Approved: March 3, 1994
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on February 24, 1994 in Room 423-S of the Capitol.

All members were present except: Rep. Weiland, excused

Committee staff present:
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Representative Lisa Benlon
Sally Finney Brazier, Director, AIDS section, Department of Health/Environment
Ann Hebberger, member of United Community Services, Johnson County (UCS)
Kimbrough D. Warber, interested citizen
Chip Wheelen, Director of Public Affairs, Kansas Medical Society
American Civil Liberties Union, (written only)
Representative Susan Wagle

Others attending: See attached list

Chairperson Flower called the meeting to order welcoming all attending, especially former Representative John Solbach who is visiting today.

Chair directed attention to the Agenda, noting the schedule would be reversed, i.e., first would be Committee reports, discussion and possible action on bills previously heard, with the hearings set for the latter part of the meeting.

Chair drew attention to **HB 2603.**

Rep. Neufeld began, noting the amendment distributed on **HB 2603,** (see Attachment No. 1), have been proposed by the Kansas Board of Nursing, Rep. Gatlin, the Kansas Nurses Association.

For the purposes of discussion, Rep. Neufeld moved to adopt the balloon amendments on **HB 2603,** on page 3, lines 15 and 17, after the word "nursing", insert, "or professional nursing" would address the concerns of Rep. Gatlin. On page 4, line 42, after the words "practical nursing, add "or programs of advanced registered professional nursing approved by the board", would address the recommendations of the Kansas Board of Nursing. Amend further on page 5, line 2, after "graduation" which has been stricken, insert the words, "nor nursing by graduates of such schools of courses pending the results of the first licensure examination scheduled following such graduation, but in no case to exceed 120 days, whichever comes first", would allow the students to practice until the examination is taken. Motion seconded by Rep. Freeborn. No discussion. Motion carried.

Rep. Neufeld then moved to report **HB 2603** out favorably, as amended. Motion seconded by Rep. Wells. Discussion began. Rep. Neufeld gave a detailed explanation of the proposed amendments that address concerns regarding nurses being allowed to practice until the examination is taken. It was noted language does provide that this practice will be allowed, however, the examination must be taken within 120 days.

Vote taken, motion carried.

Chair drew attention to **HB 2581.**

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Chair requested the Sub-Committee Chair, Rep. Wells, give the Committee report on **HB 2581.**

Rep. Wells offered a hand-out, see (Attachment No. 2). It was noted this is now **Substitute for HB 2581.** Rep. Wells stated the Sub-Committee met numerous times and a draft shown in Attachment No.2 is supported by the majority of those parties who attended discussions. She gave a detailed explanation of proposed changes, i.e., to change the name of the program to (CARE); the one page evaluation form is to be filled out for those individuals being admitted to long-term care facilities, the form being developed by the Health Care Data Governing Board; after January 1, 1995, the authority agency would be the Department on Aging, not the Department of SRS. The Secretary on Aging asked for time to develop the program, which is indicated by the January 1, 1995 date. She detailed the assessment/referral services to be done by the Secretary on Aging with the assistance of the area agencies; the voluntary oversight council will be established; the penalties for non-compliance were detailed. It was noted there is now, no prior approval process.

Rep. Wells stated, the purpose of this program proposed in **HB 2581** is spelled out on page 1, line 13, i.e., the purpose of CARE is for data collection and individual assessment and referral to community-based services and appropriate placement in long-term care facilities. She answered questions. Bach will not be reviewing the forms, she noted.

Mr. Furse indicated that the Secretary on Aging had also requested that the language related to the comprehensive resource information be included. This inclusion appears on page 4, sub-sections (g) and (h). He gave a detailed explanation. Mr. Furse, per request, detailed changes proposed regarding the recommendations requested during the Sub-Committee hearings.

After this explanation, Rep. Wells moved to amend **HB 2581** per balloon see Attachment No.2. Motion seconded by Rep. Rutledge. The issue of a grandfather clause was explained in detail. Vote taken, motion carried.

Rep. Wells moved to pass Substitute HB 2581 out favorably as amended, seconded by Rep. Neufeld. Motion carried.

Rep. Wells will carry **HB 2581** for House debate.

Rep. Wells thanked the Sub-Committee and staff members for all their hard work on **HB 2581.**

Chair thanked the Sub-Committee for their diligence in working on these difficult issues, and thanks also to the supporting staff for their hard work and dedication.

Chair drew attention to **HB 2937.** Chair noted some conferees have combined their testimony on **HB 2937** and **HB 2936.** In the interest of time Chair stated this is permissible.

HEARINGS BEGAN ON **HB 2937, HB 2936.**

Rep. Benlon offered hand-out, (Attachment No. 3). She stated the introduction of **HB 2937** was introduced because of an incident that seem so bizarre that it is difficult to believe a doctor would act so irresponsibly. Rep. Benlon noted, **HB 2937** would make it illegal for a physician to knowingly keep from a patient the fact the patient has tested positive to an HIV test. She detailed the story of Mrs. Warber, drawing attention to a news article in her hand-out. She drew attention to proposed language in **HB 2937**, i.e., the spouse or partner being made aware of the risk of exposure. In Mrs. Warber's case, the physician put Roberta's husband at risk as well as other family members and the health care personnel that came in contact with her. She answered numerous questions, i.e., certified or registered mail being the format used to notify a patient of their condition; difficulty in knowing the partners of a patient without breaching the confidentiality issue; explanation or definition of "dire diligence"; partner approval would be necessary perhaps; physician liability concerns were questioned.

HB 2937 continued.

Sally Finney Brazier, Director of AIDS Section, Department of Health and Environment offered hand-out, (see Attachment No. 4). She stated the Department is supportive of the intent in **HB 2937,** they are opposed to the bill as currently written. She noted there are disease intervention specialists that can also provide counseling, so it not just the physician that can provide counseling. She also drew attention to section 1, (j), which includes saliva in the list of body fluids. The Center of Disease Control (CDC) does not include saliva in its list of body fluids for universal precautions. She explained, and noted, contact with saliva will not cause HIV infection. She noted studies indicate that whenever a health care worker is given the HIV test results of a patient, it has a negative impact on their use of universal precautions because they fail to use proper protection in working with those patients, who may not have been infected long enough to react positive on current testing. This is a false sense of security for health care providers. Both the CDC and OSHA recommend consistent universal precautions as the best protection for personnel who may be exposed to bodily fluids that transmit HIV. She directed attention to Section 4, (b), stating concerns that would require physicians to violate CDC recommended procedures for patient notification. Under current statute, the Department is limited in efforts to assist with partner notification since HIV is reported to the Department without names or locating information. Unfortunately, the Department cannot provide necessary follow-up because when a patient leaves the physician's office, he/she is lost to the system. She noted **SB 198** would change existing laws. and deal with this barrier in an effective, responsible manner. She distributed a hand-out, (Are Universal Precautions, effective in Reducing the Number of Occupational Exposures Among Health Care Workers), see (Attachment No.5).

Ann Hebberger, Board member of United Community Services of Johnson County (UCS), offered hand-out (see Attachment No. 6). She expressed serious concerns regarding patient/partner notification, i.e., who will determine what constitutes "dire diligence, and what liability for Kansas physicians is being created by requiring "dire diligence"; also noted, **HB 2937** removes from current law, language about not creating "duty to warn by physicians; physicians notifying persons that they are HIV positive by certified mail. She urged the protection of patient confidentiality as an important tenant of the public health system. She urged for the unique identifier system of HIV reporting, and explained.

Kimbrough Warber, (see Attachment No. 7),gave his educational background in Microbiology, then noted his remarks in favor of **HB 2937** were for a more personal reason. He related the story of his Mother who had died of AIDS contracted from a blood transfusion, was not informed she had tested positive for the HIV virus for four years, and only then informed 10 days before her death. Mrs. Warber's physician, Dr. Daniel D. Zimmerman willfully withheld the information Mrs. Warber had been given blood tainted with HIV. During this four year period, Mrs. Warber's husband and other family members, health care givers were all placed as risk. By denying Mrs. right to know her complete medical history, therefore, in the belief of her family, also denied her the right to seek therapy, counseling, other conventional or experimental treatment. He directed attention to the civil liability issue, noting criminal liability is what **HB 2937** is designed to provide. He noted further, there is nothing in the provisions for notification as set forth in **HB 2937** that would violate the physician-patient privilege. He urged members to accept the current provisions in **HB 2937,** hoping that the case related to that of his own Mother will not be repeated.

Chip Wheelen, Kansas Medical Society (see Attachment No. 8), drew attention to a proposed amendments to **HB 2937**. He noted on page 4, line 2, that "may" should be added, page 4, line 11, add "of the need to schedule an appointment for post-test counseling. If it is not possible to contact the patient within one week by normal methods of communication, the physician may inform the patient of the need to schedule an appoint. He explained the importance of post-test counseling, and the KMS has great concern that a patient would be informed by either certified or registered mail. Notification of the unsuspecting spouse/partner should be the function of the counselor. The patient should have the opportunity to inform the spouse/partner that has been exposed to HIV. If this patient chooses not to do that on their own, then the physician should be allowed by law, to breech the normal physician/patient relationship, which is protected by the U.S. Constitution, in order to communicate with that spouse/partner of the patient. He noted further amendatory language on page 4, line 23, to add, (d) "Nothing in this section shall be construed to create a duty to warn any person of possible exposure to HIV infection." He detailed "duty to warn" language. He noted also he had conferred with Rep. Benlon with this language.

HB 2937: continued.

Numerous questions were asked of several conferees, i.e., The Board of Healing Arts might possibly answer questions regarding Dr. Zimmerman; there is no guarantee the patient has truly informed their sexual partner; yes, the Kansas Medical Society does believe that physicians will be opened up for liability,therefore have proposed the language to be amended into **HB 2937** , (d) as explained earlier; universal precautions should be the procedure used by health care providers; it would be best to assume that each and every patient has been tested positive, so that great care/precautions are taken with each and every patient, in order to protect the health care providers; regarding a standard of care issue, it was noted there continually are changes being made in the standard of care; the patient has a fundamental right to know medical information about their health, protected under the U.S. Constitution. It was noted by both the Kansas Medical Society and the United Community Services representatives this date, there is perhaps a better way to address this issue. A physician is informed on changing standards of care through the continuing education process, they are expected to be knowledgeable of the applicable standard of care for the specialties which they practice. It was determined the update on standard of care is not mandated by law, but that is what the continuing education process addresses. It was noted, patients can be reasonably sure that physicians know what the most current standards of care are.

Hearing Closed on: **HB 2937.**

Chair drew attention to **HB 2936.**

Representative Wagle (No written testimony), drew attention to factual information(U.S.Public Health Service), i.e., over 1 million Americans are infected with HIV; despite billions of dollars being spent on research, there is still limited information on the HIV virus. However, it is known that HIV is a communicable disease, has a lengthy latency period, a deadly disease, is spreading in epidemic proportions. She stated, as State Legislators, must act responsibly and act as quickly as possible to help stop the spread of this infection. **HB 2936** would require that physicians compile the information detailed in the language of the bill. Then, it becomes the burden for the Secretary of Department of Health/Environment to personally/confidentially interview these persons, counsel/educate these victims in, obtain the names and whereabouts of the sexual and needle sharing partners,notify these individuals of their possible exposure, the availability diagnostic testing, and responsibility of the infected person not to knowingly infect others. She detailed her beliefs that 95% of those infected will wish to know and deal with it appropriately so that others will not be placed at risk. She asked for favorable passage for **HB 2936.**

Sally Finney Brazier, Department of Health/Environment (Attachment No. 9). She noted the support of the concept of partner notification proposed in **HB 2936,** however, there are concerns related to specifics, i.e., funding to support the partner notification activities in regard to compliance with provisions in New Section 4 of **HB 2936.** She drew attention to page 4, line 31, change the word "establish" to "maintain". She also recommended another change, on Page 4, line 37, after "establish" to concern that any information other than statistical will not be obtained. She also detailed concerns regarding obtaining infected Kansans. She noted at first glance, the impact of this proposed language may seem minor, when it is in fact, significant.

Ann Hebberger, United Community Services of Johnson County, Inc, (Attachment No. 6 was provided earlier as she testified on another bill.) She expressed concerns regarding HIV/AIDS testing and reporting requirements. She noted mandatory name reporting is likely to discourage individuals from seeking early testing. Those who do not seek testing do not have access to the benefits of education and counseling. Education/counseling are the main weapons for reducing the risks and controlling the spread of the virus. She recommended Committee consider an alternative system for reporting HIV cases, called unique identifier. She explained, i.e., the system uses demographic characteristics such as race, gender, birthdate, county of residence, last four digits of the patient's social security number. This reduces the risk of accidental disclosure; thereby eliminating the major barrier to testing, and at the same time meets the criteria of CDC's to access funding. Texas has received a $250,000 federal grant within the past year to implement a unique identifier system. She stated concern **HB 2936** requires federal agencies to report to Kansas the results of involuntary HIV test results. She questioned whether or not involuntary testing is ethical. Certainly, she noted, any desired results may be obtained more ethically through other HIV public policies.

Chip Wheelen, Kansas Medical Society, (attachment No. 8 contains testimony on both **HB 2936 and 2937.** He stated major reservations regarding proposed provisions in **HB 2937,**i.e., notifying a patient by certified mail of their test results for HIV. He drew attention to the following proposed changes, i.e., the physician should be allowed to decide when the need exists for other health care or emergency professionals to know if a patient is HIV positive; the patient should be informed of the need for post-test counseling regardless of the test results; the physician should not be exposed to extraordinary liability because he/she is willing to provide medical care to a patient exposed to HIV.

