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March 3, 2009

Dear Senator Stillman, Representative Dargan and members of the Public Safety and Security Committee,

My name is Paul J. Rapanault. I am the Director of Legislative and Political Affairs for the Uniformed Professional Fire Fighters Association of Connecticut. Our 4,000 members serve in 50 fire departments throughout the state.

I am addressing you today in **SUPPORT** of **S.B. 1010 AN ACT CONCERNING EXPOSURE TO INFECTIOUS DISEASES AND EMERGENCY RESPONDERS**.

The Ryan White Act was first passed by Congress in 1990 and provided for funding for AIDS research and treatment along with provisions that pertain to notification of emergency responders in the event of exposures to deadly diseases in the course of their work. The rationale behind this section of the bill was to provide emergency workers with knowledge of exposure so that they could take appropriate action to protect themselves and their families. The Ryan White Act was reauthorized in 2006 and the language providing for this critical notification of emergency workers was inadvertently deleted. Attempts to reinstate the language are ongoing but tediously slow enough to require state assistance in protecting the health and safety of our members and their families.

In 1990, the list of diseases included in the federal legislation that required the notification of emergency workers were **Infectious pulmonary tuberculosis, Hepatitis B, HIV, including AIDS, Diphtheria, Hemorrhagic fevers, Meningococcal disease, Plague and Rabies**. Since that time, there are additional health threatening diseases that have come on the scene. *Hepatitis C, Pandemic Flu, Hepatitis A, and MRSA* have become a great concern to the emergency medical community and should also require notification of EMS workers exposed to them.

There will be **no economic impact on the state and municipal governments** as the structure for compliance with these provisions is already in place and functioning. That is also the case with hospitals or other medical facilities charged with notifying the EMS providers.

Thank you for your consideration.

A handwritten signature in black ink, appearing to read 'Paul J. Rapanault', is written over a horizontal line.

Paul J Rapanault
Legislative/Political Affairs



Uniformed Professional Fire Fighters Association

THE NEED FOR S.B. 1010 AAC EXPOSURE TO INFECTIOUS DISEASES AND EMERGENCY RESPONDERS

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.

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 provide 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.

Some 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.

The law also requires 48 hour notification of disease status. This "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 ability to manage the post-exposure situation enabled the designated infection control officer to set up meetings with the medical facilities and establish the



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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.

How Did The Federal Provisions Vanish?

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.

But this will not happen until at least 2010 when the Ryan White is again reauthorized. Washington sources say that most likely this will occur but given the current financial situation, nothing is for certain. Since the act is the largest federally funded program for people living with HIV/AIDS and sought funding to improve availability of care for low-income, uninsured and under-insured victims of AIDS and their families, the fate of the bill will not be known until next year's financial outlook is clearer. That is why it is imperative to pass this legislation now and protect our emergency workers.

DISPATCH



Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Subtitle B - Emergency Response Employee Notification

Summary

The Ryan White CARE Act, Subtitle B contains provisions for the notification of emergency response personnel exposed to infectious diseases while attending, treating, assisting, or transporting a victim. The law provides for emergency response employee notification following a documented exposure to blood or body fluids, verified by the receiving hospital. It also provides for automatic notification of the emergency response employee if the transported patient is found to have infectious tuberculosis. This notification by the medical facility must be made to the designated officer in writing as soon as possible, but within a period not exceeding 48 hours after the receipt of the request by the designated officer. The designated officer will then inform the employee or employees involved of the determination.

The guidelines include the infectious diseases covered and their mode of transmission. These diseases are only those which are life-threatening by carrying a substantial risk of death if acquired by a healthy, susceptible host, and the disease can be transmitted from person to person. The diseases covered by the exposure notification guidelines as listed in Part II are:

- Infectious pulmonary tuberculosis
- Hemorrhagic fevers
- Hepatitis B
- Meningococcal disease
- HIV, including AIDS
- Plague
- Diphtheria
- Rabies

The guidelines detail the manner in which medical facilities must determine whether emergency personnel were exposed to an infectious disease. If an emergency response employee believes he or she was exposed to blood or blood products of a patient during the performance of normal job duties, the designated officer must investigate the incident. If the designated officer determines through investigation an exposure was sustained then a signed written request can be submitted to the receiving hospital for notification of the patient's infectious status. This must be performed within 48 hours.

The designated officer must provide all collected information regarding the exposure to the medical facility. It is ultimately the receiving medical facility's responsibility to verify and establish the possibility of an exposure to the emergency response employee. If the medical facility has found insufficient evidence exists to determine an exposure, they must notify the designated officer in writing within 48 hours. The designated officer may further pursue the determination of an exposure through a request of the public health officer in the community. If warranted, the public health officer may resubmit the request to the medical facility.

