Approved 4-6-88
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn Chairperson at

1:30 ~~A.M.~~/p.m. on March 24, 1988 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Marilyn Bradt, Kansans for Improvement of Nursing Homes
John Grace, Kansas Association of Homes for the Aging
(Printed testimony only)
Basil Convey, Kansas Retired Teachers Association
(Printed testimony only)
Carolyn Middendorf, Ks. Nurses Assoc. (Printed testimony only)
Mark Intermill, Ks. Coalition on Aging, (Printed testimony only)
Oscar Haugh, AARP (Printed testimony only)
Senator Bond
Dr. Donald Hattan, President of Ks. Medical Society, former member of AIDS Task Force
Dr. William Wade, AIDS Task Force, practicing physician
Darrel Newkirk, M.D., Director of K.C., Kansas-Wyandotte County Health Department

Chair called meeting to order when quorum was present. Chair apologized for meeting beginning late. House Session ran very long this a.m.

Chair drew attention to Hearings on SB 585 that were unfinished at meeting yesterday. Many could not return and their written testimony will be recorded as Attachments this date.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, (Attachment No. 1, spoke to support of SB 585. She noted provisions of SB 585, then called attention to page 2 of her hand-out, i.e., current law and SB 585 refer to non-compliance with regulations which "significantly and adversely affect the health, safety, nutrition or sanitation of the adult care home residents". She cited conditions most often cited by the Department of Health and Environment on homes that do not comply. Not all violations are necessarily life-endangering, though they may be. We feel the Department of Health and Environment is correct in defining the term "significant and adverse" when they issue correction orders. She concluded by saying SB 585 is a long overdue step toward deterring violations and enforcing adult care home regulations. She asked for favorable support. No questions.

(Attachment No. 2) printed text from John Grace, Ks. Association of Homes for the Aging.
(Attachment No. 3), printed testimony from Basil Convey, Ks. Retired Teachers Association.
(Attachment No. 4), printed testimony from Carolyn Middendorf, Kansas Nurses Association.
(Attachment No. 5), printed text from Mark Intermill, Kansas Coalition on Aging.
(Attachment No. 6),printet text from Oscar Haugh, AARP.

(Attachment No.7) Correction order forms provided from Health and Environment for member's evaluation.

Hearings began on SB 686:-
Senator Bond, as Chairman of a sub-committee on SB 686 offered a detailed explanation of the bill section by section. In his view, the bill is a measured and reasonable approach to Aids problems. The bill is broad based and implemented in it, all the recommendations from the Governor's Task Force. He explained definitions, reporting of the disease, operating room personnel being made aware if a patient has the infection so that precautions can be taken, spoke to confidentiality and cited violation code. Noted it allows the Secretary of Health and Environment to adopt rules and regulations for the prevention and control of the disease AIDS. He explained the section that would provide protection for Funeral Directors and their staff; explained section that language will provide children may continue to attend public schools if they have become infected with the virus.
He spoke of the section that deals with sexual assualt victims, and noted it is the victims that need to be tested, not the perpetrator. He answered questions, yes, the Task Force did discuss the availability of health care for AIDS patients, yes new Section 4 was proposed by the Kansas Medical Society, yes, there now has been a duty created for the physicians, which may carry with it connotations, but he felt that since line 111 has changed the word "may" to "shall", this should take care of those concerns.

It was noted that Senator Steineger was to have given testimony and offer amendments, but he was unable to attend this meeting today.
Dr. Donald Hatton, President of Kansas Medical Society, and former member of the Governor's Task Force on AIDS offered testimony on SB 686. (May it be noted Attachment No. 8 position statement from Kansas Medical Society and numerous reference materials recorded in minutes this date.)

He noted, with AIDS, more has been learned in a shorter period of time than any disease in medical history. Emphasis has been on education, however, he has been looking into mandatory reporting of AIDS and HIV. Counseling will suggest those who have AIDS contact their partners, or the Department of Health and Environment could follow through with contact tracing. We will need to find a middle ground on this issue. We need to keep in focus the confidentiality situation. We need to focus on contact tracing, anonymous testing, confidentiality.
He suggested amended language for SB 686, i.e., line 112, after the word "who", insert language, "in such physician's opinion".
He concluded by saying, we need to be flexible as new findings are made available, and we must be willing to accept changes.
He answered questions, i.e., we have suggested in our guidelines that if a physician feels he cannot personally take care of a individual, they are to take it upon themselves to see that individual finds treatment from someone else; the transmission of AIDS can be transmitted more easily by blood, than by tears or saliva; no, a person that empties a wastebasket in the doctor's office isn't likely to be at risk; there are new tests for AIDS that will be available soon.