Mr. Wheelen continued:-

He noted the Senate Committee on Public Health and Welfare may take action soon on **SB 198**, which closely resembles **HB 2936,** and he noted his testimony is identical to that which he presents today on **HB 2936.** He stated, in summary, the Kansas Medical Society does not promote any of these bills under discussion but do acknowledge the need to more aggressively intervene and monitor cases of HIV infection. He urged for consideration of the amendments he proposed. He drew attention to a minor technical amendment related to current law, i.e., page 2, line 8, after physician, add "knows". He explained.

Further questions were asked of several conferees. It was noted that Mr. Wheelen's suggestion to amend **HB 2936** by adding "knows" after "physician", would also apply to **HB 2937** in regard to K.S.A. 66-6002. Mr. Wheelen agreed this was correct.

It was noted that the HIV virus is unlike any other communicable disease, and detailed in regard to medical complications and exposure to others. It was noted a patient's knowledge that his/her condition may not be privileged information can deter patients from seeking needed medical care, particularly if there is likely to be a stigma attached to persons with HIV. This could actually be counterproductive to disease prevention strategies. The procedures for reporting (other) communicable diseases was detailed; current law allows physicians to counsel spouses/partners; it is the hope of the physicians this will continue so they may counsel prior to intervention by the Department of Health/Environment or other personnel. It was brought out that the Department of Health/Environment supports partner notification, but not health care worker notification. It was indicated that a patient's chart would contain the information, in some coded form, i.e., there is sensitive information on file in another area, that they are an HIV infected patient, but would not be worded in than manner (HIV) on the chart.

Hearing closed on **HB 2936.**

Chair asked the wishes of Committee in regard to working **HB 2936, HB 2937** today in Committee. She stressed that there was limited time, however, the decision is up to the Committee members. Some stated they felt there was not enough time to work the bills thoroughly, they are too complex. More time to study the bills was requested. Others felt since this is the last day of Committee meetings before the deadline to get bills out of Committee, it would benefit many people should this legislation be advanced. It was suggested the Chair might request both these bills be placed in an exempt Committee and have them re-referred after the deadline. Chair noted the likelihood of having these pieces of legislation sent to exempt Committees was zero. At this point the Chair asked members to vote to work **HB 2936 and HB 2937.** Vote taken, Chair in doubt. Show of hands indicated 8 in favor, 10 opposed, motion failed.

Noted, Written testimony only presented by American Civil Liberties Union. (see Attachment No. 10).

A fiscal note on **HB 2937** is indicated in (Attachment No. 11).

A fiscal note on **HB 2936** is indicated in (Attachment No. 12).

Chair adjourned the meeting at 3:15 p.m.

The next meeting is scheduled for March 7, 1994, or on call of Chair.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-24-94

NAME	ORGANIZATION	ADDRESS
Douglas Johnston	Planned Parenthood	Wichita
Kimbrough D. Warber, Ph.D.	"INTERESTED CITIZEN"	LENEXA, KS.
REP. LISA BENLON		SHAWNEE
Kirk Peters	intern	Shawnee
Sally Finney Brazier	KDHE	Topeka
RAY Schen	SRS	Topeka
GREG VALENTINE	INTERN SRS/MHRS	TOPEKA
Peggy Jarman	PCAL	Wichita
Sue Lee Cotte	NOW	Wichita
Patsy Maker	KDHE	
Lynda Dunn	KDOA	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	TOPEKA
Deborah Alfano	KDHE	Topeka
Rich Guthrie	Health Midwest	KC
Annette Siebert	KAHHA	Topeka
Chip Wheelen	KS Medical Soc.	Topeka
Tom Bell	KHA	Topeka

~~state if the applicant has not been engaged in practice of nursing for five years preceding application. The 180-day temporary permit may be renewed by the board for one additional period not to exceed 180 days.~~

Sec. 2. K.S.A. 1993 Supp. 65-1116 is hereby amended to read as follows: 65-1116. (a) *Qualification.* An applicant for a license to practice as a licensed practical nurse shall file with the board a written application for a license and submit to the board satisfactory proof that the applicant: (1) Has graduated from a high school accredited by the appropriate legal accrediting agency or has obtained the equivalent of a high school education, as determined by the state department of education; (2) ~~has successfully completed the prescribed curriculum in an accredited school of practical nursing and~~ holds evidence of graduation from ~~the~~ *an accredited* school *of practical nursing in the United States or its territories* or ~~has successfully completed the prescribed curriculum in an accredited~~ *from a* school of practical nursing ~~located outside this state which maintains standards at least equal to schools of practical nursing which are accredited by the board and holds evidence of graduation from the school~~ *in a foreign country which is approved by the board as defined in rules and regulations*; and (3) has obtained other qualifications not in conflict with this act as the board may prescribe *by rule and regulation*.

or professional nursing

(b) *If the board finds in evaluating any applicant that such applicant is deficient in qualification or in the quality of such applicant's educational experience, the board may require such applicant to fulfill such remedial or other requirements as the board may prescribe.*

(c) License. (1) *By Examination.* The applicant shall ~~be required to~~ pass an examination ~~in such subjects~~ as the board may prescribe. Each examination may be supplemented by an oral or practical examination. Upon successfully passing such examinations, the board shall issue to the applicant a license to practice as a licensed practical nurse. (2) ~~*Without examination.* The board may issue a license to practice as a licensed practical nurse without examination to any applicant who has been duly licensed or registered by examination as a licensed practical nurse or a person entitled to perform similar services under a different title under the laws of any other state, territory or foreign country if, in the opinion of the board, the applicant meets the requirements for licensed practical nurses in this state.~~ *Refresher course. Notwithstanding the provisions of subsections (a) and (b), an applicant for a license to practice as a licensed practical nurse who has not*

PH+W 2-22-94 attm #1

PH+W 2-22-94 attm #1

been licensed to practice practical nursing for five years preceding application shall be required to successfully complete a refresher course as defined by the board. (3) *Renewal license.* A licensed practical nurse licensed under this act shall be eligible for renewal licenses upon compliance with K.S.A. 65-1117 and amendments thereto. (4) *Repeated examination failure.* Persons who are unsuccessful in passing the licensure examination after four failures shall petition the board for permission prior to subsequent attempts. The board may require the applicant to submit and complete a plan of study prior to taking the licensure examination for the fifth time or any subsequent attempt.

(c) *Title and abbreviation.* Any person who holds a license to practice as a licensed practical nurse in this state shall have the right to use the title, "licensed practical nurse," and the abbreviation, "L.P.N." No other person shall assume the title or use the abbreviation or any other words, letters, signs or figures to indicate that the person is a licensed practical nurse.

(d) *Temporary permit.* The board may issue a temporary permit to practice nursing as a licensed practical nurse for a period not to exceed 90 days. The 90-day temporary permit may be renewed for an additional 30 days not to exceed a combined total of 120 days. ~~The board may issue a temporary permit to practice nursing as a licensed practical nurse for a period not to exceed 180 days to an applicant for a license as a licensed practical nurse who is enrolled in a refresher course required by the board for reinstatement of a license which has lapsed for more than five years or for licensure in this state from another state if the applicant has not been engaged in practice of nursing for five years preceding application. The 180-day temporary permit may be renewed by the board for one additional period not to exceed 180 days.~~

Sec. 3. K.S.A. 65-1124 is hereby amended to read as follows: 65-1124. No provisions of this law shall be construed as prohibiting:

(a) Gratuitous nursing by friends or members of the family;

(b) the incidental care of the sick by domestic servants or persons primarily employed as housekeepers;

(c) caring for the sick in accordance with tenets and practices of any church or religious denomination which teaches reliance upon spiritual means through prayer for healing;

(d) nursing assistance in the case of an emergency;

(e) the practice of nursing by students enrolled in accredited schools of professional or practical nursing or programs of advanced registered professional nursing approved by the board ~~nor nursing by graduates of such schools or courses pending the results of the first li-~~

P&W
2-24-94
Attm # 1
Pg 2 of 3

~~censing examination scheduled by the board following such graduation~~; nor nursing by graduates of such schools or courses pending the results of the first licensure examination scheduled following such graduation but in no case to exceed 120 days, whichever comes first

(f) the practice of nursing in this state by legally qualified nurses of any of the other states as long as the engagement of any such nurse requires the nurse to accompany and care for a patient temporarily residing in this state during the period of one such engagement not to exceed six months in length, and as long as such nurses do not represent or hold themselves out as nurses licensed to practice in this state;

(g) the practice by any nurse who is employed by the United States government or any bureau, division or agency thereof, while in the discharge of official duties;

(h) auxiliary patient care services performed in medical care facilities, adult care homes or elsewhere by persons under the direction of a person licensed to practice medicine and surgery or a person licensed to practice dentistry or the supervision of a registered professional nurse or a licensed practical nurse;

(i) the administration of medications to residents of adult care homes or to patients in hospital-based long-term care units, including state operated institutions for the mentally retarded, by an unlicensed person who has been certified as having satisfactorily completed a training program in medication administration approved by the secretary of health and environment and has completed the program on continuing education adopted by the secretary, or by an unlicensed person while engaged in and as a part of such training program in medication administration;

(j) the practice of mental health technology by licensed mental health technicians as authorized under the mental health technicians' licensure act;

(k) performance in the school setting of selected nursing procedures, as specified by rules and regulations of the board, necessary for handicapped students;

(l) performance in the school setting of selected nursing procedures, as specified by rules and regulations of the board, necessary to accomplish activities of daily living and which are routinely performed by the student or student's family in the home setting;

(m) performance of attendant care services directed by or on behalf of an individual in need of in-home care as the terms "attendant care services" and "individual in need of in-home care" are defined under K.S.A. 65-6201 and amendments thereto; ~~or~~

(n) performance of a nursing task by a person when that task is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment, and is performed with reasonable

P H+W 2-24-94 Attm # 1 pg 3 of 3

Substitute for HOUSE BILL NO. 2581

AN ACT establishing the client assessment, referral and evaluation program (CARE); assessment and referral to community-based services and long-term care facilities; establishing a voluntary oversight council; amending K.S.A. 39-931a and repealing the existing section; also repealing K.S.A. 39-966.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) To achieve a quality of life for Kansans with long-term care needs in an environment of choice that maximizes independent living capabilities and recognizes diversity, this act establishes a program which is intended to encourage a wide array of quality, cost-effective and affordable long-term care choices. This program shall be known as client assessment, referral and evaluation (CARE). The purposes of CARE is for data collection and individual assessment and referral to community-based services and appropriate placement in long-term care facilities.

(b) As used in this section:

(1) "Assessment services" means evaluation of an individual's health and functional status to determine the need for long-term care services and to identify appropriate service options which meet these needs utilizing the client assessment,

2-24-94
Attm #2

referral and evaluation (CARE) data form.

(2) "Health care data governing board" means the board created under K.S.A. 1993 Supp. 65-6803 and amendments thereto.

(3) "Secretary" means the secretary of aging.

(c) There is hereby established the client assessment, referral and evaluation (CARE) program. The CARE program shall be administered by the secretary of aging and shall be implemented on a phased-in basis in accordance with the provisions of this section.

(d) Prior to January 1, 1995, the health care data governing board shall adopt by rules and regulations a client assessment, referral and evaluation (CARE) data form of not to exceed one page in length. The purpose of this form is for data collection and referral services. Medicaid eligibility determinations shall be subordinate to this purpose, but may be included so long as the primary purpose of the form is not compromised. The client assessment, referral and evaluation (CARE) data form shall include, but not be limited to, the preadmission screening and annual resident review (PASARR) questions. Prior to the adoption of the client assessment, referral and evaluation (CARE) data form by the health care data governing board, the secretary of aging shall approve the form. The client assessment, referral and evaluation (CARE) data form shall be used by all persons providing assessment services.

(e) (1) Prior to January 1, 1995, assessment and referral services for persons who are required by federal law to have such services prior to admission to an adult care home shall be

pg 2 of 7
PNelli
2-24-94
attm # 2-2

provided by the secretary of social and rehabilitation services except that such services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of an adult care home upon discharge from the medical care facility.

(2) On and after January 1, 1995, the secretary of aging, with the assistance of area agencies on aging, shall provide for assessment services and the preparation of the client assessment, referral and evaluation (CARE) data forms for individuals to be admitted to adult care homes where such assessment services are required prior to admission to an adult care home to comply with federal law, except that such assessment services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of an adult care home upon discharge from the medical care facility.

(3) On and after July 1, 1995, each individual who is admitted to an adult care home and who is not required by federal law to receive assessment services prior to admission to the adult care home, preceding admission to the adult care home or within 10 days subsequent to admission to the adult care home, shall receive assessment services. Assessment services under this paragraph shall be provided by the secretary of aging with the assistance of area agencies on aging except that (A) such assessment services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of an adult care home upon discharge from the medical care facility and (B) if the assessment services have not

PHCC
2-24-94
Attm #23
Pg 3 of 4

been provided prior to admission to the adult care home, the adult care home shall request that an area agency on aging serving the geographic area in which the adult care home is located provide the assessment services within 10 days after admission of the resident to the adult care home.

(f) The secretary of aging shall cooperate with the area agencies on aging providing assessment services under this section.

(g) The secretary of aging shall assure that each area agency on aging shall compile comprehensive resource information for use by individuals and agencies related to long-term care resources including all area offices of the department of social and rehabilitation services and local health departments. This information shall include, but not be limited to, resources available to assist persons to choose alternatives to institutional care.

(h) Adult care homes as defined under K.S.A. 39-923 and amendments thereto and medical care facilities as defined under K.S.A. 65-425 and amendments thereto shall make available information referenced in subsection (g) to each person seeking admission or upon discharge as appropriate. Any person licensed to practice the healing arts as defined in K.S.A. 65-2802 and amendments thereto shall make the same resource information available to any person identified as seeking or needing long-term care. Each senior center and each area agency on aging shall make available such information.

