Approved: 3-22-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 10, 1993 in Room 526-S of the Capitol.

All members were present except: Senator Salisbury, Excused

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Stephen N. Paige, Director, Bureau of Environmental Health Services, Kansas Dept. of Health and Environment
Cathy Rooney, Director, Health Occupations Credentialing Unit, Kansas Dept. of Health and Environment
Sally Finney, Director, AIDS, Division of Health, Bureau of Disease Control, Dept. of Health and Environment
Katharine C. Rathbun, M.D., M.P.H., Topeka-Shawnee County Health Agency
Gordon Risk, M.D., American Civil Liberties Union
Ann Hebberger, United Community Services of Johnson County

Others attending: See attached list

Hearing on **HB 2108** - Repealing bedding labeling requirements.

Stephen N. Paige, KDHE, stated the department has no objection to the passage of **HB 2108** which would amend the Kansas Bedding Act. Passage of the bill would remove requirements for sterilization and disinfection of bedding products intended to be resold and remove the requirement for bedding articles to carry the official tag identifying manufacturer and materials used. (Attachment 1) Committee discussion related to removal of a tag reading "under penalty of law" being a misdemeanor if enforced, and federal law that is used universally in textile labeling (mattresses, pads and cushions) enforced by the Federal Trade Commission. This bill would not affect the federal law and would eliminate 2 pages in the statutes books. No conferees appeared in opposition to the bill. Senator Hardenburger made a motion **HB 2108** be recommended favorably for passage and placed on the consent calendar, seconded by Senator Papay. The motion carried.

Hearing on **HB 2110** - Adult care home licensing fees.

Cathy Rooney, KDHE, testified in support of **HB 2110** and outlined specific amendments in the bill. The Board of Adult Care Home Administrators and the Kansas Department of Health and Environment are jointly responsible for administering the Kansas adult care home administrators' licensing program. The bill is being sought to allow for statutory authority for setting fees to cover the administrative cost of the program, and to establish reinstatement and endorsement processes that are consistent with other licensure programs in Kansas and across the nation. (Attachment 2) In answer to a member's question, the Kansas Professional Nursing Home Administrators and the Kansas Health Care Association opposed the bill as originally introduced, but they now support the bill since amendments restore a statutory cap on fees that may be established by the Board. Language relating to "training acquired by an applicant" on page 4, line 4 of the bill, and "licensure fee and an endorsement fee", on line 6, was discussed, and it was suggested the reciprocity fee language be left in the bill. Staff suggested that the language regarding the examination fee that the board shall fix be clarified on page 2, line 22.

Final Action on **HB 2110**

Staff briefed the Committee on suggested changes and recommendations: On page 1, in the title, delete "fee structure for"; on page 2, line 22, strike "examination fee" after the word "and", and reinsert "an examination fee" after "if necessary"; on page 2, line 25, it should read "the secretary of health and environment" and not

"the secretary of the department of"; on page 4, line 6, "an endorsement" stricken, and "a reciprocity" inserted. Senator Walker made a motion to adopt the technical changes, seconded by Senator Langworthy. The motion carried. Senator Hardenburger made a motion to recommend **HB 2110 as amended** favorably for passage, seconded by Senator Papay. The motion carried.

Hearing on **SB 198** - HIV-AIDS monitoring and research.

Sally Finney, KDHE, appeared in support of **SB 198** which proposes that the nature of reporting of cases of infection with the Human Immunodeficiency Virus (HIV) be changed from anonymous (no names provided) to confidential (names provided). In the proposed legislation, there is a provision that would allow the Secretary of KDHE to designate up to five HIV counseling and testing sites which would continue to provide anonymous testing. This would make allowances for those persons who are at-risk for HIV infection, but who would not access testing services knowing that they would be asked to provide their name. Under existing statute, both physicians and laboratories are required to report HIV infection cases to KDHE. The proposed revisions would require only physicians to submit names, and laboratories would continue to conduct HIV antibody tests without being sent the name by the site of origin except in situations where the laboratory had access to such information. (Attachment 3) In answer to a question, Ms. Finney stated there is no data available on the number of persons that come to Kansas for HIV testing from states where testing is not confidential, and there is no way of knowing if the name given is that person. The location of the five testing sites would be decided by the Secretary of KDHE.