William Wade, D.O., Family medicine/Counseling, former member of Task Force, offered hand-out, (Attachment No.9). He stated SB 686 indicates a lot of hard work done by the Senate and has some very good things in the bill. It is many steps further along than just months ago. However, it falls short in addressing the rights of individuals infected with HIV and AIDS. Individuals infected with HIV should be guaranteed protection under Kansas law to protect and preserve their civil rights including freedom from discrimination in employment, housing, health care, and physician-patient confidentiality.

Hearings continued on SB 686:-Dr. Wade continued:---- Reporting of persons diagnosed as having AIDS is set down in Section 2 (a), but also added in that section is a dangerous category of persons suspected of AIDS to be reported. I recommend the provision of persons being suspected of having AIDS should be amended out of SB 686. New Section 4 (a) requires disclosure of HIV testing results, and he is not in favor of reporting of names. (Initials and birthdates would be sufficient). He recommended deletion of the provision in lines 106-116, as it was not recommended by the Task Force. Amending line 111 to "may disclose" is good. Mandatory testing of convicted sex offenders does not affect the need for immediate counseling and personal testing of survivors of these perpetrations. The vistims of such crimes should be counseled immediately after the crime. He recommended for consistency on confidentiality issues provided by this bill, and those guilty should be classed as C misdemeanor crime. He felt the new Section 9 unnecessary and should be deleted. The changes in the bill recommended above, he said, address the protection of those who find they are infected with a frightening and socially unpopular virus. This bill, SB 686, will affect the health and well being of thousands of families in our state. Your signature deserves to be affixed to legislation which preserves human dignity, not threaten it. This bill needs the revisions I have proposed however, if these goals are to be achieved. He answered numerous questions, i.e., 1½ to 2 million people are already infected with this virus; he explained the risk of a child being born with the AIDS infection if the mother is infected.

Darrel Newkirk, M.D. Director of Kansas City, Kansas-Wyandotte County Health Department, offered hand-out (Attachment No. 10). He spoke to proposed amendments to SB 686. Local Public Health Departments need the provision of reporting of HIV positive by approved labs, as it will allow them to deal with the epidemic, and help to prevent the transmission of the virus. We need to know who these persons are and their sexual contacts in order to prevent the spread of the virus. We need names and addresses, not just initials and birthdates. We have been very successful in controlling other infectious diseases, and the HIV infection is no different. The chain of transmission can be broken, and the spread can be prevented if we use the same public health principles which have been followed successfully in controlling other infectious dieseases. He spoke to the need for strong confidentiality provisions, and feels persons who have the virus should be given provisions to prevent any discrimination against them because of this infection. He urged for support of SB 686. He answered questions, yes we do voluntary testing, at about 150 tests per month; yes, they use the ELISA test; he feels it doesn't make sense to leave AIDS and HIV off the list of contagious diseases.

Chair asked how many members would be available for a meeting on Monday morning at 9:00 for a Public Health and Welfare meeting. He noted we would attempt to continue hearings on SB 686 at a later time in order to give those scheduled and not heard an opportunity to give their testimony.

Meeting adjourned 3:18 p.m.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 3-24-88

NAME	ORGANIZATION	ADDRESS
Richard Mowrey	KDHE	Topeka
Jack F Koger	KDHE	"
Renee Hodges	Intern	Lawrence
Larry Henderson	Ks. Supreme Court	Topeka
Kathy Mills-Olivier	SRS-ADAS	Topeka
Robert Frank	Ks Dept Health & Env.	Topeka
R.L. PARKER	KDHE	Topeka
V.L. Hays	KDHE	Topeka
Bob Corkins	independent	Lawrence
Edith Hulse	Dept Nurse	Topeka
KEITH LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Gordon Risk	ACLU of Kansas	Topeka
Marilyn Bradt	KINH	Lawrence
LINDA McGILL	KS. FUNERAL DIR. ASSN.	TOPEKA
Jim Clark	Ks Co Dist Attys Ass	Topeka
Elizabeth E. Taylor	Assn of Local Health Depts	Topeka
Dick Hummel	Ks Health Care Assn	Topeka
Floyd Eaton	KNCA	"
Stan Grant	KDHE	"
Karl Skrejes	KTKA-TV	"