(i) (1) There is hereby established a nine-member voluntary

Pl. & W 2-24-94 attm #2-4

oversight council which shall meet monthly prior to July 1, 1995, for the purpose of assisting the secretary of aging in restructuring the assessment and referral program in a manner consistent with this act and shall meet quarterly thereafter for the purpose of monitoring and advising the secretary regarding the CARE program. The council shall be advisory only, except that the secretary of aging shall file with the council each six months the secretary's response to council comments or recommendations.

(2) The secretary of aging shall appoint two representatives of hospitals, two representatives of nursing facilities and two consumers. The secretary of health and environment and the secretary of social and rehabilitation services, or their designee, shall be members of the council in addition to the six appointed members. The secretary of aging shall serve as chairperson of the council. The appointive members of the council shall serve at the pleasure of their appointing authority. Members of the voluntary oversight council shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the council.

(j) The secretary of aging shall report to the governor and to the legislature on or before December 31, 1995, and each year thereafter on or before such date, an analysis of the information collected under this section. In addition, the secretary of aging shall provide data from the CARE data forms to the health care data governing board. Such data shall be provided in such a

P Hall
2-24-94
Attm #2-5
pg 5 of 7

manner so as not to identify individuals.

Sec. 2. K.S.A. 39-931a is hereby amended to read as follows: 39-931a. (a) As used in this section, the term "person" means any person who is an applicant for a license to operate an adult care home or who is the licensee of an adult care home and who has any direct or indirect ownership interest of 25% or more in an adult care home or who is the owner, in whole or in part, of any mortgage, deed of trust, note or other obligation secured, in whole or in part, by such facility or any of the property or assets of such facility, or who, if the facility is organized as a corporation, is an officer or director of the corporation, or who, if the facility is organized as a partnership, is a partner.

(b) Pursuant to K.S.A. 39-931 and amendments thereto, the licensing agency may deny a license to any person and may suspend or revoke the license of any person who:

(1) Has willfully or repeatedly violated any provision of law or rules and regulations adopted pursuant to article 9 of chapter 39 of the Kansas Statutes Annotated and acts amendatory of the provisions thereof or supplemental thereto;

(2) has been convicted of a felony;

(3) has failed to assure that nutrition, medication and treatment of residents, including the use of restraints, are in accordance with acceptable medical practices; or

(4) has aided, abetted, sanctioned or condoned any violation of law or rules and regulations adopted pursuant to article 9 of chapter 39 of the Kansas Statutes Annotated; or

(5) ~~has willfully admitted a person to an adult care home as~~

PH+W
2-24-94
Attm #2-6
Page 1 of 7

~~a resident of the home in violation of subsection (c)(2) of K.S.A. 39-966 and amendments thereto~~ has willfully admitted a person to an adult care home as a resident of the home who has not received assessment and referral or assessment services under the provisions of paragraph (1) or (2) of subsection (e) or has as a resident in the adult care home a person who has not received assessment services in accordance with the provisions of paragraph (3) of subsection (e).

Sec. 3. K.S.A. 39-931a and 39-966 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

2-24-94
Attm #2-7
pg 7 of 7

LISA L. BENLON
REPRESENTATIVE, 17TH DISTRICT
REPRESENTING PORTIONS OF
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STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: FEDERAL AND STATE AFFAIRS
MEMBER: EDUCATION
GOVERNMENTAL ORGANIZATION
AND ELECTIONS

HB 2937
Testimony Before the House Public Health and Welfare Committee
February 24, 1994

Chairman Flower and Fellow Legislators,

I appreciate the opportunity to discuss an issue that is extremely sensitive.

HB 2937 was introduced due to an incident that happened to a friend. The circumstances seem so bizarre that it will be difficult to believe a doctor would act so irresponsibly. I have attached a copy of a newspaper article describing the details. I encourage you to read it.

The peanut of HB 2937 is found on page 4, lines 9-13. In essence, what I am attempting to do, is to make it illegal for a physician to knowingly keep from a patient the fact that the patient has tested positive to an HIV test. Furthermore, it is important that a spouse or partner also be aware of the risk of exposure. That is covered on page 4, beginning on line 14.

In the case of Roberta Warber, the doctor chose to make the decision to not notify her of her condition. In making that choice, the doctor put Roberta's husband, Marvin at risk as well as other family members and health care personnel that came in contact with her.

With the seriousness of this deadly disease, we can not afford to have doctors act so irresponsibly without legal ramifications. Please consider taking these steps.

I stand for questions.

P H+W
2-24-94
attm #3

THE KANSAS CITY STAR.

TUESDAY, February 23, 1993 JOHNSON COUNTY EDITION 50c

"I felt that, to be notified of an HIV infection, with her emotional state, as I knew it, would serve her no purpose"
— Daniel D. Zimmerman, Roberta Warber's physician

It is "difficult to imagine a scenario ... that would justify withholding information"
— Steven Miles, University of Minnesota

On her deathbed, she found out it was AIDS

By ALAN BAVLEY
Medical Writer

Roberta Warber beat a diagnosis of lung cancer, but she didn't get a fighting chance against AIDS.

That's because her doctor didn't tell her she had it.

He didn't want to upset her, so he never warned her that a blood transfusion in her cancer treatment was tainted with the deadly HIV virus.

The 65-year-old Lenexa woman was in a hospital bed — just a few days from death in 1989 — before she learned she had AIDS.

Medical ethicists interviewed by *The Kansas City Star* said that as a rule, a doctor shouldn't withhold information about a patient's condition, even when it's terminal.

Warber's sons agree.

"She should have been told earlier," said Kimbrough Warber, 39. "This put my father at risk. It put every health-care worker who came in contact with her at risk.

"And she should have been offered every medical option available. Certainly, she should have been educated about the infections she would encounter, so she knew that a cold was not just a cold to someone with AIDS."

On Monday, Kimbrough and his brother, Craig Warber, 37, settled their wrongful-death lawsuit against the doctor, Daniel D. Zimmerman, for $600,000 in Jackson County Circuit Court. They also settled for $48,000 with Menorah Medical Center, where

See **DOCTOR, A-8,** Col. 1

Roberta Warber with her husband, Marvin. The Warbers were from Lenexa.

PH+W 2-24-94 Attm # 32-2

PH+W 2-24-94 Attm 3 Pg 2 of 3

Doctor kept AIDS diagnosis from patient

Continued from A-1

she was treated for cancer. They had settled previously for an undisclosed sum with the Community Blood Center of Greater Kansas City, which supplied the tainted blood.

Zimmerman's lawyer, Gardiner Davis, said neither he nor his client would discuss the case. A Menorah spokesman said the hospital had no comment.

Blood center policy leaves it to physicians to notify patients that they have received contaminated blood.

In a deposition last year, Zimmerman explained his decision not to tell Warber:

"She had a very high anxiety level and could not face the severity of the (cancer) that she had apparently survived. I felt that, to be notified of an HIV infection, with her emotional state, as I knew it, would serve her no purpose."

Not telling her "allowed her to live a useful, functional life without the emotional burden of another life-threatening illness . . . which was not even treatable."

Further, Zimmerman said: "I thought there was still substantial risk she would die with her malignancy . . . and never know" she had AIDS.

Myra Christopher, executive director of the Midwest Bioethics Center in Kansas City, said it's "very paternalistic to think people can't handle this information about their diagnosis. People have an amazing capacity to deal with this."

"And when you think of HIV, people need that information to be responsible in relationships."

Steven Miles, a physician at the University of Minnesota's Center for Biomedical Ethics, said it is "difficult to imagine a scenario, particularly for a contagious disease, that would justify withholding information."

A person with AIDS ought to have a chance to seek treatment, he said. Not offering this opportunity "is just not acceptable medical practice."

Roberta Warber's final years have been reconstructed through court records and interviews with her sons:

Warber had been smoking two packs of cigarettes a day for 40 years when she went to Zimmerman in February 1984. She complained of pain on the right side of her chest.

Zimmerman X-rayed her chest in his office and discovered a large mass. He admitted her to Menorah, where further tests indicated cancer.

"The physicians believed my mother would die," Kimbrough said. "They told her on at least two occasions there would be a fatal outcome and soon."

Warber visited the hospital for nine monthly rounds of chemotherapy. Because chemotherapy can cause anemia, Warber received a dozen transfusions of red blood cells.

The year Warber got the transfusions was a time of great apprehension in the blood-bank community. As more and more hemophiliacs, who depend on blood products, developed AIDS, concern grew that donor blood might be transmitting the virus.

"By 1984, there was a recognition of the risk of transfusions," said Joel Solomon, chief executive officer of the American Association of Blood Banks. "But there just wasn't much we could do about it except to question the donors."

An HIV test for blood banks to use to identify contaminated blood would not be introduced until March 1985.

Early on the morning of Sept. 6, 1984, her 61st birthday, Warber received two units of blood. The second one was contaminated with HIV.

Two months later, Warber finished her chemotherapy. Her health improved, and she began living a normal life as a grandmother and retiree.

She busied herself in the kitchen. She traveled to Hawaii and made frequent trips to Miami to see Kimbrough and her granddaughter.

Unknown to Warber, the Community Blood Center, which supplies blood to local hospitals, learned late in 1986 that HIV-contaminated blood from one of its donors had infected another patient.

The blood center tested other samples from that donor and discovered that Warber also had received tainted blood.

The blood center notified Menorah, which notified Zimmerman.

Zimmerman said in his deposition that he mulled over the information for several days.

"In the past, lack of disclosure by a doctor was pretty common. But what in the past had been a common scenario has become the exception," said Joseph Fins, a physician at the Hastings Center, a bioethics organization in Briarcliff Manor, N.Y.

Even as recently as the 1950s, Fins said, doctors often withheld information about untreatable illnesses, thinking it would be more humane than leaving a patient without hope.

But medical care has improved. Doctors can offer many alternatives, and patients have demanded a greater say in their treatment, Fins said.

"Telling patients, giving them information, need not be harmful," he said. "It can be productive."

Warber remained healthy until she traveled to Florida in August 1988.

"When my mother arrived in Miami, she was very fatigued, more than I could ever remember," Kimbrough said.

Warber also experienced night sweats, early symptoms of AIDS that she and her family assumed were due simply to the Florida heat.

The following February, she came down with what she thought was the flu. She developed a cough she couldn't shake. She slept on a couch because she was too weak to climb the stairs to her bedroom.

She had switched to another doctor by then, and at his insistence she entered Humana Hospital-Overland Park on April 10, 1989.

In his deposition, her doctor, Mark Kahler, said he contacted Zimmerman to ask about her condition and was told she had received HIV-contaminated blood. Lab tests at the hospital confirmed it.

On April 14, Kahler went to Warber's hospital room and told her and her husband, Marvin.

"Mrs. Warber was very stoic," Kahler said in the deposition. "She often didn't show her emotions right then, but I could tell that she was greatly affected by it. It was devastating to her."

Warber was diagnosed with a type of pneumonia commonly found in people with AIDS. But by the time she was hospitalized, it was too advanced to treat effectively.

"She already was dying," Kimbrough said. "There was nothing they could do to stop the infection."

On April 21, Roberta Warber died.

Marvin Warber never showed signs of HIV infection. But in March 1990 he died of a heart attack.

"My father was never the same after my mother died," Kimbrough said. "He was broken-hearted."

P/H+W 2-24-94 attm #3 pg 3 of 3

P/H+W 2-24-94 attm # 33 Pg 2 of 3

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

Robert C. Harder, *Secretary*

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2937

The Kansas Department of Health and Environment, though supportive of the intent of HB 2937, is opposed to the bill as it is written.

Section 1 (j) includes saliva in the list of body fluids. CDC does not include saliva in its list of body fluids for universal precautions because saliva does not carry sufficient amounts of active virus and has been shown in laboratory studies to deactivate HIV. Therefore, contact with saliva will not cause HIV infection.

The changes in Section 2 making positive HIV tests reportable for Kansas residents only would have a strong negative impact on HIV/AIDS surveillance activities conducted by the agency. It would encourage Kansans who believe themselves to be positive to provide false information to HIV antibody counseling and testing sites in order to avoid being reported to KDHE. thereby hindering the agency's capacity to conduct case investigations.

The provisions of Section 4 as amended have the potential to place health care workers at increased risk for HIV infection. Studies conducted in the past several years have shown that whenever a health care worker is given HIV test results of patients, it has a negative impact on their use of universal precautions. This is because they fail to use proper protection in working with patients who test negative. This places them at greater risk because the patient may in fact be HIV-infected but may not have been infected long enough to react positive on the tests that are now in use. Both CDC and OSHA recommend universal precautions as the best protection for personnel who may be exposed to those bodily fluids that transmit HIV. The best protection for a health care worker has consistently been proven to be the proper, consistent use of universal precautions.

Section 4, paragraph (b) would require physicians to violate CDC-recommended procedures for patient notification, specifically those that urge in-person notification of tests results. Studies as well as our years of experience in the area of HIV counseling and testing indicate that the best way to provide results both positive and negative is in person, because it offers a means by which the counselor can conduct primary prevention through risk reduction education and can serve as a source of emotional support.

Conducting proper notification of persons diagnosed with HIV infection and AIDS has long been a priority for KDHE. The Bureau of Disease Control currently has 10 staff members located at local health agencies throughout the state to assist with providing appropriate counseling

HB 2937
2-24-94
Att. #4

for patients and in assisting them with partner notification. This is an activity to which KDHE is committed.

Under current statute, we are limited in our efforts. Because HIV infection is reported to KDHE without the names or locating information, many persons are lost to the system. In 1993, 52% of HIV case reports were made by physicians who are outside of the public health system and unable to conduct the field work associated with partner counseling. This is an important responsibility of the public health system. Unfortunately, KDHE cannot provide the necessary follow-up, because on the patient leaves the physician's office, he or she is lost to the system. A bill presently under consideration by the Senate, SB 198, would change the existing laws and deal with this barrier in an effective, responsible manner.

