



RYAN WHITE NOTIFICATION LAW

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ISSUE

This report provides a brief summary of provisions in the federal Ryan White Comprehensive AIDS Resource Emergency (CARE) Act regarding notification to emergency responders possibly exposed to infectious diseases when treating, assisting, or transporting victims of an emergency.

SUMMARY

In 1990, Congress enacted the Ryan White CARE Act (P.L. 101-381) which, among other things, provided federal funding for HIV and AIDS programs for low-income, underinsured, and uninsured people. It also established a process for medical facilities to notify emergency responders (e.g., firefighters, paramedics, EMTs, law enforcement officers, and EMS volunteers), through designated officers, that they may have been exposed to certain infectious diseases (often referred to as the "Ryan White Notification Law"). When Congress reauthorized the act in 2006, it eliminated the notification provisions, but then reinstated them in the 2009 reauthorization (P.L. 111-87).

By law, notification occurs by either (1) an inquiry initiated by an emergency responder or (2) notification by a medical facility that determines that the victim of an emergency has a federal Department of Health and Human Services (HHS)-listed infectious disease.

The notification provisions do not apply to states with existing notification laws that HHS designates as being substantially similar to the federal law. (Connecticut must comply with the federal law.)

The law prohibits any cause of action for damages or any civil penalty against a medical facility, designated officer, or other public health official for failing to comply with the law.

EMS NOTIFICATION PROVISIONS

Part G of the 2009 Ryan White HIV/AIDS Treatment Extension Act establishes a process for medical facilities to inform emergency responders that they may have been exposed to certain infectious diseases, so that they can make informed decisions about subsequent diagnosis, prevention, or treatment measures (42 USC §§ 300ff-131 to -140).

Notification can occur two ways:

1. the EMS provider initiates an inquiry based on a potential exposure incident (e.g., contact with body fluids, needlestick injury, etc.) or
2. the medical facility provides notification if it determines that the victim of an emergency has a federal HHS-listed infectious disease (see below) transmitted by airborne or aerosolized means.

Emergency Responder Inquiry

The law requires each state's public health officer to identify a designated infection control officer for each emergency services entity. The designated officer must respond to requests from an emergency responder for an assessment of whether he or she may have been exposed to one of the listed infectious diseases. The designated officer then collects and evaluates the facts about the potential exposure and determines whether an exposure likely occurred.

If exposure is likely, the officer requests that the medical facility that treated the emergency victim determine whether an exposure occurred or there is inadequate information to make a determination. If the emergency victim died, the facility also provides a copy of the inquiry to the medical facility that ascertained the victim's cause of death, if it is a different facility.

The medical facility must provide this information to the designated officer who then notifies the emergency responder. The law requires medical facilities to respond to requests from designated officers as soon as possible, but no later than 48 hours after receiving the request (42 USC § 300ff-133).

Routine Notification by Medical Facilities

Medical facilities must notify the designated officer as soon as possible, but not later than 48 hours after determining that an emergency victim transported by an emergency responder (including victims who die at or in route to the facility) had an infectious disease transmitted by airborne or aerosolized means. The designated officer must then notify the emergency responder. However, the law does not

require medical facilities to test emergency victims for any infectious disease (42 USC § 300ff-132).

Reportable Infectious Diseases

The law required HHS to establish:

1. a list of potentially life-threatening infectious diseases routinely transmitted by (a) contact with body fluid, (b) aerosolized airborne means, (c) aerosolized droplet means, and (d) agents potentially used for bioterrorism or biological warfare and
2. guidelines describing the (a) circumstances in which emergency responders may be exposed to these diseases and (b) manner in which medical facilities should make determinations for notifying emergency responders of such exposure (42 USC § 300ff-131).

HHS designated these responsibilities to the Centers for Disease Control and Prevention (CDC). When the notification provisions were reinstated in 2009, Congress required the CDC to update its list of infectious diseases covered by the law. The CDC [published](#) its updated list in 2011 (see Table 1).

Table 1: CDC Infectious Diseases List

	<i>Diseases Included in the Original List</i>	<i>Diseases Added in 2011</i>
Blood Borne Diseases	HIV and AIDS	Cutaneous Anthrax
	Hepatitis B	Hepatitis C
	Rabies	Vaccinia Virus
	Viral Hemorrhagic Fevers	Smallpox
Airborne Diseases	Tuberculosis	Varicella Zoster Virus (chickenpox)
		Measles
Droplet Diseases	Diphtheria	Mumps
	Meningitis	Novel Influenza A and other strains with pandemic severity index greater than or equal to three
	Pneumonic Plague	Pertussis
		Rubella
		Severe Acute Respiratory Syndrome (SARS-CoV)

Source: CDC website, <http://www.cdc.gov/niosh/updates/upd-11-02-11.html>

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