Katharine C. Rathbun, Topeka-Shawnee County Health Agency, appeared in support of **SB 198** as well as written testimony from Dr. Larry Jecha, Wichita-Sedgwick County Department of Community Health. (Attachments 4 and 4a) Dr. Rathbun stated their primary responsibility is the protection of the public and the community, and gave an overview of the process in reporting an infectious disease and those using fictitious names.

Gordon Risk, M.D., representing ACLU of Kansas, stated his opposition to **SB 198** which he felt would shrink the number of anonymous testing sites for the HIV virus from 79 to a maximum of 5, would require physicians and laboratory directors to report the names and addresses of those who test positive for the virus, and would reverse the AIDS policy the legislature has pursued since 1988. Dr. Risk stated data should be obtained from the Center of Disease Control that would show if mandatory reporting scared off people from getting tested and if mandatory reporting resulted in better disease control. (Attachment 5) During Committee discussion it was noted there is mandatory reporting of measles, and if reporting of HIV cases would be more beneficial in comparison with measles reporting in order to protect the health of the general public.

Ann Hebberger, United Community Services of Johnson County, appeared in support of **SB 198** but would urge that reporting guidelines be carefully analyzed and constructed to limit reporting of positive test results as far as is possible. Ms. Hebberger stated her organization question Section 4, 64-6004, paragraph (a) which allows disclosure of information to health care providers, emergency personnel, correctional officers and law enforcement officers. Given mandatory compliance with OSHA regulations regarding precautions for dealing with blood-borne pathogens, and she questions the risk to these groups and the "need to know." Ms. Hebberger urged the Committee to support by-name reporting for HIV. (Attachment 6)

Sally Finney commented that in 1992 24% tested through a local health department and these were sites where the disease intervention specialists could be called in for follow-through, however, 76% tested in physicians' offices and that is the area where there is most concern of no follow-through.

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for March 11, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 3-10-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Ann Kellenyer	6703 Hadley O.P.	U.C.S
Betsy Topper	6400 Glenwood Ste 205 OPKS	Limited Community Services Health
Kate Rathbun MD	1615 W 8th Topeka	Topeka/Shawnee Co
Gordon Risk		ACLU
Cathy Rees		KDHE
Stephen N. Paige	Topeka	KDHE
Kathy Tyson	Topeka	KDHE
Scott Focke	Topeka	SRS
Marvin Stottsmire	TOPEKA	KDHE

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

[redacted]

Robert C. Harder, Secretary

Reply to:

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2108

Passage of House Bill 2108 would amend the Kansas Bedding Act. Passage of H.B. 2108 would remove requirements for sterilization and disinfection of bedding products intended to be resold. In addition, passage of H.B. 2108 would remove the requirement for bedding articles to carry the official tag identifying manufacturer and materials used.

The provisions of the Kansas Bedding Act were adopted in the 1920's. At that time there was justifiable concern regarding the quality of manufacturing materials and the suitability of articles intended for resale. Mandating tagging of bedding articles was a means in which assurances could be provided that bedding articles were made of safe materials. In the early part of this century it was not uncommon to find bedding articles made from dirty rags, old clothing, carpets or the sweepings from hen house floors.

The public health concerns regarding the manufacture of bedding articles have been abated by the manufacturing industry. Sales of used articles pose little if any concern other than aesthetic appeal. Consideration should be given to the usefulness of tagging providing consumer information regarding hypo-allergenic materials or instructions for product care. In large part, the industry will likely continue the practice of providing consumer information through product tagging.

The KDHE has no objection to passage of H.B. 2108.

Testimony presented by:

Stephen N. Paige
Director
Bureau of Environmental Health Services
Division of Health
March 10, 1993

Senate PHW
Attachment #1
3-10-93

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
[redacted]
Robert C. Harder, Secretary
Reply to:

TESTIMONY PRESENTED TO

THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

by

THE BOARD OF ADULT CARE HOME ADMINISTRATORS

and

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2110 as Amended

The Board of Adult Care Home Administrators and the Kansas Department of Health and Environment are jointly responsible for administering the Kansas adult care home administrators' licensing program. The statutes require the Board to develop, impose, and enforce licensing standards, issue licenses, investigate complaints against licensees and revoke or otherwise discipline licensees, if necessary. The Department is the administrative and enforcement arm of the board. There are approximately 800 persons licensed as adult care home administrators.