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO THE HOUSE PUBLIC HEALTH & WELFARE COMMITTEE
CONCERNING SB 585 - CIVIL PENALTIES FOR VIOLATION OF NURSING HOME REGULATIONS
March 23, 1988

Mr. Chairman and Members of the Committee:

Kansans for Improvement of Nursing Homes is a consumer organization of some 900 members, most of whom have relatives in nursing homes. As such, we have a strong interest in the regulatory process for adult care homes, both the substance of the regulations and the way in which they are enforced.

In July of last summer the General Accounting Office of the federal government (GAO) issued a well-documented report concerning the need, nationwide, for better enforcement of Medicare and Medicaid regulations for nursing homes. In that report, the GAO showed very clearly that enforcement of regulations is a major problem in many states. Kansas was one such state, and was among the 5 states singled out for a closer examination of specific problem homes which had violated the same regulations over and over again. The underlying problem, said the GAO, is that neither federal nursing home regulations nor state regulations in many states, provide for a full range of enforcement mechanisms capable of dealing appropriately with a wide variety of violations. The intent of SB 585 is to provide a usable mid-range sanction to assist in enforcing regulations in situations which are not necessarily life-threatening or endangering but are serious enough that they cannot be permitted to continue.

PROBLEMS WITH KANSAS'CURRENT ENFORCEMENT MEASURES

1. Decertification (closing a home) is too severe a penalty for any but the most serious, life-threatening deficiencies. The goal of good enforcement is not to close nursing homes; it is to protect the welfare of nursing home residents by assuring that the homes comply with state and federal regulations.
2. Receivership is not a practical alternative to decertification unless the state is willing to provide money and staff for that process. Further, receivership, like decertification, is too extreme an action for any but the most serious categories of violation.
3. The current Civil Penalties statute is far too weak to be an effective enforcement tool. It is neither a deterrent to violation nor a significant penalty even when the same violation occurs repeatedly.

The GAO report points out that "nursing homes with deficiencies that seriously threaten the health and safety of residents are able to remain in the Medicare and/or Medicaid programs by correcting the deficiencies between the inspection and the end of the certification period. When the facility is out of compliance with the same requirement during the next inspection, it can again avoid decertification by correcting the deficiencies."

The current Kansas Civil Penalties law does not speak in any respect to repeat deficiencies or to the "yo-yo effect" which is the term often used for the home that repeatedly goes in and out of compliance with regulations.

4. The current ban on Medicaid admissions has been useful in some instances, but when a home has few Medicaid residents the ban has essentially no effect.

Attm. #1
3-23-88
PH+W

MAJOR PROVISIONS OF SB 585

1. Increases the penalty for violation of nursing home regulations which "significantly and adversely affect the health, safety, nutrition or sanitation of the adult care home residents" from the current $100 per day per deficiency to $500. The current maximum cumulative penalty of $500 would be increased to $2500.
2. Permits the Secretary of Health & Environment to double those penalties if some or all of the deficiencies recur within 18 months.
3. Speeds the process of assessing the penalty by eliminating one step.
4. Permits the Secretary of Health & Environment to prohibit the home from admitting any new residents until the deficiencies have been corrected.

Several amendments were added in the Senate which detail the process somewhat but do not affect these basic provisions.

CIRCUMSTANCES IN WHICH THE CIVIL PENALTIES STATUTE IS APPLIED

Current law and SB 585 both refer to non-compliance with regulations which "significantly and adversely affect the health, safety, nutrition or sanitation of the adult care home residents" as conditions for which a correction order may be issued. In applying that term, the conditions the Department of Health & Environment has most frequently cited are:

1. Improper use of resident restraints.
2. Improper administration of medications.
3. Insufficient staffing, including unqualified persons.
4. Inadequate health services in caring for bedfast residents, incontinent residents and residents with decubitus ulcers.
5. Failure to provide nursing services as ordered.
6. Failure to meet dietetic needs of residents.
7. Environmental deficiencies.

Within categories such as these, some judgment must, of course, be used in assessing the severity of the conditions and the frequency of occurrence--the professional judgment of the nurse-surveyors and the sanitarians.