This act does not authorize or require a medical facility to test any such victim for any infectious disease, nor can this act be construed to authorize any emergency response employee to fail to respond, or to deny services, to any victim of an emergency.

States that already have notification laws that are at least as comprehensive as the federal notification law must apply for a waiver from the federal government. If the state does not apply for a waiver, the federal notification law will be used in place of the state notification law.

Subtitle B of the Ryan White CARE Act applies to all emergency response employees (fire fighters, paramedics, and EMTs) throughout the United States. The geographic location of an exposed ERE (such as within an OSHA state plan state) does not affect the applicability of this law.

Action Items

- Each employer of emergency response employees in the state must have selected one designated officer responsible for coordinating requests for and responses of notification, investigating exposure incidents to obtain sufficient information, and who is bound to rules of confidentiality regarding the infectious status of the emergency responder and the victim. In other words, each department, as employer, must have a designated officer. The local should take an active role in recommending to the fire department a suitable individual for this position.
- The receiving medical facilities must have in place procedures for responding to written requests from designated officers regarding the determination of exposure to the diseases covered under this Act.
- The receiving medical facilities must have in place procedures for automatically notifying the designated officer of any emergency responders who have transported a victim found to have infectious pulmonary tuberculosis. This notification must be provided within 48 hours of determining the victim's tuberculosis status.
- Your department must have in place procedures by which you, as an emergency response employee, can make requests to the designated officer regarding a suspected exposure incident. In addition, procedures must be in place by which the designated officer can properly handle all such requests regarding exposure.
- Your local public health agency must also have in place procedures for handling requests for exposure incident evaluation from designated officers.
- Your state public health officer should have received the list of potentially life-threatening diseases and the exposure guidelines for such diseases from the Secretary of Health and Human Services.
- Your local is entitled to the list of potentially life-threatening diseases and exposure guidelines.
- Your state or municipality must be aware of the procedures adopted by the Secretary of Health and Human Services for handling allegations of violations of the exposure notification process.



INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS®

HAROLD A. SCHAITBERGER
General President

VINCENT J. BOLLON
General Secretary-Treasurer

May 23, 2008

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Dingell and Ranking Member Barton:

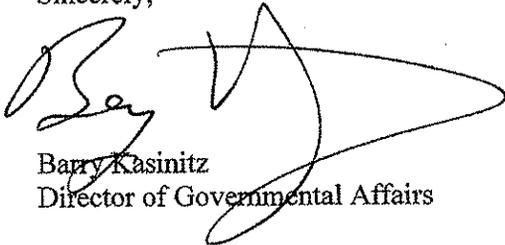
On behalf of the nation's more than 287,000 professional fire fighters and emergency medical personnel, I am writing to bring your attention to a troubling oversight from the 2006 reauthorization of the Ryan White Act. Public Law 109-415 repealed, perhaps inadvertently, provisions providing for the notification of emergency response personnel exposed to certain infectious diseases during the course of duty.

Since their inception in 1990, the Ryan White emergency response employee notification requirements have ensured that emergency responders exposed to life-threatening diseases such as tuberculosis or hepatitis receive rapid notification. Rapid notification enables responders to receive appropriate testing and treatment, as well to take appropriate precautions to avoid further transmissions to family members and coworkers.

Unfortunately, since the elimination of these protections we have noted several instances of medical facilities refusing to provide a patient's disease status to responders with documented exposures. We therefore respectfully request that you work swiftly to restore the notification requirements in law.

Thank you for your attention to this crucial issue. I look forward to working with you to restore these life-saving protections for our nation's first responders.

Sincerely,



Barry Kasinitz
Director of Governmental Affairs

JEMS.com

Article



EMS Community Mobilizes to Restore Exposure-Reporting Rules

Congress cut requirements when reauthorizing Ryan White Act

Mannie Garza

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Congress may have inadvertently created the perfect opportunity for all factions of the fractured EMS community to join forces to restore

provisions critical to prehospital employee safety, which lawmakers deleted from the Ryan White Act when they reauthorized it in December 2006. That move escaped notice until an article by EMS infection expert James Cross was published this March. (See Cross J: "Emergency responder provisions of Ryan White law repealed." *JEMS*. 33(3):136-137.)