This bill is being sought to allow for statutory authority for setting fees to cover the administrative cost of the program, and to establish reinstatement and endorsement processes that are consistent with other licensure programs in Kansas and across the nation.

The specific amendments made by House Bill 2110 to meet these objectives are as follows:

1 Section 1, page one, lines 26-27, grants specific statutory authority for the temporary license fee to be fixed by rules and regulations adopted by the Board of Adult Care Home Administrators;

Senate PH&E
Attachment #2
3-10-93

2 Section 2, page two, lines 20-30, lists the different fees established in the licensing act, requires these fees to be fixed in rules and regulations to cover the administration costs of the program, establishes a cap of $200 on any fee set in regulations, and establishes the fee remittance, deposit, and credit process;

3 Section 3, page two, lines 33-35, requires the applicant to pay a license fee and the examination fee, if required, to the Secretary of Health and Environment thus allowing the fees to be separated;

4 Section 3, page two, line 36, removes the maximum cap that was set just for the license and/or examination fees. (Section 4(b), page 3, line 21, removes the maximum cap on the renewal fee as well);

5 Section 4(b), page three, lines 25-32, determines that to renew a license within 30 days following its expiration requires a late renewal fee; that a license expired for 31 or more days is considered lapsed, and will require reinstatement prior to renewal;

6 Section 4(d), page three, lines 42-43 requires submission of a renewal fee and reinstatement fee when reinstating (currently only a reinstatement fee is required); and

7 Section 4(e), page four, allows endorsement of training received by applicants outside the State of Kansas and requires that a reciprocity fee and license fee be paid for persons seeking reciprocity from another state or endorsement of out-of-state training (currently only a reciprocity fee is required).

These changes are consistent with other licensure statutes and legislative directive to move toward encumbering the cost of the program through fees.

The Board and the Department recommend the passage of House Bill 2110 as amended.

Presented by: Cathy Rooney, Director
Health Occupations Credentialing Unit
Bureau of Adult and Child Care
March 10, 1993

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
[redacted]
Robert C. Harder, Secretary
Reply to:

Testimony presented to

Senate Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill 198

I am here today to speak in favor of SB198 which proposes that the nature of reporting of cases of infection with the Human Immunodeficiency Virus (HIV) be changed from anonymous (no names provided) to confidential (names provided).

Under existing state statute, cases of HIV infection are reported to the Kansas Department of Health and Environment with demographic information only. Names, which are frequently known by the physician or HIV counseling and testing site, are removed before the report forms are forwarded by the testing site to the department. The omission of names from these reports has posed a major obstacle for KDHE in the areas of case follow-up and collecting accurate information about the status of the HIV epidemic in Kansas.

Trained Disease Intervention Specialists (DIS) at KDHE offer assistance with partner notification and contact tracing for every person diagnosed with a sexually transmitted disease in the state. This would include persons with Acquired Immune Deficiency Syndrome (AIDS) and HIV infection. The counseling provided by Disease Intervention Specialists to sexual and needle-sharing partners of HIV-infected persons is an important tool in preventing new cases. Persons who are highest risk for HIV infection receive one-on-one counseling that focuses on reducing their risks by addressing their needs as individuals. However, in most instances, the intensive prevention counseling and follow-up is impossible because the

Mills Building • 109 SW 9th • Topeka, Kansas 66612-1228 • (913) 296-1500

identity of the infected person and his or her sexual or needle-sharing partners is unknown to the DIS.

More than 75% of case reports are made by physicians who are unable to conduct the field work associated with partner notification and contact tracing. This is the responsibility of the public health system. However, KDHE cannot provide the necessary follow-up, because there is no name available to Disease Intervention Specialists to locate the HIV-infected patient for interview. This obstacle only exists for HIV infection. All other sexually transmitted disease case reports, including those for AIDS, are submitted to KDHE for follow-up with the name of the patient.