Certainly violations of this order significantly and adversely affect the health, safety, nutrition, and sanitation of nursing home residents. Not all of them are necessarily life-endangering in themselves, though they may be. Any one of them or any combination of them can make for a generally miserable existence of the kind I do not believe Kansas legislators would find acceptable as a quality of life for frail, sick, elderly Kansans. The Department of Health & Environment is, in our opinion, quite correctly defining the term "significant and adverse" at present when they issue correction orders.

The correction order is only the beginning of the process. It simply gives the home notice that it is in violation of regulations and sets out a time period within which the deficiency must be corrected. The nursing home always has an opportunity to correct. Only when the problem is not corrected is the penalty assessed.

CONCLUSION

SB 585 is a long overdue step toward deterring violations and enforcing adult care home regulations. KINH has never looked upon the GAO report as an indictment of the will of the Department of Health & Environment to enforce nursing home regulations; it is, rather, a clear indication that the laws of Kansas are indequate as enforcement tools. We ask your support SB 585.

KAHA

The Organization of
Nonprofit Homes and
Services for the Elderly

Kansas Association of Homes for the Aging
641 S.W. Harrison
Topeka, Kansas 66603

913-233-7443

Testimony for House Public Health and Welfare Committee

Re: SB 585

March 23, 1988

Presented by John Grace, Executive Director

We support SB 585

98% of the adult care homes in Kansas have never received a fine. All homes receive deficiencies and some receive correction orders, but only a few that continue to violate the law receive a fine. Our current statute simply does not provide for a swift and effective deterrent for those few providers that put the safety, health and welfare of residents in jeopardy.

SB 585 will shorten the time period, increase the amount of the fine, and allow no new admissions to occur when the provider refuses to correct the problems.

In any penalty system, the provider should have the opportunity for a fair hearing. Under current law, adult care homes could appeal the decision under the administrative procedures act.

We see the purpose of this bill as providing a more effective way for the state to deal with a few homes that are giving all nursing homes a bad name.

Thank you.

Attm. #2
3-24-8
PH&W

Kansas Retired Teachers Association

Retired — Not Withdrawn

1987 - 1988

March 23, 1988

Members of the House Public Health and Welfare Committee:

My name is Basil Covey and I represent the Kansas Retired Teachers Association.

We support SB 585 that relates to correction orders, citations and assessments for owners and managers of adult care homes.

When adults give up living in their homes they have occupied a number of years they expect the new institutional home will be as good or better than the one they are leaving.

The trust and confidence they expect, and in most cases promised, must not be shattered by mismanagement or neglect.

We favor strict monitoring by the secretary of health and environment for corrections to be made.

We have first hand knowledge of some of the violations:

1. Employees not properly trained and qualified.
2. False fire alarms going off.
3. Stopped up plumbing not taken care of.
4. The present of insects--cockroaches.
5. Food not properly heated.
6. Security not adequate, especially on weekends.
7. Drugs given by employees not qualified.
8. Insect spraying while occupants are present.
9. Mistreatment of patients by employees.
10. Cleaning not adequate.
11. Stealing private property by employees.

We urge you to give SB 585 a positive vote.

Sincerely,

Basil Covey

Basil Covey
KRTA

Attm. #3
3-24-8
PX+w

KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
820 QUINCY, SUITE 520
TOPEKA, KANSAS 66612
(913) 233-8638
March 23, 1988

S.B. 585 Civil Penalties for Nursing Homes

Representative Littlejohn and Members of the House Public Health and Welfare Committee, my name is Carolyn Middendorf, R.N., M.N. and I am presently a nursing instructor at Washburn University School of Nursing. I have been in the field of Gerentological Nursing for 12 years, including working as a Consultant to the Bureau of Nursing Homes; Kansas Department of Health and Environment, and consulting for several nursing homes. I represent the Kansas State Nurses' Association on the Kansas Coalition on Aging, serve on the Advisory Board of the NAMFE project for Frail Elderly out of the KU School of Nursing and am currently the Legislative Chairperson for the Kansas State Nurses' Association.

The Kansas State Nurses' Association (KSNA) supports S.B. 585 which strengthens the current statutory remedies to be used when Kansas Nursing Homes fail to comply with correction orders for cited deficiencies.

The General Accounting Office (GAO) of the federal government issued a report in July, 1987 indicating that a number of states, including Kansas, have had a great deal of difficulty enforcing state and federal standards.

