other close or confined space with the patient?

If the answers to either are "yes", then the exposure may be significant. The DO should then determine whether the ERE was protected:

Did the patient wear a mask?

Did the ERE wear a particulate respirator?

If the answer is "yes" to either question, then the exposure is not significant.

UNCOMMON OR RARE DISEASES

When a DO receives information from a health care facility that an ERE in the organization transported a patient subsequently found to have infectious diphtheria, meningococcal meningitis, plague, a hemorrhagic fever, or rabies, the DO should immediately determine the identity of those individuals who had any contact with the patient. The DO should call the designated public health officer for the geographic area who should be involved in recommendations for post-exposure follow-up.

SIGNS AND SYMPTOMS OF A CERTAIN LISTED COMMUNICABLE DISEASES

An ERE who transports a patient who he/she suspects may have a communicable respiratory disease covered under the Ryan White CARE Act may issue a request for information. Signs and symptoms which suggest the possibility of these diseases include:

Pulmonary tuberculosis: productive cough, often with blood-streaked sputum, night sweats, fever, weakness.

Meningococcal meningitis: severe headache, fever, lethargy, confusion, vomiting, stiff neck, petechiae.

Diphtheria: moderate to severe sore throat with whitish membrane, serosanguinous nasal discharge, cervical lymphadenopathy, possible swelling and edema of the neck.

Rabies: apprehension, fear of water, headache, fever, malaise, indefinite sénsory changes, paresis or paralysis, delirium, convulsions.

Symptoms of plague and the viral hemorrhagic viruses have not been included here due to their exceedingly rare occurrence and the probability that they will evoke an immediate public health response when suspected or diagnosed.

Requests for information on patients suspected of having a bloodborne infection (HIV, hepatitis B) should only be initiated when there has been an exposure event that would constitute a significant risk to the ERE.

DOs may wish to consult with a medical expert regarding the interpretation of the above.

III. REQUESTING INFORMATION AND COMMUNICATING THE RESULT OF FINDINGS TO EREs

Request for Evaluation Forms

Each employer of an ERE is responsible for establishing a procedure for requesting information when an ERE suspects exposure to a bloodborne or respiratory pathogen. The attached "Sample" request form can serve as a model for this procedure.

The names of exposed EREs or patients who are the source of the exposure should not appear on the request form. Numbers from incident reports, logs, PCR forms or other mechanisms which can be used by the emergency care organization and health facility to link the affected individuals should be used.

Communication with Health Care Facilities and Public Health Officers

DOs are responsible for communicating with health care facilities regarding the findings of a request for evaluation. Where the response indicates there is insufficient information, the DO may contact the designated public health officer for the geographic area for subsequent review.

The possibility of exposure that could result in infection is stressful, anxiety producing, and sometimes fraught with feelings of anger and bitterness. The DO is responsible for communicating the results of requests for information. If the results are negative, it will be a relief to both the ERE and DO. If the results support the possibility of exposure, the DO will need to communicate that information with appropriate sensitivity and guide the ERE to resources for medical management if this process has not already been initiated.

Whenever the DO discloses HIV-related information, a statement prohibiting redisclosure (enclosed) should accompany the communication as required under Public Health Law 27F.

REFERENCES

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