KDHE receives federal funding through Title II of the Comprehensive AIDS Resources Emergency (CARE) Act of 1990 to provide essential services for persons with HIV infection and AIDS. (This act is also referred to as the "Ryan White Act.") The State's allocation for Title II funds is based on a formula which uses the number of reported AIDS cases. This will amount to nearly $1,160 per case in fiscal year 1993[1]. Title II funding to Kansas is used to provide medications, assistance with private health insurance premiums, and home health care for eligible persons with HIV infection and AIDS. Under the current reporting system, there is no way to monitor the progression of disease from HIV infection to AIDS. If KDHE had the name of the infected person, it would give staff the ability to conduct periodic reviews of physician records and assist physicians in reporting an AIDS case once that patient's diagnosis had changed. KDHE employs trained staff who are available to assist physicians with case reporting.

Finally, because there is no way to sort out duplicate records for reports of HIV infection, KDHE is unable to obtain an accurate picture of the number of new cases being reported. The same person can be tested in one location, move, then be re-tested another. The report would be submitted to KDHE twice and recorded as two cases. By providing names with reports, the AIDS Epidemiologist for KDHE would be able to eliminate these duplicate reports.

In the proposed legislation, there is a provision that would allow the Secretary of KDHE to designate up to five HIV counseling and testing sites which would continue to provide anonymous testing. This would make allowances for those persons who are at-risk for HIV infection but who would not access testing services knowing that they would be asked to provide their name.

Under existing statute, both physicians and laboratories are required to report HIV infection cases to KDHE. The proposed revisions would require

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[1] Estimate calculated by the United States Department of Health and Human Services, Health Resources Services Administration.

only physicians to submit names; laboratories would continue to conduct HIV antibody tests without being sent the name by the site of origin, except in situations where the laboratory had access to such information.

Approval of SB198 would greatly expand KDHE's capacity to provide follow-up for Kansans diagnosed with HIV infection. It would enhance the department's ability to obtain accurate information relating to the presence of HIV infection in Kansas. And it would benefit the state through increased funding for persons with HIV infection and AIDS; it also offers substantial hope of reducing transmission of the disease.

Testimony presented by: Sally Finney, M.Ed.
Director, AIDS Section
Division of Health, Bureau of Disease Control
March 10, 1993

Topeka-Shawnee County

Health Agency
1615 S.W. 8th Street
Topeka, Kansas 66606
Phone 913-233-8961

Testimony on SB 198 - An Act Relating to HIV Infection

Katharine C. Rathbun, M.D.,M.P.H. 10 March 1993

As the director of a major health department, I strongly support the need for this legislation to improve our ability to control the spread of Human Immunodeficiency Virus in Kansas.

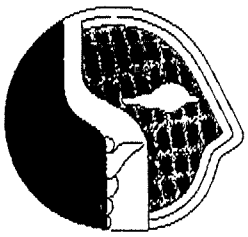
This legislation has the full support of all of the public health physicians now practicing in Kansas. It also has the support of all the public health professional organizations in the state including the Kansas Public Health Association and the Kansas Association of Local Health Departments.

The reason for reporting contagious diseases to the health department is to allow public health professionals to intervene and stop the spread of the disease. For sexually transmitted diseases such as HIV this is called contact tracing. Recent studies have shown what VD doctors have known for years, infected individuals will not bring their own partners for treatment or education. In several studies, fewer than 10% of partners were notified by the individual. But, when the health department did the notification more than 50% were located. When the physician also gave information on contacts to the health department, the number notified went up over 80%.

Notifying and testing contacts is important because this is the only real opportunity to intervene and stop the disease from spreading. Testing and counseling have been shown to be a resounding failure at stopping the spread of HIV. All we are doing by testing people who come to the clinic on their own, is document the spread of the disease. When it is done anonymously, we can't even do that.

In the studies, between 75% and 85% of the contacts were HIV negative at the time they were contacted by the health department. Over 90% did not know they were being exposed to HIV. These are the people who can and will change their behaviors and avoid getting this disease.

Senate PH&W
Attachment #4
3-10-93



Senate Committee on Public Health & Welfare

Testimony on SB 198, An act relating to HIV infection

March 10, 1993

Senators, staff and visitors, I am Dr. Larry Jecha, Health Officer and Director of the Wichita-Sedgwick County Department of Community Health. Although I am unable to be with you in person today, I do appreciate this opportunity to have our views expressed at this hearing.