The current cap of $500 civil penalty is unfortunately not a significant deterrant to Nursing Homes. Repeated violations for the same deficiencies, that could be life- threatening are inexcuseable for licensed nursing homes and make a mockery out of well meaning statutes and regulations.

There are severe sanctions already in place for conditions that are life-threatening. These will place a home in receivership or close its doors. Such extreme measures should not be necessary for a facility to maintain a safe, healthy place for older adults.

Lesser sanctions in place now are fines of $100 up to $500 per day for each deficiency that is adverse to health and safety. This is merely a "slap on the hands" and is considered with amusement by the nursing home industry. These fines are only imposed after a very lengthy and time consuming process. Under current law, a home may be denied Medicaid reimbursement if not compliant after the long process with the licensing agency.

Attm. #4
3-24-8
pHow

The three significant changes in the civil penalties proposed by S.B. 585 should assist the Kansas Department of Health and Environment in enforcement of current regulatory standards and provide greater lattitude to the agency for Nursing Homes that have repeatedly violated state and federal standards.

The three significant changes in S.B. 585 are:

(1) stiffer penalties -- $ 500 per day per deficiency that adversely affects the life and health of residents up to a maximum of $2500,

(2) denial of admissions until compliant, and

(3) removal of the issuing of a citation as part of the process, to allow KDHE to initiate the fine immediately when resurvey finds non-compliance.

KSNA would strongly encourage this committee to pass out S.B.585 favorably and without unnecessary amendments that would weaken the integrity of the bill.

THANK YOU.

KANSAS COALITION ON AGING
TESTIMONY ON SB 585
HOUSE PUBLIC HEALTH & WELFARE
MARCH 23, 1988

My name is Mark Intermill. I am the Executive Director of the Kansas Coalition on Aging. KCOA supports SB 585. We support this bill because it provides some basic consumer protection for older Kansans who are currently receiving care in an adult care home, or who are preparing to enter an adult care home.

The first means of providing protection, increasing civil penalties for nursing homes which violate rules and regulations designed to protect the health and safety of nursing home residents, is a measure for which members of the Kansas Coalition on Aging have expressed strong support. In a survey of our membership conducted last fall, we asked whether KCOA should advocate for more stringent sanctions against nursing homes which have been cited for violations of health and safety regulations and have not taken action to resolve the violation in the prescribed time period. All respondents answered the question affirmatively. It was the only issue for which there was a unanimous response.

We believe that the provision of an intermediate range of sanctions would provide incentives for adult care homes to correct deficiencies which adversely impact on the health and safety of residents. The current level of fines has remained constant since 1978. But, since 1978, the cost of nursing home care in Kansas has increased by nearly 300%. The impact

Attm. #5
3-24-88

of the fine, as measured by the fine-rate ratio has been significantly diminished. We would hope that the proposed civil penalties would never have to be imposed on any nursing home. Many nursing homes in Kansas, which provide high quality care as a matter of course, will not be impacted by this legislation. But, we feel it is necessary to provide the Department of Health & Environment, which is charged with the responsibility of regulating the adult care homes in which the most vulnerable of our adult population resides, with the authority to impose meaningful sanctions in those cases where the health and safety of residents is jeopardized.

The second major provision of this bill bans admission of new residents to adult care homes which are in substantial noncompliance with health and safety regulations. This section is, in my opinion, the most important consumer protection provision of the bill. This action would provide persons who are preparing to enter an adult care home, and their families, with assurance that they will not be entering a nursing home which has been in substantial noncompliance with basic health and safety regulations. We believe that it is an appropriate extension to private pay residents of a protection currently provided to persons who receive Medicaid.

In closing, I want to reiterate our support for this bill, and to urge the committee to report it favorably for passage.

AARP

Mr. Chairman and Members of the House Public Health and Welfare Committee:

As Secretary of the Kansas State Legislative Committee of the American Association of Retired Persons, I am here to report to you that our organization wishes to express its unqualified support for Senate Bill 585.

It is our responsibility to support this bill because a majority of our members (now 350,276 in Kansas) have expressed their wishes that we do so. In a referendum that we held last August, we asked all of our 50 Chapters in the state to list and evaluate those issues that they felt we should address during the coming legislative session. We also took a random sample survey among our 350,000 plus members and asked the same questions. On these returns, we chose our legislative priorities. This was truly a grass roots effort and represents the majority opinion of the senior citizens of Kansas.