Testimony presented by: Sally Finney Brazier
Director
AIDS Section
February 24, 1994

PH&W
2-24-94
Attm #4
pg 2 of 2

Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?

A Prospective Study of Physicians on a Medical Service

Edward S. Wong, MD; Jennifer L. Stotka, MD; Vernon M. Chinchilli, PhD; Denise S. Williams, MT; C. Geri Stuart, MT; Sheldon M. Markowitz, MD

Using a daily questionnaire, we prospectively studied 277 physicians from two hospital medical services for incidents of exposure to blood and body fluids and barrier use before and after the implementation of universal precautions. We found that implementation significantly increased the frequency of barrier use during exposure incidents from 54% before implementation to 73% after implementation of universal precautions. Implementation led to a decrease in the number of exposure incidents that resulted in direct contact with blood and body fluids (actual exposures), from 5.07 to 2.66 exposures per physician per patient care month, and to an increase in averted exposures in which direct contact was prevented by the use of barrier devices, from 3.41 exposures per patient care month before implementation to 5.90 exposures per patient care month after implementation. Implementation affected neither the types of body fluid or procedures involved nor the overall rate of exposure incidents (8.5 per patient care month) but, through an increase in barrier use, it *did* prevent direct contact with blood and body fluids and thus converted what would have been an actual exposure into an averted one. We conclude that universal precautions were effective in reducing the risk of occupational exposures among physicians on a medical service.

(*JAMA*. 1991;265:1123-1128)

HEALTH CARE workers are at risk for acquiring hepatitis B virus (HBV) and human immunodeficiency virus type 1 (HIV-1) infections through occupational exposures to blood and certain body fluids (BBF). Exposure to HIV-1 is particularly worrisome because of the high mortality rate and the current lack of a curative treatment.[1,2] Recent studies have shown that the risk of acquiring HIV-1 infection is approximately 0.4% following percutaneous exposure and even less for mucous membrane and cutaneous exposures.[3-9] These results, while reassuring, should be interpreted with caution since the overall risk to the health care worker is dependent both on the rate of transmission per episode of exposure and the cumulative number of exposures sustained over time. Few studies have attempted to determine the cumulative risk prospectively, relying instead on periodic surveys that ask health care workers to recall exposures sustained over prolonged intervals.[5,7,10,11] Such studies are subject to the biases inherent in retrospective methods.

In 1987, the Centers for Disease Control (CDC) recommended that all hospitals adopt an infection control policy of "universal precautions" (UPs).[12] Under this policy, health care workers are to assume that the BBFs of all patients are infected with blood-borne pathogens and that they should, therefore, protect themselves with barrier devices when anticipating contact. These precautions are expensive; one recent study estimates that they cost at least $336 million per year in the United States to implement and maintain.[13] While theoretically useful, there is currently no evidence that UPs will actually reduce the number of exposures sustained by health care workers. The possibility exists that UPs may even increase certain kinds of exposures; for example, the use of gloves may interfere with tactile input and increase the number of injuries with sharp instruments during procedures. In addition, if previous studies[7,14] on compliance with infection control policies hold true, health care workers may not adhere to suggested precautions.

In order to assess the hazards of occupational exposures and the efficacy of UPs more accurately, we prospectively studied, with the use of a daily questionnaire, the frequency and types of exposures incurred by physicians during their care of patients on acute care medical wards before and after hospital-wide implementation of UPs.

SUBJECTS AND METHODS

Study Population and Design

Three acute care medical wards at the Hunter Holmes McGuire Department of Veterans Affairs Medical Center and

From the Hospital Epidemiology Unit (Dr Wong and Ms Stuart) and the Infectious Diseases Section, Medical Service, Hunter Holmes McGuire Department of Veterans Affairs Medical Center (Drs Wong, Stotka, and Markowitz and Mss Williams and Stuart), and the Medical College of Virginia, Virginia Commonwealth University (Dr Chinchilli), Richmond.

Presented in part at the National Meeting of the American Federation for Clinical Research, Washington, DC, May 5, 1989.

Reprint requests to Infectious Diseases Section (111-C), Hunter Holmes McGuire Department of Veterans Affairs Medical Center, 1201 Broad Rock Blvd, Richmond, VA 23249 (Dr Wong).

the Medical College of Virginia Hospital (both located in Richmond, Va) were chosen for the study. The Veterans Affairs Hospital (VAH) has 814 beds and draws patients from the mid- and south-Atlantic region. The University Hospital (UH) is a 900-bed, urban, inner-city, tertiary care institution and a referral center for central Virginia. Ward A at the UH has 28 beds, while wards B and C at the VAH have 40 beds each. The monthly census for ward A and the combined monthly census for wards B and C during the study period averaged 105 and 192 patients, respectively. Patients on each ward were the primary responsibility of a house staff team that consisted of an attending physician, one resident, two interns, and two or three medical students. Neither institution has a ward for patients with acquired immunodeficiency syndrome; rather, ward assignments were made based on availability of beds.

The study population consisted of attending physicians, house staff, and medical students who rotated monthly through the study wards at both hospitals. From May 1, 1988, to January 31, 1989, these physicians were monitored prospectively for occupational exposures by means of a daily questionnaire. Participants were informed that the purpose of the study was to evaluate the frequency of occupational exposures to BBFs. They were not told that compliance with use of barrier devices was being monitored. We made no attempts to influence the use of protective devices or encourage excessive precautions. We requested names on the questionnaires but, once study participation was recorded (and during the third and fifth month, data verified), physicians were assigned a study number and personal identifiers were removed. Physicians were informed of this process to encourage their participation.

Questionnaires were passed out by a member of the ward team during attending rounds. We asked physicians to complete one questionnaire for each exposure incident sustained in the preceding 24 hours. An *exposure incident* was defined on the questionnaire as an occurrence in which the physician was exposed to the BBFs of a patient, regardless of whether the exposure resulted in direct contact with BBFs or not because of the use of barrier devices (direct contact avoided). The questionnaire sought the following information for each exposure: the date and time of exposure, the procedure involved, the BBFs encountered, the contact site, and whether there was a cut, open wound, or inflamed skin at the exposure site. If the exposure site involved skin, physicians were asked to provide a semiquantitative assessment of the size of exposure: large (contact area the size of a hand), small (contact area the size of a quarter or less), or moderate (contact area intermediate between large and small). Physicians were also asked to specify which protective devices (gloves, gowns, masks, or goggles) they were wearing at the time of exposure; if they were wearing barrier devices; if the devices protected them from direct contact with BBFs; or, if they did not, would they have been protected had they donned barrier devices. Physicians experiencing no BBF exposure on a given day were asked to check the "no exposure" response to calculate the denominator (number of patient care days at risk).

Forms were collected daily. To determine compliance with the study, work schedules for physicians were obtained. Study compliance was calculated as the number of questionnaires returned divided by the number of days worked. Multiple responses by the same physician in 1 day (signifying multiple exposures during the same day) were counted as one response so as not to overestimate compliance. During the third and fifth month of the study, the information in every fourth questionnaire was verified by telephone or direct interview by one of the investigators within 24 hours of collection. The concordance between the results of the questionnaire and interview was 93%.

Universal precautions refers to the infection control policy by which the health care worker assumes that BBFs of all patients are infected with a bloodborne pathogen, advocates the use of gloves when touching mucous membranes and nonintact skin of all patients, and recommends the use of other appropriate barrier devices when indicated (eg, masks, eye coverings, and gowns when droplets or splashes are likely to occur). Under UPs, the category of BBF isolation was eliminated, but other categories (eg, respiratory isolation) were retained. Body fluids included the following types: blood, wound drainage, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, and pericardial fluid, but not urine, saliva, feces, sputum, vomitus, or tears unless they contained visible blood.

All exposure incidents reported by physicians on the questionnaires were reviewed and classified as either (1) an actual exposure when direct contact with BBFs occurred because (*a*) barrier devices were not used or, (*b*) when used, they failed to protect the health care worker (eg, a needlestick injury through a gloved hand); or (2) an averted exposure because barrier devices used by the physician at the time of exposure prevented direct contact with BBFs. Each exposure was further classified into one of the following four types: (1) cutaneous exposure when the skin at the site of contact or underneath the barrier device in an averted exposure was intact; (2) nonintact skin exposure when the skin at the site of contact or underneath the barrier device in an averted exposure was inflamed or had a cut or open wound; (3) mucous membrane exposure at the eye or mouth; and (4) needlestick injury.

The study was approved by our institutional review board. Written informed consent of physicians was not required by our institutional review board because participation was voluntary and responses to questionnaires were anonymous.

Implementation of Universal Precautions

Universal precautions were not adopted as the official hospital policy until November 1, 1988. During the preimplementation period, both hospitals practiced the traditional category-specific system of isolation by which isolation precautions were initiated in response to a patient's suspected communicable disease or diagnosis.[15,16] Routine serologic screening for HIV-1 and HBV infections was not done at either hospital.

The implementation process began on September 26, 1988. A memorandum was sent to all health care workers defining the UP policy and listing a schedule of mandatory educational sessions to review the new policy. The memorandum clearly stated that these sessions would be mandated by the Occupational Safety and Health Administration and that attendance was required.

At the UH, 40 separate educational training programs were given throughout October 1988. These sessions were presented by the hospital Epidemiology Unit and given in the form of a slide presentation. These 1-hour sessions reviewed the following: the etiologic agents (HIV-1 and HBV), the modes of transmission, the natural history of infection, and the risk of nosocomial acquisition. Universal precautions policy was explained, including the appropriate use of all barrier devices, the appropriate waste disposal procedures, and the proper use of cleaning agents to inactivate HIV-1. Proper handling of sharp instruments and needles was emphasized, and the correct procedure to report needlestick injuries was reviewed. Physicians received additional education on UPs through medical grand rounds and other teaching conferences

in November 1988.

Barrier devices required for isolation precautions under the category-specific system of isolation were supplied by means of isolation carts placed outside patients' rooms. Under the UP policy, individual isolation carts were replaced by a centralized cart stocked with gloves, masks, gowns, and goggles. These carts, one per ward, were restocked daily. Each patient's room was supplied with a box of examination gloves and a puncture-resistant, leakproof needle disposal unit. Every nurse was provided with a mouth shield to use for mouth-to-mouth resuscitation. Signs announcing the new policy of UPs were mounted strategically in the centralized nurses' station on each ward.

Implementation of UPs at the VAH followed similar programs and procedures with minor differences. The October training sessions were presented in the form of a 17-minute videotape and a 15-minute didactic lecture. Health care workers were given a multiple-choice examination before and after these sessions. Besides the initial September memorandum, the hospital Epidemiology Unit distributed a follow-up memorandum on UPs to all health care workers. A VAH medical grand rounds on UPs was given on September 30, 1988.

Statistical Analysis

The major outcome (dependent) variable of interest was the binary response relevant to whether the physician experienced either an actual or averted exposure when exposed to the patient's BBFs. Since the same physicians were repeatedly sampled over time (both before and after implementation of UPs), it could not be assumed that the binary responses for an individual were independent. Therefore, the method of analysis proposed by Prentice[17] was chosen. This approach can be considered a version of multiple regression in which the response is binary instead of normally distributed. Unlike logistic regression, the Prentice method of regression allows for correlation among repeated measurements on individuals and assumes no particular distribution.

Using the Prentice method, the following (independent) variables were evaluated for their effect on the outcome of barrier use: implementation of UPs, patient admissions to study wards, the type of hospital (VAH or UH); the number of exposure incidents sustained by physicians, the compliance rate of the physician in filling out study questionnaires (the number of questionnaires returned divided by the number of patient care days worked), the time of day when exposure occurred (day, evening, or midnight shift), and emergency status of the procedure associated with the exposure. The effect of implementation on two other outcomes (the number of actual and averted exposures) was also evaluated using the Prentice method. In the regression analyses, only data from the preimplementation period (May 1, 1988, to September 15, 1988) and the postimplementation period (November 16, 1988, to January 31, 1989) were used, omitting data from the transitional period when UPs were being implemented (September 16, 1988, to November 15, 1988). Results of our regression analysis of dichotomous variables were expressed as odds ratios (ORs) with 95% confidence intervals (CIs), calculated directly from the regression coefficients. With needlestick exposures, in which the incidence was very low and the regression approach was not applicable, a Mantel-Haenszel χ^2 test[18] was applied.

Data storage and processing were performed via the CLINFO program (BBN Software Products Corporation, Cambridge, Mass). Regression analyses were performed on a VAX 8650 with a program for Prentice's method of binary regression written by one of the investigators (V.M.C.) in PROC IML of SAS.[19] The Mantel-Haenszel tests were performed via PROC FREQ of SAS.[20]

RESULTS

The Epidemiology of Exposure Incidents

Of 294 physicians who rotated through the three study wards during the 9-month study period, 277 (94%) physicians participated in our study. These physicians returned 4573 questionnaires during 6697 patient care days on the study wards. The compliance rate of the participating physicians for returning a questionnaire, after adjustment for multiple exposures experienced on the same day, was 67%. The monthly compliance rate ranged from 65% to 70% and there was no significant difference in compliance between months either before or after implementation of UPs.

A total of 1553 exposure incidents (actual and averted exposures) to BBFs were reported during the 9-month study period. Ninety-two percent of these exposures involved blood, either by contact (1379 exposures) or by needlestick injury (49 exposures). There were 25 exposures (1.6%) each to peritoneal and cerebrospinal fluid and 20 exposures (1.3%) to wound drainage. Exposures to all other body fluids were infrequent (Table 1).