We support Senate Bill 198 and urge you to pass it, and adopt it into state law. This bill is a true public health measure designed to protect the citizens of Kansas. Senate bill 198 will enable us to treat HIV infection in a manner similar to other sexually transmitted diseases. Reporting HIV infection by both physicians and laboratories will help prevent the spread of this infection, like reporting helps prevent the spread of syphilis and gonorrhea.

Currently, only case defined AIDS is reported. This allows the passage of time, perhaps as long as ten years, for the infection to be transmitted before it is reported. Reporting cases, and notification of partners are the time tested methods of controlling sexually transmitted diseases.

You may expect to hear from non-public health physicians who are opposed to this bill . They are acting in good faith to their calling to heal individuals. Those of us in public health however must act on the basis of what is best for the **entire community**. This bill will enable us to do that.

Senate PH&W
Attachment #a
3-10-93

Wichita-Sedgwick County Department of Community Health
2000 East Ninth Street \ Wichita, Kansas 67214-3708 (316)268-8401

To: Senator Sandra Praeger, Chairperson
Senate Public Health and Welfare Committee
From: Gordon Risk, M.D., American Civil Liberties Union of Kansas
Date: March 9, 1993

Subject: S.B. #198

This bill would shrink the number of annonymous testing sites for the HIV virus from 79 to a maximum of 5, would require physicians and laboratory directors to report the names and addresses of those who test positive for the virus, and would reverse the wise AIDS public policy this legislature has pursued since 1988. When it established current policy in 1988 the legislature overruled a significant segment of the medical community, from which you will be hearing today, which insisted that there was no difference between syphilis and HIV and that the diseases should be similarly treated. The differences were then and are now more significant than the similarities. This legislature and not the Kansas public health officials of that time have been subsequently vindicated, as the attached article from the official newspaper of the American Psychiatric Association confirms. Although the article is dated, I know of no data that contradict its conclusion that mandatory reporting of names discourages people from getting themselves tested. This legislature needs to do what it can to encourage testing and to promote a collaborative relationship between doctors and their patients. This legislation would frustrate those aims.

Senate PHFW
Attachment #5
3-10-93

APA Opposes Reporting Names of People Testing Positive for HIV Infection

In the wake of studies showing that mandatory reporting of the names of people who test positive for human immunodeficiency virus antibodies appears to discourage HIV testing and provides no public health benefit, APA's Board of Trustees voted at its September meeting to oppose laws or regulations that require such reporting.

The APA Commission on AIDS, in recommending that the Board take this action, stressed that there is little reason to condone such a breach of patient confidentiality in the absence of data pointing to a positive effect in jurisdictions that have imposed mandatory name reporting.

In debating what form its position statement on mandatory name reporting should take, the commission grappled with several controversial issues including whether mandatory name reporting was necessary to implement successful contact-tracing programs.

There was little support for this contention sometimes made by government and public health officials, however, after several members pointed out that a contact-tracing program cannot succeed without the voluntary cooperation of infected individuals. Reporting names of seropositive people to health officials does not guarantee that they will be willing to comply with requests to identify their sex partners.

Another crucial issue is whether it discourages individuals from voluntarily being tested.

If this practice drives "underground" those people who would choose to learn their HIV status if testing was anonymous, as opponents of mandatory name reporting contend, then what significant public health benefit can possibly derive from it?

If fewer people learn their HIV status, the epidemic will be harder to control than it is now, argue experts opposed to name reporting.

Members of the AIDS commission were also concerned about the loss of counseling opportunities if sizable numbers of people who have engaged in high-risk activities stay away from testing sites for fear of having their names reported. Counseling sessions that focus on altering risk behaviors and on ways an individual may be endangering others contribute more to the war against AIDS than would a mandatory name reporting policy, they concluded.

There are now data that overwhelmingly indicate a substantial number of those who have been tested for the AIDS virus would not have done so if they had been told that if they were seropositive, their names would be reported to a government agency, noted James P. Krajeski, M.D., a member of the AIDS commission.

Krajeski cited studies from such diverse locales as Oregon, South Carolina, Colorado, San Francisco, and New York City, where researchers have assessed the effect of mandatory name reporting on the number of people appearing for or considering voluntary HIV testing.

In all sites except Colorado, investigators found that knowing their identity would be forwarded to public health officials if they were HIV positive negatively affected the number of those who were or would be tested.