On the attached brochure you will find that at least three of our ten legislative priorities relate to better health care for the elderly, and that one of them specifically, mentions "legislation or regulations to enhance the quality of nursing home care." Under this heading we are concerned with many issues, and one of them is the problem that S.B. 585 specifically addresses: adequate penalties for those nursing homes that violate federal and state nursing home regulations.

You know and I know that we could provide you with so many descriptive examples of nursing home violations in Kansas that you wouldn't have time to read them before this legislative session is over. However, there is one that deserves to be emphasized at this time. The report on "Nursing Home Enforcement," prepared by the General Accounting Office, on page 4, paragraph 4 of the section labeled "Executive Summary," has turned to the state of Kansas among the five states studied, for its prime example of nursing home deficiencies "...a Kansas nursing home was cited in three consecutive inspections for having unqualified personnel insert or withdraw tubes used to administer drugs or provide nourishment, storing food improperly, and failing to control facility odors, and in two inspections for failing to keep the building interior clean and well maintained. The nursing home received no penalty for repeat deficiencies because termination was the only sanction authorized under Medicare and Medicaid."

AARP hopes that you will not only support S.B. 585 but do all in your power to see that it is not emasculated by amendments that would destroy its obvious intent. You will hear arguments that the penalties proposed are too severe. Let me assure you that we question whether they are severe enough. A nursing home that is well managed has nothing to fear from the penalties provided in S. B. 585. To decrease these penalties will only make it more likely that some will find it more profitable to violate regulations than to comply with them.

We urge you to respect the wishes of thousands of Kansas citizens who are our members and support S.B. 585 and vigorously resist all efforts to weaken it.

Oscar M. Haugh

Oscar M. Haugh
Secretary, Kansas State Legislative Committee
American Association of Retired Persons
(1400 Lilac Lane, #302, Lawrence, Kansas)

1 attachment

Attm. #6
3-24-8
PHW

BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In The Matter Of The Correction Order
Against [redacted]

Case No. 87-ACF-85

CORRECTION ORDER

TO: [redacted]

Licensee and administrator for the above-captioned facility.

You are hereby notified that [redacted] has been determined to be in noncompliance with KAR 28-39-78(a)(7), KAR 28-39-87(e), KAR 28-39-87(a), KAR 28-39-87(f)(8)(B), KAR 28-39-87(h)(3), KAR 28-39-98(a), KAR 28-39-89(a), KAR 28-39-87(i)(1), KAR 28-39-87(i)(2), KAR 28-39-87(i)(3), KAR 28-39-89(f), KAR 28-39-92(d)(1), KAR 28-39-89(f)(1), KAR 28-39-97, KAR 28-39-101(e), and KAR 28-39-109(m), which provide:

> KAR 28-39-78(a)(7) -- The resident shall be free from restraints unless the restraints are authorized by a physician for a specified and limited period of time or when necessary to protect the resident from injury to self or others.
>
> KAR 28-39-87(e) -- There shall be a signed physician's order for any restraint, including justification, type of restraint, and duration of application. A resident shall not be restrained unless, in the written opinion of the attending physician, it is required to prevent injury to the resident or to others and alternative measures have failed.

Attm. #7
3-24-8
PH/HW

KAR 28-39-87(a) -- Each facility shall provide programs and personnel to meet the nursing needs of the residents.

KAR 28-39-87(f)(8)(B) -- Treatment for pressure sores shall be given according to written physician's orders.

KAR 28-39-87(h)(3) -- Food and fluid intake of residents shall be observed recorded, and reported to the charge nurse.

KAR 28-39-98(a) -- The facility shall provide a sanitary environment and shall follow proper techniques of asepsis, sterilization, and isolation.

KAR 28-39-89(a) -- The facility shall ensure safe and accurate ordering, storage, distribution, administration, review, and recording of all medications and biologicals and shall have written policies and procedures for pharmacy services.

KAR 28-39-87(i)(1) -- The facility shall have a written program of restorative nursing care which shall be an integral part of nursing services. The written program shall be directed toward assisting the resident to achieve and maintain an optimal level of self-care and independence.

KAR 28-39-87(i)(2) -- There shall be evidence of regular staff development training sessions, for all nursing personnel, in restorative nursing techniques to promote ambulation, to aid in activities of daily living, to assist in activities, to assist in bladder and bowel retraining, to encourage self-help, to promote the maintenance of normal range of motion, to ensure correct chair and bed positioning, and to prevent or reduce incontinence.