The site of exposure was the hand in 1545 incidents (99%); this included all 49 needlestick injuries. Physicians reported only two mucous membrane exposures (one involving the eye and one the mouth). Six exposures occurred on the face, but did not involve the eyes or mouth. Of 1496 cutaneous exposures, 76 (5%) occurred on nonintact skin (dermatitis or cut). The area of contact in cutaneous exposures was described as small or moderate in size 93% of the time. However, in 104 incidents (7%), the contact site covered an area the size of a hand or larger.

Table 1.—Types of Body Fluid Involved in Exposure Incidents Among Physicians

Body Fluid	No. (%) of Exposure Incidents
Blood by contact	1379 (88.6)
Blood by needlestick	49 (3.2)
Cerebrospinal fluid	25 (1.6)
Peritoneal fluid	25 (1.6)
Wound drainage	20 (1.3)
Pleural fluid	16 (1.0)
Respiratory secretions (blood-tinged)	8 (0.8)
Bloody urine	2 (0.1)
Other*	32 (2.1)
Total	1553 (100)

*Includes synovial fluid, melena, or not specified.

Table 2.—Procedures Associated With Exposure Incidents Among Physicians

Procedure	No. (%) of Exposure Incidents
Venipuncture	719 (46.3)
Intravenous catheter insertion or manipulation	533 (34.3)
Arterial puncture	123 (7.9)
Paracentesis	34 (2.2)
Nasogastric or percutaneous enterogastric tube	33 (2.1)
Lumbar puncture	30 (1.9)
Respiratory suctioning	8 (0.5)
Foley catheter insertion	2 (0.1)
Patient care*	33 (2.1)
Other†	15 (1.0)
Total	1553 (100)

*Includes wound care, moving or cleaning patient or patient area.

†Includes bone marrow biopsy, rectal tube manipulation, arthrocentesis, or not specified.

The procedures leading to exposure incidents are listed in Table 2. Eighty-nine percent of these exposures occurred during procedures that involve the insertion or manipulation of needles or catheters (719 exposures during venipuncture, 533 exposures associated with intravenous catheters, and 123 exposures during arterial punctures). Noninvasive procedures (eg respiratory suctioning, wound care, or cleaning the patient) accounted for less than 3% of the exposures.

The Impact of Universal Precautions

Before hospital-wide implementation of UPs, the frequency of barrier use (gloves, gowns, or masks) by physicians during an exposure incident was 54%. The rate of actual exposures experienced by physicians during preimple-

Table 3.—Comparison of the Rates of Actual and Averted Exposures Before and After the Implementation of Universal Precautions*

	Preimplementation				Postimplementation			
	Cutaneous	Needlestick†	Nonintact Skin	Total	Cutaneous	Needlestick†	Nonintact Skin	Total
Actual exposures	4.23	0.39	0.45	5.07	2.18	0.15	0.33	2.66
Averted exposures	3.12	...	0.29	3.41	5.49	...	0.41	5.90

*Rates are expressed as the number of exposures per patient care month. Only two mucous membrane exposure incidents were reported; both were actual exposures and occurred during the preimplementation period.
†Needlestick injuries occurring on gloved hands were considered failures of the barrier to protect and were classified as actual needlestick exposures.

mentation was 5.07 exposures per physician per patient care month (PCM), of which 4.23 were cutaneous exposures, 0.39 were needlestick injuries, and 0.45 were nonintact skin exposures. During this same period, physicians experienced averted exposures at a rate of 3.41 exposures per PCM. The majority of these exposures were cutaneous exposures (3.12 exposures), but averted nonintact skin exposures also occurred at a rate of 0.29 episodes (Table 3).

After implementation of UPs, the frequency of barrier use reported by physicians during exposures rose to 73%. The rate of actual exposures per physician after implementation fell to 2.66 per PCM, while the rate of averted exposures increased to 5.90 episodes per physician per PCM (Table 3). The rate of needlestick injuries dropped from 0.39 to 0.15 exposures per PCM in the postimplementation period ($P = .123$, Mantel-Haenszel χ^2).

Comparison of data from the preimplementation and postimplementation periods by the Prentice method of regression revealed significant increases in the frequency of barrier use ($P = 4.7 \times 10^{-7}$) and in the rate of averted exposures ($P = 2.0 \times 10^{-5}$) and a significant decrease in the rate of actual exposures ($P = 6.7 \times 10^{-7}$).

The adjusted OR for the effect of UPs on barrier use was 3.3 (95% CI, 2.0 to 5.2) Thus, physicians were more than three times as likely to take barrier precautions during an exposure incident after implementation than before. The OR for the effect of UPs on the probability of experiencing actual exposures was 0.3 (95% CI, 0.2 to 0.5), an approximately threefold reduction in risk after implementation. The likelihood of avoiding an exposure through the use of barrier devices (averted exposures) increased threefold with the implementation of UPs (OR, 2.9; 95% CI, 1.8 to 4.4).

Our analysis also revealed the following associations with barrier use, even after adjustment for the impact of implementation: physicians who were more compliant with the study questionnaire and those who suffered frequent exposures more often used barrier precautions, whereas physicians performing emergency procedures used barrier precautions significantly less frequently than when performing nonemergency procedures (Table 4).

Table 4.—Variables Assessed for Their Effect on Barrier Use by Physicians

Variable	P Value*	Odds Ratio†	95% Confidence Interval
Monthly admissions to study wards	NS‡	...	...
Type of hospital§	NS	...	...
No. of exposures	.019	...	...
Compliance with questionnaire	.004	...	...
Time of exposure	NS	...	...
Emergency status	.013	0.61	0.41-0.91
Implementation of universal precautions	4.7×10^{-7}	3.25	2.04-5.18

*Multiple regression (Prentice); result adjusted for effect of all other significant variables in model.
†Expressed only for dichotomous variables.
‡NS indicates not significant.
§University Hospital vs Veterans Affairs Hospital.

The rate of exposure incidents (actual and averted exposures combined), the frequency distribution of procedures leading to exposure, the sites of involvement, and body fluids involved before and after implementation of UPs were compared and found not to have been affected by implementation.

COMMENT

In August 1987, the CDC published recommendations for the universal use of protective barrier devices to protect health care workers from blood-borne pathogens.[12] However, despite the theoretical benefits of UPs and strong endorsements for their adoption, little evidence exists to show that UPs will protect health care workers as intended. Our study is one of the few to demonstrate that UPs can reduce the number of occupational exposures. We demonstrated by prospective surveillance that implementation of UPs was associated with a significant reduction in the number of actual exposures sustained by physicians from 5.07 exposures per PCM in the preimplementation period to 2.66 exposures per PCM in the postimplementation period. We attribute this benefit largely to the effect of implementation on barrier use, since the decrease in actual exposures was inversely proportional to the increase in the frequency of barrier use and to the increase in the number of averted exposures (Table 3). Although we cannot be certain that implementation was the only factor, we are unaware of any other factor or change in patient care routine occurring during the study period that may have contributed to this reduction. In particular, we considered the number of patients admitted to study wards to be an important and potentially confounding variable since admissions directly affect the number of diagnostic procedures and patient care manipulations performed and, therefore, exposure risk. However, the monthly census was similar in both the preimplementation and postimplementation periods, and regression analysis found it not to be a contributing factor (Table 4).

To the extent that implementation reduced the number of actual exposures, it should also reduce the risk of occupationally acquired blood-borne infections. Variables that affect acquisition include the cumulative number of exposures, the transmission rate per exposure, and the prevalence of disease.[11] For HIV infection, needlestick injuries carry the highest risk of transmission at 0.4% per episode of exposure. Since the rate of needlestick injuries fell from 0.39 to 0.15 episodes per PCM (a reduction of 62%), we estimate that the implementation of UPs should reduce the risk of occupational HIV infection by the same rate (62%) since the other variables (transmission rate and prevalence) remain unchanged. For HBV, implementation of UPs should have an even greater impact since in most localities the prevalence of HBV is higher than HIV, the efficacy of transmission per exposure episode is greater (6% to 32% per

exposure episode vs 0.4% for HIV), and exposures other than needlestick injuries (mucous membrane or nonintact skin exposures) have been known to transmit infection.[22-24]

We noted in our study that the majority (99%) of the exposure incidents involved the hand, with only eight exposures affecting the face or mucous membranes. In addition, in 345 (89%) of 389 actual exposures when barriers were not used, physicians reported that, had gloves been worn, their exposures could have been avoided. We also noted that the number of needlestick injuries fell from 0.39 episodes per month on the study wards before implementation to 0.15 episodes per month after implementation of UPs, a trend that was also observed in another recent study.[13] A possible explanation for this reduction might have been improved access to disposal units (one provided per patient room), which, although unlikely to affect the frequency of needlestick injuries associated with procedures, could have reduced the number of needlestick injuries related to transport and inappropriate disposal. The CDC recommendations emphasized all elements of UPs equally.[12] Our findings suggest that the use of gloves is the largest contributor to the efficacy of UPs.

We were also able to identify problem areas that led to occupational exposures (Table 2); this information should be useful in efforts to further reduce such exposures. Specifically, we noted that venipuncture and the insertion or manipulation of intravenous access catheters led to 1252 (81%) of 1553 of reported exposure incidents among physicians. This suggests that, at a minimum, efforts should be directed specifically to improve physicians' techniques in venipuncture and catheter insertion and care. Alternatives include the use of phlebotomy and intravenous care teams. Although the value of such teams remains controversial,[25] we noted that the proportion of exposure incidents related to catheter insertion and maintenance was significantly lower at the UH, which had an intravenous care team, than at the VAH, which did not (64 of 290 vs 469 of 1263, $P = .001$, χ^2).

Our study design raises several methodologic issues requiring comment. First, we did not begin our study until 8 months after the CDC published their recommendations for UPs and, as a result, many of our physicians were already practicing barrier precautions before official hospital adoption of the policy. Had we begun our study earlier, the baseline frequency of barrier use would have been lower and the impact of UPs might have been more dramatic. Despite this, we were still able to demonstrate a substantial gain in the frequency of barrier use and a reduction in occupational exposures. Second, we relied on a daily questionnaire as our surveillance tool. We would have preferred direct observation, but to adequately monitor several hundred health care workers over the extended study period would have required a large number of observers that, even if practical, would have likely introduced its own form of bias through the observer or Hawthorne effect. In addition, the process of completing questionnaires itself can have an effect on the use of barrier devices by focusing attention on occupational exposures. However, since the same questionnaires were used before and after implementation of UPs, whatever effect it may have should be qualitatively and quantitatively similar before and after implementation, leaving the difference in barrier use between these two periods—the outcome of interest—unchanged.

Third, the participation rate among physicians in filling out the questionnaires was 67%. This rate is less than ideal, but perhaps should not be unexpected given voluntary participation and patient care duties of a busy medical staff. Nonetheless, potential biases can arise. For example, we observed that physicians who were more compliant in filling out the questionnaires were also more likely to use barrier devices (Table 4); thus, any improvement in participation during the postimplementation period could theoretically account for the improved barrier use. However, as noted, we observed no significant variation in the participation rate from month to month. We should emphasize that, although compliance with questionnaires was 67%, study compliance, when judged by the number of physicians who participated out of the pool of physicians who rotated through the study wards, was 94%. Thus, there was little selection bias in the types of physicians who participated.

Finally, our questionnaire solicited data on the frequency of barrier use during procedures and patient care manipulations associated with an exposure incident. Thus, barrier use during procedures not leading to an exposure to BBFs could not be ascertained. But, because a physician's decision on whether to don barrier devices is made before an exposure incident has occurred, we believe that our data, although based on a subset, can validly be extrapolated as representative of overall usage patterns.

The strength of our study lies in its prospective design, which allowed us to sample our cohort of physicians daily, obtaining detailed information on the epidemiology of exposures as well as on their incidence before and after the implementation of UPs. The validity of our results has recently been corroborated by Lynch et al.[26] Based on periods of direct observation, these authors found overall glove use among their health care workers to be 61% before implementation and 81% after implementation of body substance isolation, a system of infection control similar to UPs.[27] Thus, their results are remarkably similar to ours despite differences in method. Unlike their study, however, our investigation was extended to assess what impact the increase in barrier use had on the incidence of occupational exposures, the critical issue.

Based on our findings, we conclude that UPs, as advocated by the CDC, are effective in protecting physicians from occupational exposures to BBFs. We should emphasize that our study was conducted at two urban medical centers. Procedural skills of health care workers, the frequency of performance of invasive vs noninvasive procedures, and the prevalence of infections (HIV-1 and HBV) all affect exposure risk and these variables will differ from service to service as well as from institution to institution. For example, Gerberding et al[28] recently reported on the risk of occupational exposures among operating room personnel. The differences in the epidemiology and incidence of exposures between their study and ours highlight differences in exposure risk between medical and surgical personnel. Whether and to what degree varying exposure risk affects the efficacy of UPs is an important issue that warrants further investigation. In addition, more prolonged follow-up studies will be needed to evaluate how long the effect of implementation persists and the need, if any, for further intervention to maintain compliance with UPs.

The authors are indebted to the medical house staff for their cooperation and support; to C. Glenn Mayhall, MD, and Richard J. Duma, MD, for their assistance in the design of the study; to study coordinators, Patricia Jefferson, RN, and Robin Taylor, RN; and to Bettie Duke, director of the Clinical Research Center, Medical College of Virginia, for her help in data processing.

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United Community Services
of Johnson County, Inc.

TESTIMONY BEFORE

House Public Health and Welfare Committee

February 24, 1994

RE: House Bill 2936 and 2937

Good afternoon. My name is Ann Hebberger. I am a member of the board of United Community Services of Johnson County (UCS). UCS is a private, nonprofit health and human service planning agency in Johnson County. As a planning agency, we look at the whole spectrum of health and human service needs, and at the programs designed to address those needs. My testimony reflects concerns that UCS has about HIV/AIDS testing and reporting requirements currently under consideration by this committee.