Representatives of some national EMS and fire organizations are starting to meet with members of Congress to address their concerns, and the International Association of Fire Chiefs EMS Section voted April 20 to work with others to create "a committee of constituents and stakeholders to speak with one voice" on the issue and perhaps to develop legislation to rectify the situation. IAFC Government Affairs Manager Lucian Deaton subsequently contacted the EMS lobbying organization Advocates for EMS, which had already begun gathering information and working with members on possible solutions. Lori Moore-Merrell, DrPh, MPH, EMT-P, assistant to the International Association of Fire Fighters' president, said IAFF was already working with IAFC on Ryan White.

Some background

When Congress passed the original Ryan White Act in 1990 (an HIV-program funding bill named for a child infected with HIV during a blood transfusion), it included provisions to protect first responders and ambulance staff. Those provisions (in Public Law 101-381, Part E, Section 2681-2690) required EMS and first response agencies to designate an infection control officer who would contact the receiving hospital and request the patient's disease status following a responder's needle-stick or other exposure to blood or body fluids. The law then required the hospital to test the patient and inform the ICO in writing within 48 hours—sooner when possible—that the emergency responder had or had not been exposed to an infectious disease.

A hospital's failure to comply could result in a complaint to the Centers for Disease Control and Prevention and, ultimately, in an injunction preventing the flow of federal funds to the noncompliant facility. "No injunctions were issued, but the existence of that provision made a hospital think twice about not complying with the law," said Cross, legal consultant for Katherine West's Infection Control/Emerging Concepts in Manassas, Va.

"That language was included in subsequent reauthorizations of the Ryan White law until H.R. 6143 was passed in 2006 (Public Law 109-415). Subpart II was inexplicably stricken from the legislation that was signed into law on December 20, 2006," noted Steve Isaacson, EMS chief and ICO, Overland Park (Kan.) Fire Department, in a briefing to the IAFC EMS Section.

Cross noted that many hospitals insisted that the Health Insurance Portability and Accountability Act prevented them from providing EMS and first response agencies with patient test results—until the CDC provided official word that they were misinterpreting HIPAA.

"This legislation has been extremely important for emergency responders because it forced hospitals to cooperate with them in post-exposure treatment," Cross said. Without rapid testing and notification, he said, many emergency responders will be forced to take unnecessary prophylactic HIV medications, which are costly and can cause severe side effects.

Although the federal Occupational Safety and Health Administration's blood-borne pathogen standard aims to protect emergency responders, the National Association of State EMS Officials notes, "OSHA does not have jurisdiction over state and local governments in about half of the states" and "does not provide the clear coverage of volunteers that the Ryan White law provided." Unlike the Ryan White Act, NASEMSO notes, OSHA's standard also "doesn't provide a clearly stated post-exposure procedure to be followed and does not give clear timeframes for testing and notification."

The changes have taken effect

Some EMS leaders believed—mistakenly—that the emergency response provisions would remain in effect until Oct. 1, 2009, when the Ryan White Act would have expired if Congress had not passed the reauthorization bill in December 2006.

But Cross explained, "The Ryan White Act as reauthorized will be repealed [Oct. 1, 2009] if it is not reauthorized. The law as reauthorized does not contain the sections of the original law covering disease exposure to emergency responders. [Those sections] are already gone and [have] been gone since December 2006."

"I just had an [employee] exposure in the past couple of weeks, and the word is out with the hospitals that they no longer need to give us this information," Isaacson said.

"I recently got word from a hospital on the Missouri side [of the Mississippi River] saying, 'I don't have to give you that information anymore. In fact, I can't give it to you anymore.'"

What now?

In early April, National Association of EMTs President Jerry Johnston, former NAEMT president Nathan Williams and Advocates for EMS lobbyist Lisa Meyer visited the office of Sen. Mike Enzi, R-Wyo., ranking member of the Senate Committee on Health, Education, Labor and Pensions, which has jurisdiction over the Ryan White Act. "We met with Enzi's office to discuss the issue in general and potential next steps," Meyer said.

"We're now in communication with the CDC and OSHA to figure out what's in place, what language needs to be updated from the original law and what other blood-borne pathogens should be covered. We will then go back to [Capitol] Hill and discover what, if anything, should be done legislatively and what can be done via regulations," Meyer said.

"All the different groups are starting to reach out and work together on a fix, and I'm

hoping we'll have a meeting with all the players within a month or so where we can put something together to talk with all those agencies," Meyer added.

"This is a cross-cutting issue that affects us all," Johnston said. "I think united, we can make something happen."

For more information, visit www.advocatesforems.org, contact James Cross or Katherine West by e-mail at info@ic-ec.com, Steve Isaacson at steve.isaacson@opkansas.org or Lucian Deaton at Ideaton@iafc.org. Organizations interested in participating should contact Lisa Meyer at lmeyer@cgagroup.com.



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