KAR 28-39-87(i)(3) -- Written records shall be maintained regarding all restorative nursing services performed.

KAR 28-39-89(f) -- The facility shall ensure that all medications are administered to residents in a safe and accurate manner and in accordance with a physician order and requirements of law.

KAR 28-39-92(d)(1) -- Menus shall be planned and followed to meet the nutritional needs of residents in accordance with physicians' orders, the residents' nutritional care plans, and to the extent medically possible, the current recommended daily allowances of the food and nutrition board of the national research council, national academy of sciences, as in effect on July 1, 1981.

KAR 28-39-89(f)(1) -- All medications shall be administered by physicians, licensed nursing personnel, or by other personnel who have completed a state-approved training program in medication administration. Injectables shall be administered only by physicians or licensed nurses.

KAR 28-39-97 -- The skilled nursing home and intermediate nursing care home shall provide staff and services to ensure a clean, safe, and comfortable environment for residents and shall meet the environmental sanitation and safety requirements prescribed in KAR 28-39-98 to KAR 28-39-102, inclusive.

KAR 28-39-101(e) -- Building and equipment supplies shall be stored in areas not accessible to residents.

KAR 28-39-109(m) -- The facility shall provide laundry areas and equipment appropriate to the needs of the residents and non-residents served the facility.

Relative to this matter [redacted] has been inspected on the following occasions: June 1, 2, 3, 4, and 5, 1987, by [redacted] and [redacted], and on June 8, 1987, by [redacted]

This facility was determined to be in noncompliance on the following dates and was notified by preliminary inspection reports dated June 5 and 11, 1987, and signed by [redacted]. Attached as Exhibit A and incorporated herein is a copy of the deficiency reports setting forth the factual basis for this order.

These deficiencies (nonconformities) are deemed to significantly and adversely affect the health, safety, nutrition, or sanitation of the residents.

IT IS THEREFORE ORDERED pursuant to KSA 39-945, that [redacted] provide:

1. That a physician's order for physical restraints be obtained prior to administering any physical restraint in accordance with KAR 28-39-78(a)(7) and KAR 28-39-87(e) immediately upon receipt of this order.

2. That adequate health services be provided to ensure that nursing services are provided as ordered as required by KAR 28-39-87(a) immediately upon receipt of this order.

3. That decubitus treatments be administered as ordered by the physician and using proper nursing techniques as required by KAR 28-39-87(a) and (f)(8)(B) immediately upon receipt of this order.

4. That adequate health services be provided to ensure that proper catheter care is given as required by KAR 28-39-87(a) immediately upon receipt of this order.

5. That food and fluid intake of each resident shall be observed, recorded, and reported to the charge person as required by KAR 28-39-87(h)(3) immediately upon receipt of this order.

6. That proper nursing techniques be followed in administration of medications as required by KAR 28-39-89(a) and KAR 28-39-98(a) immediately upon receipt of this order.

7. That adequate rehabilitation servces be provided to meet the resident's needs as required by KAR 28-39-87(i)(1)(2)(3) immediately upon receipt of ths order.

8. That all medications be administered according to physician's orders as required by KAR 28-39-89(f) immediately upon receipt of this order.

9. That all therapeutic diets be served as ordered as required by KAR 28-39-92(d)(1) immediately upon receipt of this order.

10. That all injectables are administered by either physicians or licensed nurses in accordance with KAR 28-39-89(f)(1) immediately upon receipt of this order.

11. That all hazardous chemicals, such as cleaning solutions, be stored in areas not accessible to residents as required by KAR 28-39-97 and KAR 28-39-101(e) immediately upon receipt of this order.

12. That the facility shall provide a laundry areas and equipment appropriate to meet the needs of the residents and non-residents as required by KAR 28-39-109(m) immediately upon receipt of this order.

Dated this 15th day of July, 1987.

Richard J. Morrissey, Director
Bureau of Adult & Child Care Facilities

CERTIFICATE OF MAILING

I hereby certify that on the 15th day July, 1987, a true and correct copy of the foregoing Correction Order was mailed to: [redacted] depositing the same in a properly addressed envelope, postage prepaid, certified mail, return receipt requested in the U.S. mail.