Current Kansas law provides for anonymous and confidential reporting of the results from HIV/AIDS tests. House Bill 2936 would require by-name reporting of HIV test results (See line 22, page 2). Mandatory name reporting is likely to discourage individuals from seeking early testing. Individuals who do not seek testing do not have access to the benefits of education and counseling. Education and counseling continue to be the main weapons for reducing the risk of HIV infection and controlling the spread of the virus.

P H+W
2-24-94
Attm. 6

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

UCS would like to recommend that you consider an alternative system for reporting HIV cases, called unique identifier. The unique identifier system of reporting HIV cases uses demographic characteristics such as race, gender, date of birth, and county of residence plus the last four digits of the patient's social security number. The use of a unique identifier instead of name for reporting HIV test results significantly reduces the risk of unnecessary or accidental disclosure, thereby eliminating the major barrier to testing. At the same time, it would meet the Center for Disease Control's criteria for verifiable HIV case numbers to access federal funds. Texas has received $250,000 in federal grant monies to implement a unique identifier system within the past year.

Also of concern, HB 2936 [Section (d), page 5] requires federal agencies to report to Kansas the results of involuntary HIV test results. We question whether or not involuntary testing is ethical. Certainly any desired results may be obtained more ethically through other HIV public policies.

Referring to another bill under consideration today, HB 2937 preserves the patient confidentially contained with current Kansas law [See lines 18, 19, 35, & 36, page 2). We support this aspect of HB 2937.

We have a couple of serious concerns about the sections of the bill regarding patient and partner notification [See (b) & (c), page 4]. First, HB 2937 requires physicians to "exercise dire diligence to inform spouse or partners of exposure" [See line 18 & 19, page 4]. Who will determine what constitutes "dire diligence" and what liability for Kansas physicians are we creating by requiring "dire diligence?" In addition, HB 2937 removes from current law the language about not creating "duty to warn" requirements for physicians

PH&W 2-24-94 attm # 6-2 pg 2 of 4

[See lines 23 & 24, page 4]. How will this impact the specific body of existing law regarding "duty to warn?" Secondly, HB 2937 would permit physicians to notify persons that they are HIV positive by certified mail [See lines 9-13, page 4]. In addition to being inhumane, we would lose one the best tools we have, post-test counseling, to protect partners and educate the HIV positive person about case management services which have been shown to save HIV health care dollars.

In closing, HIV testing and reporting requirements are a critical element in Kansas' response to HIV/AIDS and worthy of your consideration. I urge you to protect patient confidentiality as an important tenant of our system of public health. I recommend your consideration of a unique identifier system of HIV reporting, which could accomplish the following goals: 1) increase the willingness of individuals to seek testing because they are assured confidentiality; 2) reduce duplicate reporting of positive test results; 3) ensure accurate statistical documentation to pull down federal funding; and 4) enable proactive planning at the state and local level for future needs for HIV services.

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PH&W
2-24-94
attm # 6-3
pg 3 of 4

HIV TESTING & REPORTING -- CHART
5/4/93

STATE HIV REPORTING REQUIREMENTS

REPORTING BY NAME ONLY	PRIMARILY NAME REPORTING WITH SOME OPPORTUNITIES FOR REPORTING BY DEMOGRAPHICS ONLY	PRIMARILY REPORTING BY DEMOGRAPHICS WITH NAMES REPORTED IN SPECIFIC SITUATIONS	ANY DEMOGRAPHIC CHARACTERISTICS OTHER THAN NAMES	NO HIV REPORTING REQUIREMENTS
ALABAMA CONNECTICUT[1] IDAHO MINNESOTA MISSISSIPPI NEVADA NORTH CAROLINA NORTH DAKOTA SOUTH CAROLINA SOUTH DAKOTA TENNESSEE VIRGINIA WYOMING	ARIZONA ARKANSAS COLORADO INDIANA MICHIGAN MISSOURI NEW JERSEY OHIO OKLAHOMA UTAH WEST VIRGINIA WISCONSIN	CALIFORNIA[2] ILLINOIS[3] MARYLAND[4] OREGON[5]	GEORGIA[6] IOWA KANSAS KENTUCKY MAINE MONTANA NEW HAMPSHIRE RHODE ISLAND TEXAS	ALASKA[7] DELAWARE[8] DISTRICT OF COLUMBIA FLORIDA HAWAII LOUISIANA[9] MASSACHUSETTS NEBRASKA NEW MEXICO[10] NEW YORK PENNSYLVANIA VERMONT WASHINGTON
13 STATES	12 STATES	4 STATES	9 STATES	13 STATES

NOTES:

[1] HIV is only reportable in cases of pediatric HIV and TB

[2] Allows individuals convicted of certain sex crimes such as prostitution to be reported by name for the purpose of "conviction enhancement" in the case of future arrests.

[4] Names are obtained for reports of HIV infected school-aged children to provide for statute mandated notification to school principals.

[5] HIV symptomatic individuals are reported by name.

[3] The following individuals are reported by name: blood/plasma donors, sexual offenders, children under the age of 6, persons under the age of 21 with special education needs, persons who request public sector assistance with partner notification, and individuals with TB

[6] The Division of Public Health has asked that a proposed regulation to make HIV reportable by name and address be temporarily withdrawn until a "unique identifier" system can be tested and implemented. If the division's request isn't honored, the regulation is slated to take effect by July 1, 1993.

[7] Obtains demographic data on all people tested for HIV at state laboratories.

[8] Blood banks are required to report all individuals who test positive for HIV. Other facilities may elect to report the total number of HIV positive patients.

[9] The health department is presently planning rules to add HIV to the list of reportable disease.

[10] The possibility of implementing an HIV reporting system is under review and discussion.

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, August 1993.

PWHCW
2-24-94
Attn #6-4
pg 4 of 4

TO: Chairperson Flower and Members of the Public Health & Welfare Committee

RE: HB 2937

An Act Concerning AIDS and HIV Infections; Providing for Disclosure of Certain Information Relating Thereto.

My name is Kimbrough D. Warber. I hold a Ph.D. in Microbiology granted to me by the University of Kansas, Lawrence, in 1983. My dissertation research was in immunology, the study of the immune system.

Notwithstanding my vocational interest in and study of Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV), I am here to testify in support of HB 2937 for a far more personal reason.

My mother, Roberta Jeanne Warber, died on 21 April 1989. The cause of her death was respiratory failure as a consequence of a Pneumocystis carinii infection, which infection was opportunistic relative to a primary infection by HIV. Certain health care providers in the Kansas City area were aware, in 1985, that my mother had been exposed to HIV and was very likely infected with the AIDS virus. However, my mother was first informed of this exposure only ten days before her death in 1989, when she entered a hospital believing she had a severe case of the flu.

From March through November of 1984, my mother underwent chemotherapy for what had been diagnosed as terminal cancer. During the course of that therapy, my mother received a total of eleven units of transfused blood product. One of

PHCW 2-24-94 Attm #7

those units was tainted with HIV. The contamination was discovered in 1985 by virtue of a "look-back" program in which stored samples from transfused units of blood products were tested for the presence of HIV-reactive antibodies.

The discovery was reported by the testing blood bank to the hospital in which my mother had undergone the chemotherapy. The hospital notified the primary care physician who had admitted my mother as a patient and who was principally responsible for ordering the blood product transfusions. That primary care physician, Daniel D. Zimmerman, M.D., a Kansas-licensed practitioner, willfully decided to withhold from my mother the information concerning the likelihood of HIV infection.

As I have mentioned, in April, 1989, and under the care of a different physician, my mother was admitted to another hospital due to severe pulmonary distress. At the time, my mother believed she was suffering a bad cold-turned-bad flu. The truth was, my mother was suffering the late stages of a by then irreversible infection by Pneumocystis carinii (PC). I say "by then irreversible" because a PC infection can be successfully treated when appropriate therapy is begun early enough. PC pneumonia is an opportunistic infection common in patients with severely compromised immune systems, as is the case in patients with "full-blown" AIDS. My mother died ten days after admission to the hospital, having been informed only at that time (during the April, 1989 admission) that she was infected with HIV and indeed had developed "full-blown" AIDS.

Dr. Zimmerman willfully decided to withhold from my mother information concerning her risk for developing AIDS and of the consequent risks of secondary and life-threatening infections. In making that decision, Dr. Zimmerman placed my father

(my mother's husband and sexual partner of 37 years) at risk of infection. Dr. Zimmerman placed at risk every health care worker who subsequently dealt with my mother. This risk was genuine, I believe, because who would be especially cautious in dealing with blood and/or other body fluids from a 63 year-old grandmother with a drug-free history and still in a 37 year monogamous marriage? Dr. Zimmerman, by his own admission, placed my daughter at risk because, in August of 1988, my mother permitted her then two year-old granddaughter to kiss an "owie" to make it better.

By withholding the information of her HIV-status from my mother, Dr. Zimmerman denied my mother her right to know her complete medical history. In not knowing this aspect of her medical history, my mother was prescribed Prednisone by a different physician, in 1988. Prednisone is an anti-inflammatory agent which acts to inhibit certain processes of the immune system. It is unlikely that an immunosuppressant drug would have been prescribed to a patient known to be at risk for developing a severely compromised immune system as occurs due to HIV infection. My mother was denied the opportunity to seek a second opinion and to seek therapy, either conventional or experimental, with regard to her HIV infection. Dr. Zimmerman's decision effectively denied my mother her right to be much more vigilant in regarding any illness or infection as life-threatening. And it is as a consequence of this last point that my mother died from what she thought was the flu, from what could have been a curable opportunistic infection. I have no illusion that my mother would not have died, eventually, from complications of her HIV infection. I do believe, however, that the infection that did kill her could have been cured, and her life reasonably prolonged, had she been informed of the risk to her health of which Dr. Zimmerman was aware.

PKHall
2-24-94
Attm# B
93395

Dr. Zimmerman was permitted to make arbitrarily a decision affecting the health and health care opportunities of a patient, and indirectly the health of others. He was permitted to do this because we all generally trust that health care providers will always act in the patient's best interest without being legally or statutorially required to do so. Dr. Zimmerman's action (or inaction) in my mother's case demonstrates that we cannot be so blindly trusting any longer. What Dr. Zimmerman did was atrocious. What Dr. Zimmerman did should have been criminal.

We have all heard members of the health care community complain bitterly of their burdensome risk of civil liablity in today's litigious society. It is not inconceivable that a health care provider might one day learn that he/she did something regarding a patient's care that might expose that health care provider to civil liability. Faced with the prospect of costly civil litigation, that health care provider might decide to avoid informing the patient, in hopes that, with the passage of sufficient time, a statute of limitation or some other masking illness or accident would ultimately protect the health care provider from civil liability. It is unfortunate, but I must suggest that the threat of criminal liability would be necessary to assure that such a scenario would not come to pass. That criminal liability is what HB 2937 is designed to provide.

Perhaps more importantly, however, the provisions for notification as set forth in HB 2937 will help to guarantee something that most of us take for granted - a guarantee that all information concerning our health be made available to us. Guaranteed notification will empower patients to participate more fully in their health care; it will empower patients to become more fully educated about their condition; it will empower patients to seek any and all therapies that might be

PNCW 2-24-94 Attmt 7-4 HB 2937

available. Guaranteed notification will empower patients to be able to better protect themselves and those with whom they might be intimate.

I understand that confidentiality concerning a person's HIV status is a paramount concern to all of us. There is nothing in the provisions for notification as set forth in HB 2937 that would violate the physician-patient privilege. And even if my mother's case is one-of-a-kind (is there any way to be sure at this time?), the provisions of HB 2937 would assure for all of us that my mother's case would remain one-of-a-kind.

I urge the members of this committee to accept HB 2937 as written, and to recommend its passage to the full House. I ask the members of this committee to work to see that the legislature of the State of Kansas enacts this bill and thereby guarantees that each of us can be confident that we are fully informed of our health status and our health care options.

Thank you all for allowing me to appear here today and for listening to my concerns regarding the provisions of HB 2937.

PH+W
2-24-94
Attm+75
HB 2937

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February 24, 1994

To: House Public Health and Welfare Committee

From: Chip Wheelen, KMS Director of Public Affairs

Subject: House Bill 2936; Name Identification of HIV Positive Patients and Partner Notification
House Bill 2937; Patient Notification of HIV Test Results

The Kansas Medical Society wishes to request a technical amendment to HB2936 and substantive amendments to HB2937 prior to any action that your Committee may take on these bills. The requested amendments are described in the attached documents.

As you deliberate on these bills, we would ask that you keep in mind some important considerations. Historically, physicians and public officials have given special protections to information obtained by a physician as a result of his or her relationship with a patient. This physician-patient privilege is both an ethical obligation in the medical profession and a legal standard under Kansas law (K.S.A. 1992 Supp. 60-427). Furthermore, there are court cases which have established that the U.S. Constitution protects the patient's medical information by virtue of his or her right to privacy.

There are, however, specific statutory exceptions to the physician-patient privilege for reporting of persons suffering from contagious diseases. In the past, public officials have chosen to suspend the privileged nature of communications between patient and physician in an effort to prevent epidemics. But there is a risk involved in such exceptions.

The knowledge that his or her condition may not be privileged information can deter patients from seeking needed medical care, particularly if there is likely to be stigmatization of those persons suffering from the malady. This can actually be counterproductive to disease prevention strategies.

Most contagious diseases cause significant symptoms to develop within a rather brief period from the time of exposure. This usually compels the patient to seek medical care regardless of his or her concerns about loss of physician-patient privilege. A patient who is suffering or dying and knows that there are medical interventions that will likely cure his or her disease, will probably sacrifice the privilege in order to be cured or at least relieved of symptoms.