In Colorado, which has a statewide mandatory name-reporting requirement, there was little change in the numbers appearing for testing after the law was enacted, but this may be attributed to the option of using a false name, Krajeski suggested, which the state permits but does not encourage.

'Spirit of Good Will'

Mandatory name reporting is a particularly bad idea, because it often ends up alienating "the spirit of good will" that is necessary to combat the spread of the virus, said Stuart E. Nichols, M.D., chair of the APA Commission on AIDS.

In terms of prevention efforts, "voluntary cooperation is the only game in town," and sacrificing an opportunity to educate people about the disease, as seems to be the case with mandatory name reporting, sets a dangerous course, he added.

Before governments decide to sacrifice some citizens' civil rights, there needs to be a clearly demonstrated advantage for public health policy, Nichols said in an interview, and this has yet to be shown for mandatory name reporting of infected individuals.

As of July, 10 states had already passed laws requiring that names of HIV seropositive individuals be reported to health departments; most are states with a relatively small incidence of AIDS. Another 18 states require reporting of infected individuals, but do not insist that their identities also be reported.

These 28 states account for 45 percent of the U.S. population, but only 24 percent of its AIDS cases, according to the Centers for Disease Control.

All states require that AIDS cases be reported to health officials.

Psychiatric News
Newspaper of the
American Psychiatric Association

5-2

United Community Services
of Johnson County, Inc.

TESTIMONY
before the
Senate Public Health and Welfare Committee

March 10, 1993

Re: Senate Bill 198

Good Morning. My name is Ann Hebberger. I am a member of the board of United Community Services of Johnson County. UCS is a private, nonprofit, research-based agency engaged in planning for health and human services in Johnson County, Kansas. One issue area in which we have been particularly active throughout 1992 and the beginning of 1993 is HIV/AIDS.

I am here this morning to testify as a proponent of Senate Bill 198. Our reading of this bill is that it would encourage, by limiting the number of available anonymous test sites for HIV, by-name reporting of positive results of tests for HIV. Having names and contact information for individuals who test positive for HIV would directly benefit those persons, their loved ones, others who are also infected, and uninfected Kansans, as well.

Having names and contact information would facilitate follow-up with persons who are HIV positive. This would mean that physicians, clinics and local health departments could ensure that such persons understand the nature of their illness, know what services are available to them and have access to professionals who can facilitate entrance to those services. The benefit to persons who test positive

Senate PH&W
Attachment 6
3-10-93

6400 Glenwood, Suite 205, Overland Park, KS 66202-4021 913-432-8424 FAX: 913-432-8427
Planning Affiliate of Heart of America United Way

for HIV is improved and timely access to services that could prolong their productive years.

By-name reporting would enable service providers to plan services and programs to proactively meet emerging needs. In addition, because federal dollars for HIV/AIDS services and supports are tied to cases reported by name, by-name reporting would allow the Kansas Department of Health and Environment to pull down additional dollars for early intervention, care coordination and home health care.

HIV has become a chronic disease. Individuals who test positive for HIV are living longer and remaining in the labor force for a longer time. HIV/AIDS has clear economic implications for the state, over and above the expense of caring for those who have been diagnosed as having AIDS, the end-stage of HIV.

To this point, I have talked exclusively about the benefits of by-name reporting. We, at UCS, feel that we would be irresponsible to pretend that by-name reporting carries no risk. As the statutes are currently written, physicians and laboratories must report positive HIV test results to the Secretary of Health and Environment. By-name reporting would mean that the person's name would accompany or replace what now is often anonymous case information. The risk of disclosure looms large, especially given the current public attitudes of fear and suspicion regarding HIV and AIDS.

* We would urge that reporting guidelines be carefully analyzed and constructed to limit reporting of positive test results as far as is possible. In particular, we question Section 4, 64-6004, paragraph (a) which allows disclosure of information

to health care providers, emergency personnel, correctional officers and law enforcement officers. Given mandatory compliance with OSHA regulations regarding precautions for dealing with blood-borne pathogens, we question the risk to these groups and the "need to know."

We urge you to support by-name reporting for HIV. We recognize the risks of by-name reporting and ask that you limit disclosure of results based on "the need to know."