PH+W
2-24-94
Attm #8

Infection with human immunodeficiency virus is almost entirely different from other infectious diseases for a variety of reasons. There is no test for HIV but instead the available technology allows us to test for the presence of antibodies to HIV. This means that a patient may be infected and extremely contagious, but test negative because his or her immune system has not yet produced sufficient antibodies to test positive.

Even if the patient is infected, he or she may not suffer any symptoms of illness for an extended period of time, perhaps several years. One must ask what motivation exists for a person to seek testing for HIV status when he or she is not ill, and whether the knowledge that his or her name will be reported to public health officials will discourage or deter the patient from submitting to testing. If this is the case, the opportunity to counsel such individuals would be lost entirely.

In this context, it is important to note that a nationwide survey published in the October 6, 1993 edition of the Journal of the American Medical Association concluded that "An alarmingly high proportion (more than 60%) of those at highest risk for HIV infection have not yet been tested for HIV antibody." The study also concludes that "While some in high-risk groups may still be unaware of the availability of testing or of their risk for infection, others may deny their risk or be deterred by their fears." This is why we urge you to proceed cautiously in your deliberations.

In the past the Kansas Medical Society has maintained the position that HIV test results must remain privileged. Our reason for that position was based on the assumption that regardless of the test results, the patient should receive extremely important counseling. The goal, of course, is to urge such patients to modify their behavior in a way that would preclude future exposure of themselves or others; not only to HIV but hepatitis B and other similarly transmitted diseases.

Our previous position regarding HIV testing was endorsed by the Kansas Legislature and has been the law for several years. But there are many critics who do not agree with our strategy for HIV prevention who insist that public health officials must intervene in order to prevent further spread of this insidious illness. They argue that patients will not respond to counseling in a responsible fashion and that they must be "monitored." They assert that we lack the data necessary for epidemiological studies and that anonymity results in the loss of federal grant funds that are available to states where HIV reporting by name is mandated.

PH&W
2-24-94
Attm. #8-2
Pg 2 of 8

After years of resisting pressure from those who desire name reporting of HIV positive patients, our Medical Services Committee agreed that such a requirement as envisioned in HB2936 may be acceptable. In September 1993 the KMS Council adopted the recommendations of our Committee, thus altering the official position of the KMS.

We are extremely concerned, however, that the mandatory partner notification program described in new section four (p.4, line 29) could be counterproductive if it sends a message to the public that a positive HIV test could result in a form of inquisition into the patient's private life. Although the patient would ostensibly "not be penalized for refusing or failing to volunteer the identity of sexual or needle-sharing partners" (p.4, lines 41-42), this would not necessarily diminish the deterrent effect of the partner notification program. If you decide to enact new section four, it is imperative that the existing provision in subsection (b) of K.S.A. 1993 Supp. 65-6004 be retained and that the 30-day reporting period be incorporated. This would allow the patient's physician to provide post-test counseling prior to intervention by the KDHE staff.

We must also question whether the cost of the partner notification program would be an effective allocation of health care resources. We believe that the same funding could probably be better applied in the form of medical care for the infected patient.

We also have major reservations about the provisions of HB2937. While it contains a much improved definition of "HIV infection" (p.1, lines 32-33), the balance of the bill would constitute a serious departure from acceptable standards of care. We cannot endorse the concept of notifying a patient by certified mail that he or she is infected with a serious illness. Therefore, if the Committee decides to report HB2937 favorable for passage, we urge you to adopt the amendments contained in the attached balloon.

We believe that the following points are extremely important: (1) The physician should be allowed to decide when there exists a need for other health care or emergency professionals to know that the patient is HIV positive, (2) the patient should be informed of the need to obtain post-test counseling regardless of the test results, (3) the notification of the unsuspecting spouse or other partner by the physician should be a product of counseling the infected patient, and (4) the physician should not be exposed to extraordinary liability because he or she is willing to provide medical care to a patient who has been exposed to the HIV.

PH & W
2-24-94
Attm #8-3
~~pg 3 of 8~~

We understand that the impetus for HB2937 was a situation that raises many ethical questions. Oftentimes these kind of issues should be resolved by the Board of Healing Arts rather than attempting to define appropriate standards of medical care in the statutes. Attached for your information are (1) a recent article from the Journal of the American Medical Association which describes the most recent standards of care for an HIV infected patient and (2) a copy of K.S.A. 1993 Supp. 65-2837 which defines the various grounds for disciplinary action by the Board of Healing Arts.

We should also mention the possibility that the Senate Public Health and Welfare Committtee may soon take action on legislation that resembles HB2936. Our testimony on SB198 has been nearly identical to our statements to you on this subject.

In summary, we do not promote any of these bills under discussion but we acknowledge the prevailing consensus regarding the need to more aggressively intervene and monitor cases of HIV infection. We urge you to consider favorably our requested amendments prior to taking action on these bills.

Thank you for the opportunity to comment and for considering our requests.

PH+W
2-24-94
Attm #8-4
pg 4 of 8

(j) "Sexual partner" means a person with whom the HIV-infected individual has had intimate sexual relations during the period in which the secretary believes the individual may have been infected.

(k) "Needle-sharing partner" means any person with whom the HIV-infected person has shared equipment, products or materials of any kind which are used to inject a substance into the human body.

Sec. 2. K.S.A. 65-6002 is hereby amended to read as follows: 65-6002. (a) Whenever any physician ~~has information indicating~~ knows that a person is suffering from or has died from AIDS, such knowledge or information shall be reported immediately to the secretary, together with the name and address of the person who has AIDS, or the name and former address of the deceased individual who had such disease. ~~Any laboratory director shall report all positive reactions to an AIDS test to the secretary.~~ Any physician who is in receipt of a report indicating a positive reaction to a test for HIV infection *laboratory confirmation of HIV infection* resulting from the examination of any specimen provided to a laboratory by such physician shall report all such positive reactions *information* to the secretary. Reports by physicians and ~~laboratory~~ directors shall be provided within one week *30 days* of receipt or interpretation of the positive test results and shall designate *include the name and address of the person tested,* the type of test or tests performed, the date of performance of the test or tests, the results of the test or tests, the sex, date of birth, county of residence and racial/ethnic group of the person tested. ~~For the purpose of reporting HIV infection only, the name of the patient shall not be reported.~~ The provisions of this subsection shall not apply to a physician who, while performing services, other than the direct rendition of medical services, for an insurance company, health maintenance organization or nonprofit medical and hospital service corporation, becomes aware that a person has tested positive for HIV or is suffering from or has died from AIDS.

(b) Whenever any laboratory director has information on laboratory confirmation of HIV infection, this information shall be reported to the secretary. Reports shall be provided within 30 days of testing and shall include the type of test or tests, the results of the test or tests, dates of performance of the test or tests, the name of the physician or facility requesting the test or tests, and any identifying information about the person tested as the laboratory director has access to, such as the name and address of the person tested, the sex, date of birth, county of residence and racial/ethnic group of the person tested.

(b) *(c)* Any physician or laboratory director who reports the in-

2-24-94
Attach #5

KMS
KANSAS MEDICAL SOCIETY

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Chip Wheelen
Director of Public Affairs

who the physician knows has AIDS or has had a positive reaction to an AIDS test may *HIV test shall* disclose such information to other health care providers, emergency personnel or law enforcement officers who have been or will be placed in contact with bodily fluids *body fluid* of such patient. The information shall be confidential and shall not be disclosed by such health care providers, emergency personnel or law enforcement officers except as may be necessary in providing treatment for such patient.

(b) *Notwithstanding any other law to the contrary, a physician who knows that a patient of the physician has AIDS or has had a positive reaction to an HIV test shall notify the patient by certified mail, return receipt requested, at the time that the information becomes known to the physician.*

(c) Notwithstanding any other law to the contrary, a physician who has reason to believe that the spouse or partner of a person who has had a positive reaction to an AIDS test *a test for HIV infection* or who has AIDS may have been exposed to HIV and is unaware of such exposure may ~~*shall exercise due diligence to*~~ inform the spouse or partner of the risk of exposure. The information shall be confidential and shall not be disclosed by such spouse or partner to other persons except to the spouse or partner who has had a positive reaction to an AIDS *HIV* test or who has AIDS.

(e) Nothing in this section shall be construed to create a duty to warn any person of possible exposure to HIV.

~~(d) Any physician who discloses information in accordance with the provisions of this section in good faith and without malice shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such disclosure. Any such physician shall have the same immunity with respect to participation in any judicial proceeding resulting from such disclosure.~~

Sec. 5. K.S.A. 65-6006 is hereby amended to read as follows: 65-6006. The secretary shall prepare for distribution to the district courts of the state educational material explaining the nature, causes and effects of AIDS *and HIV infection* and other information relating to AIDS *and HIV* as may be appropriate. The clerks of the district courts or judges thereof, when applied to for a marriage license, shall provide copies of such educational material to the parties to the proposed marriage.

Sec. 6. K.S.A. 65-6001, 65-6002, 65-6003 and 65-6006 and K.S.A. 1993 Supp. 65-6004 are hereby repealed.

may

of the need to schedule an appointment for post-test counseling. If it is not possible to contact the patient within one week by normal methods of communication, the physician may inform the patient of the need to schedule an appointment

may

(d) Nothing in this section shall be construed to create a duty to warn any person of possible exposure to HIV infection.

KMS

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Chip Wheelen
Director of Public Affairs

From the Agency for Health Care Policy and Research

Managing Early HIV Infection: The AHCPR has released a clinical practice guideline on evaluation and management of early human immunodeficiency virus (HIV) infection. Although the document will be useful to a wide spectrum of providers whose practice includes patients who are HIV-positive, it is especially designed to meet the information needs of family physicians and other primary care providers.

The evaluation and management of HIV infection, at least in the early stages, is well within the professional capability of family physicians and other primary care providers, and usually does not require the services of a specialist.

See also p 487.

The major recommendations are listed below in broad outline. In the nearly 200-page guideline, they are clearly spelled out in detail, with charts and graphs augmenting the text.

The guideline is not a comprehensive guide to early HIV care; rather, it covers selected issues of special relevance to practice in a primary care setting. These include the following:

Disclosure Counseling

When disclosing HIV status to a patient, include a face-to-face discussion of the psychosocial and medical effects of HIV infection, following careful assessment of the person's psychosocial status. Discuss available therapies and social services and, where applicable, explain state requirements for reporting the infection. Discuss the potential advantages and disadvantages of voluntary disclosure to family, friends, and associates.

Urge patients to disclose their HIV status to significant others, particularly sex partners and needle-sharing partners. Emphasize the need to prevent further transmission of HIV infection.

Assess the need of the person infected with HIV for counseling and initial care, and make referrals for services that cannot be provided on-site.

Evaluation and Care of Adults and Adolescents

Take a thorough medical, sexual, and substance use history and perform a complete physical examination of the patient.

Assess the patient's immune status by determining the number of CD4 cells. Measure CD4 cells every 6 months when the cell count is higher than 0.60×10^9/L (600/μL) and at least every 3 months when the cell count is 0.20 to 0.60×10^9/L. Begin therapies to prevent *Pneumocystis carinii* pneumonia (PCP) if any of the following conditions is met: (1) the CD4 cell count is less than 0.20×10^9/L; (2) there has been a prior episode of PCP; or (3) oral candidiasis or constitutional symptoms such as unexplained fevers are present. Discuss the potential risks and benefits of using antiretroviral therapies.

Screen for *Mycobacterium tuberculosis* infection using the purified protein derivative (PPD) test. If the patient is PPD-positive, follow up with a chest roentgenogram and sputum smears and cultures, and begin preventive therapy. When selecting medications, consider patterns of *M tuberculosis* drug resistance in the community.

Evaluate patients for syphilis through careful history-taking and a nontreponemal test (ie, VDRL or rapid plasma reagin [RPR] test). Perform a treponemal test if the nontreponemal test is reactive. Obtain evaluation of cerebrospinal fluid if the treponemal test is positive. Begin penicillin treatment if necessary.

Conduct a thorough oral examination and discuss the need for special attention to the development of oral lesions and the possible rapid onset of periodontal disease; recommend a biannual visit to the dentist, with more frequent dental follow-up if problems appear.

Conduct an eye examination, including funduscopy. Refer the patient to an ophthalmologist when there are signs that suggest ocular cytomegalovirus infection.

For pregnant women, measure CD4 cells at entry into prenatal care or at delivery if the woman has gone without prenatal care. Discuss with the patient the potential risks and benefits of beginning antiretroviral therapy. Administer PCP prophylaxis if any of the three previously defined conditions relating to the need for prophylaxis is met. Assess for syphilis infection and, if necessary, complete penicillin treatment at least 4 weeks before the due date to prevent congenital syphilis.

Assess adolescents based on their level of sexual maturity, and adjust the dosages of any drugs that are indicated accordingly. Evaluate sexually active adolescents for sexually transmitted diseases and counsel them in an ag propriate manner.

Conduct annual gynecological e: nations of HIV-infected female pat making sure to include Papanicolaou tests.

Conduct objective, nonjudgmental pregnancy counseling, including discussion of the risks of perinatal transmission of HIV infection, effects of pregnancy and childbirth on disease progression, and the long-term impact of pregnancy decisions on the family. Advise against breast-feeding.

Evaluation and Care of Infants and Children

Evaluate the CD4 cell count and percentage at designated intervals, beginning at 1 month of age. Begin PCP prophylaxis after an episode of PCP or if CD4 cells or percentage falls below age-adjusted normal values. Begin antiretroviral therapy if there is symptomatic HIV infection or if the CD4 cell count or percentage falls below age-adjusted values.

Conduct a neurological assessment, including baseline computed tomographic or magnetic resonance imaging scan. Perform a follow-up neurological assessment, including age-related developmental assessment at each office visit. Treat infants and children who display HIV-related central nervous system disease with antiretroviral drugs. Consultation with a specialist may be indicated.

Coordination of Care

Coordinate medical care and support services for patients, or refer them to a formal case management system.

Recognize that in the early stages of HIV infection, such services will emphasize assistance with housing, job, and financial issues. Later, the focus of assistance will shift to medical issues.

Ensure that patients are referred to case management programs that are administered by knowledgeable, resourceful, empathetic individuals.

Written comments on the clinical practice guideline *Evaluation and Management of Early HIV Infection* should be addressed to: Acting Director, Office of the Forum, AHCPR, Willco Bldg, Room 310, 6000 Executive Blvd, Rockville, MD 20852.

—by J. Jarrett Clinton, MD
Administrator

Editor's Note: Free copies of the HIV guideline and a companion *Quick Reference Guide for Clinicians, Managing Early HIV Infection*, may be obtained by writing to AHCPR

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attn #8-7
PG 788

continuing education requirements established by the board. The request shall be on a form provided by the board and shall be accompanied by the license fee established pursuant to K.S.A. 65-2852 and amendments thereto. The board shall adopt rules and regulations establishing appropriate continuing education requirements for exempt licensees to become licensed to regularly practice the healing arts within Kansas. Nothing in this subsection (f) shall be construed to prohibit a person holding an exempt license from serving as a coroner or as a paid employee of (1) a local health department as defined by K.S.A. 65-241 and amendments thereto, or (2) an indigent health care clinic as defined by K.S.A. 75-6102 and amendments thereto.

History: L. 1957, ch. 343, § 9; L. 1966, ch. 35, § 1 (Budget Session); L. 1969, ch. 299, § 2; L. 1976, ch. 273, § 6; L. 1976, ch. 274, § 3; L. 1978, ch. 249, § 5; L. 1986, ch. 229, § 34; L. 1986, ch. 239, § 1; L. 1987, ch. 242, § 2; L. 1988, ch. 250, § 1; L. 1991, ch. 192, § 1; L. 1992, ch. 253, § 2; L. 1993, ch. 29, § 1; April 1.

Attorney General's Opinions:
Persons engaged in residency training for services to indigent health care clinics are covered under Kansas tort claims act. 93-74.

65-2837. Professional incompetency, unprofessional conduct, false advertisement and advertisement, license and licensee defined. As used in K.S.A. 65-2836, and amendments thereto, and in this section:

(a) "Professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.

(2) Repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board.

(3) A pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.

(b) "Unprofessional conduct" means:

(1) Solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.

(2) Representing to a patient that a manifestly incurable disease, condition or injury can be permanently cured.

(3) Assisting in the care or treatment of a patient without the consent of the patient, the attending physician or the patient's legal representatives.

(4) The use of any letters, words, or terms, as an affix, on stationery, in advertisements, or otherwise indicating that such person is entitled to practice a branch of the healing arts for which such person is not licensed.

(5) Performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion.

(6) Willful betrayal of confidential information.

(7) Advertising professional superiority or the performance of professional services in a superior manner.

(8) Advertising to guarantee any professional service or to perform any operation painlessly.

(9) Participating in any action as a staff member of a medical care facility which is designed to exclude or which results in the exclusion of any person licensed to practice medicine and surgery from the medical staff of a nonprofit medical care facility licensed in this state because of the branch of the healing arts practiced by such person or without just cause.

(10) Failure to effectuate the declaration of a qualified patient as provided in subsection (a) of K.S.A. 65-28,107, and amendments thereto.

(11) Prescribing, ordering, dispensing, administering, selling, supplying or giving any amphetamines or sympathomimetic amines, except as authorized by K.S.A. 65-2837a, and amendments thereto.

(12) Conduct likely to deceive, defraud or harm the public.

(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind.

(14) Aiding or abetting the practice of the healing arts by an unlicensed, incompetent or impaired person.

(15) Allowing another person or organization to use the licensee's license to practice the healing arts.

(16) Commission of any act of sexual abuse, misconduct or exploitation related to the licensee's professional practice.

(17) The use of any false, fraudulent or deceptive statement in any document connected

with the practice of the healing arts including the intentional falsifying or fraudulent altering of a patient or medical care facility record.

(18) Obtaining any fee by fraud, deceit or misrepresentation.

(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations.

(20) Failure to transfer patient records to another licensee when requested to do so by the subject patient or by such patient's legally designated representative.

(21) Performing unnecessary tests, examinations or services which have no legitimate medical purpose.

(22) Charging an excessive fee for services rendered.

(23) Prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice.

(24) Repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by a reasonably prudent similar practitioner as being acceptable under similar conditions and circumstances.

(25) Failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results and test results.

(26) Delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience or licensure to perform them.

(27) Using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records or without having periodic analysis of the study and results reviewed by a committee or peers.

(28) Prescribing, dispensing, administering or distributing an anabolic steroid or human growth hormone for other than a valid medical purpose. Bodybuilding, muscle enhancement or increasing muscle bulk or strength through the use of an anabolic steroid or human growth hormone by a person who is in good health is not a valid medical purpose.

(29) Referring a patient to a health ca entity for services if the licensee has a significant investment interest in the health care entity, unless the licensee informs the patient in writing of such significant investment interest and that the patient may obtain such services elsewhere.

(c) "False advertisement" means any advertisement which is false, misleading or deceptive in a material respect. In determining whether any advertisement is misleading, there shall be taken into account not only representations made or suggested by statement, word, design, device, sound or any combination thereof, but also the extent to which the advertisement fails to reveal facts material in the light of such representations made.

(d) "Advertisement" means all representations disseminated in any manner or by any means, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of professional services.

(e) "Licensee" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean all persons issued a license, permit or special permit pursuant to article 28 of chapter 65 of the Kansas Statutes Annotated.

(f) "License" for purposes of this section and K.S.A. 65-2836, and amendments thereto, shall mean any license, permit or special permit granted under article 28 of chapter 65 of the Kansas Statutes Annotated.

(g) "Health care entity" means any corporation, firm, partnership or other business entity which provides services for diagnosis or treatment of human health conditions and which is owned separately from a referring licensee's principle practice.

(h) "Significant investment interest" means ownership of at least 10% of the value of the firm, partnership or other business entity which owns or leases the health care entity, or ownership of at least 10% of the shares of stock of the corporation which owns or leases the health care entity.

History: L. 1957, ch. 343, § 37; L. 1976, ch. 273, § 15; L. 1979, ch. 198, § 4; L. 1979, ch. 200, § 1; L. 1983, ch. 214, § 2; L. 1984, ch. 237, § 2; L. 1986, ch. 229, § 42; L. 1987, ch. 176, § 6; L. 1989, ch. 196, § 2; L. 1991, ch. 192, § 3; L. 1993, ch. 205, § 1; July 1.

65-2859. Filing false documents with board; forgery; penalty. Any person who shall file or attempt to file with the board any false or forged diploma, certificate, affidavit or iden-

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

Robert C. Harder, *Secretary*

Testimony presented to

House Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

House Bill 2936

The Kansas Department of Health and Environment strongly supports the concept of partner notification for persons known to have been exposed to the Human Immunodeficiency Virus. We have some concerns about specifics of HB 2936 as it is currently written and would like to suggest some changes in it.

Our current efforts to counsel the sexual and needle-sharing partners of persons diagnosed with HIV infection are greatly limited because of anonymous reporting. The Bureau of Disease Control has long been committed to partner notification. Trained Disease Intervention Specialists (DIS) are available to assist with partner counseling for persons diagnosed with sexually transmitted diseases. KDHE sees this counseling as an important tool in preventing new cases of infection, because it allows those individuals who are at highest risk to receive one-on-one counseling designed to instruct the person in risk reduction techniques. DIS are unable to provide this assistance to more than half of the persons diagnosed with HIV infection in Kansas because their identities are unknown to us, even though they are known by the physician, drug treatment facility, hospital, or local health department where the test was conducted. The changes made in Section 2 of HB 2936 would remedy this.

However, the nature of funding to support our partner notification activities poses a potential problem where compliance with the provisions of New Section 4 is concerned. Given that the staffing necessary to conduct partner notification is supported primarily with federal funds (that are renewed annually), would the State be in violation of the law if funds for the program were reduced and staffing cut?

With regard to New Section 4, paragraph (d), I have an additional concern that it will not be possible to obtain anything other that statistical information from most of the studies listed. The federal government defines the reporting requirements for the studies it funds. At the present time, states receive only statistical information. I have been unable to determine whether or not individual information is available. I believe further study is needed to identify workable elements of this section in order to determine what its full programmatic and fiscal impacts would be. At first glance, the impact of this language may seem minor when it is, in fact, significant.

Testimony presented by:

Sally Finney Brazier, M.Ed.
Director
AIDS Section, Bureau of Disease Control
February 24, 1994

PH+W
2-24-94
attm #9

AMERICAN CIVIL LIBERTIES UNION
OF KANSAS AND WESTERN MISSOURI
706 West 42nd Street, Kansas City, Missouri 64111 (816) 756-3113

Testimony in Opposition to House Bill 2936
House Public Health and Welfare Committee, Hon. Joann Flower, Chair
Thursday, February 24, 1995

The American Civil Liberties Union of Kansas and Western Missouri includes 1,200 members in the state of Kansas. We are a private, nonprofit public advocacy and service organization, and an affiliate of the national ACLU, which began in 1925. The purpose of the ACLU is to protect and advance civil liberties as guaranteed under the Bill of Rights through litigation, lobbying, and education.

The American Civil Liberties Union stands in strong opposition to House Bill 2936, which would require laboratory directors to report the names of persons testing positive for HIV to the Secretary of Health and Environment, for the following reasons:

-- No system of providing confidentiality can be 100% effective. Any violations of the constitutional right to privacy are likely to result in much more grievous consequences for persons with HIV than for persons with other communicable diseases, or in the case of persons whose other health factors are revealed, because of the great potential for discrimination in employment, housing, and other accomodations, and because of the intense societal stigma still attached to the disease.

-- Even though there may be legal remedies for the violation of privacy, they are rendered moot in practice because lawsuits are public documents. A person who has suffered significant and actionable discrimination on the basis of a breach of the State's responsibilty for confidentiality may not be able to file a lawsuit for fear of publicizing his or her condition even further, with even more harmful results.

-- There is a need for accurate statistical reporting, but these statistics do not have to include the name of the affected individual. In fact, it is likely that reporting by name will have the reverse effect than that desired by this Committee, since the knowledge that the names of those testing positive will be sent to the state will encourage many persons who need the testing to avoid it. Avoidance of testing has obviously adverse effects both for public health, the health of those individuals and persons with whom they have sexual contact, and for the accurate statistics desired by the Kansas Department of Health and Environment, even considering the fact that there may be some duplication of coded statistics.

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2-24-95
Attm#10

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
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Joan Finney
Governor

Gloria M. Timmer
Director

February 24, 1994

The Honorable Joann Flower, Chairperson
House Committee on Public Health and Welfare
Statehouse, Room 426-S
Topeka, Kansas 66612

Dear Representative Flower:

SUBJECT: Fiscal Note for HB 2937 by Representative Benlon

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2937 is respectfully submitted to your committee.

HB 2937 would require a physician to provide immediate notification to a patient by certified mail upon learning that the patient has AIDS or has tested positive for HIV. It would also require physicians to "exercise dire diligence" to inform the partner of the person who has AIDS or has a positive HIV test of the risk of exposure. Current law only "allows" the physician to notify the partner. The bill would also define the term bodily fluids, clarify certain reporting requirements, and make other technical amendments.

The passage of HB 2937 would have no impact on state revenues or expenditures.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

2937.fn

P H+W
2-24-94
attm #11

STATE OF KANSAS

DIVISION OF THE BUDGET
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Joan Finney
Governor

Gloria M. Timmer
Director

February 23, 1994

The Honorable Joann Flower, Chairperson
House Committee on Public Health and Welfare
Statehouse, Room 426-S
Topeka, Kansas 66612

Dear Representative Flower:

SUBJECT: Fiscal Note for HB 2936 by Representatives Wagle, et al.

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2936 is respectfully submitted to your committee.

HB 2936 would create the HIV Partner Notification Act. The bill would require the Secretary of Health and Environment to establish a program for partner notification and referral services for persons with human immunodeficiency virus (HIV) infection. It would require the Department to interview any person reported either to have AIDS or to have been infected with HIV to try to gain information from that person in order to notify sexual or needle-sharing partners. The identity of the person with AIDS or HIV would not be revealed to any partner the Department contacts to notify and provide information of possible infection.

The Department would be required to request monthly HIV infection reports on residents of the state who have been tested by federal agencies. The Department would compile a monthly statistical report based on the information received from the federal reports. The bill would also require physicians and laboratories to provide notification to the Secretary of Health and Environment of any laboratory confirmations of HIV infection.

PH+W
2-24-94
attm #12

Estimated State Fiscal Impact				
	FY 1994 SGF	FY 1994 All Funds	FY 1995 SGF	FY 1995 All Funds
Revenue	--	--	--	--
Expenditure	--	--	$59,294	$59,294
FTE Pos.	--	--	--	2.0

The Department of Health and Environment reports that the passage of HB 2936 would require 2.0 additional FTE Disease Intervention Specialist positions at a cost of $59,294 from the State General Fund for FY 1995. The Department indicates provisions of the bill would change HIV reporting to include names and this would increase the possibility of case investigations. There would be a need for the additional staff to ensure that the agency could comply with the new mandates. Any expenditures resulting from the passage of this act would be in addition to amounts included in the *FY 1995 Governor's Budget Report*.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Laura Epler, KDHE

2936.fn

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Attm #12-2
pg 2 of 2