[redacted]
Staff Member

Certified Mail # 518644875

Certified Mail # 518644874

PRELIMINARY INSPECTION REPORT OR FOLLOW-UP REPORT

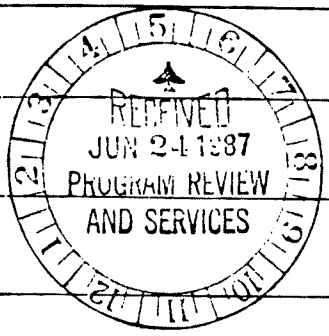
LICENSE OR PROVIDER NUMBER [redacted]

DATE OF VISIT Exit 6-8-87

NAME OF FACILITY [redacted]

STREET ADDRESS, CITY, STATE, ZIP CODE [redacted]

ITEM	PRESENT STATUS
	COMMENTS



The signatures below acknowledge discussion of the deficiency list and receipt of a copy of the same.

DATE	SURVEYOR'S SIGNATURE	ADULT CARE HOME REPRESENTATIVE'S SIGNATURE	DATE
6-11-87	[redacted]	[redacted]	6-11-87

Pink—State Agency, Goldenrod—Adult Care Home, Blue—Public Assistance, White—OLTC, Green—DO, Canary—Single State Agency 1303-H

PRELIMINARY INSPECTION REPORT ~~OR FOLLOW-UP REPORT~~

~~LICENSE OR~~ PROVIDER NUMBER [redacted]

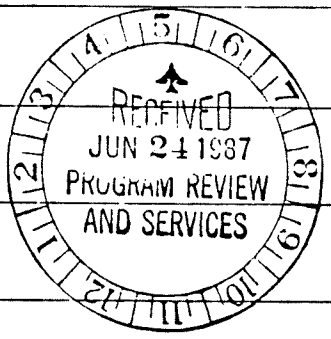
DATE OF VISIT 6/1-5/87

NAME OF FACILITY [redacted]

STREET ADDRESS CITY STATE ZIP CODE [redacted]

ITEM	PRESENT STATUS

I felt the survey team was very helpful and helped our staff understand the survey process. I believe the process was fair and the problems noted were different enough detail to allow our staff adequate information to correct the issue. This was a good experience.



The signatures below acknowledge discussion of the deficiency list and receipt of a copy of the same

DATE	SURVEYOR'S SIGNATURE	ADULT CARE HOME REPRESENTATIVE'S SIGNATURE	DATE
6/5/87	[redacted]	[redacted]	6-5-87

Pink—State Agency, Goldenrod—Adult Care Home, Blue—Public Assistance, White—OLTC, Green—DO, Canary—Single State Agency

303-H

DEPARTMENT OF H[illegible] AND HUMAN SERVICES
HEALTH CARE FINA[illegible] ADMINISTRATION

FORM APPR[illegible]
OMB No. 0[illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Generalist 6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
D F47 F49	CFR 405.1121(k)(1)(2), 442.311(a)(3)(4) KAR 28-39-78(a)(1),(5)(3) and 83(2)(5) The admission financial agreement and recipition of resident rights were signed by someone other than the resident or legal guardian in 4 of 13 indepth residents reviewed.			
2 F65 F68	CFR 405.1121(k)(6), 442.311(2) and 442.320(a)(2) KAR 28-39-83(j)(1)(4) The facility has managed funds for 15 residents since March, 1987 but did not have authorization for any of these residents. Receipts for disbursements were signed by the activity director and not the resident in 6 cases.			
3 F71 F118	CFR 405.1121(k)(7) and 405.1124(c), 442.311(g)(2)(i) 442.335 KAR 28-39-78(a)(7) and 87(2) Three residents lacked a physician order for the use of physical restraints, one resident lacked a current order for the use of dutch door restraints, two residents with dutch door restraints			

page 1 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

►Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(3) [redacted]	continued ..... locked and order for duration and justification for use, one resident locked order for type of restraint used (sheet). One resident was observed restricted in a wheelchair for 3¾ hours before release and opportunity for exercise or change of position.			
F113	CFR 405.1124(c) and 442.338(a)			
F114	KAR 28-39-876(a) Nursing services were not provided to meet the needs of each resident because of the following reasons: a) Resident #12 had 4+ pitting edema of feet and lower legs and an order for TED hose but were never applied. b) Blood pressure readings were not available as ordered for 3 of 13 sampled residents c) Weights were not taken for 2 sampled residents as ordered by the physician. (residents had congestive heart failure, cardiac arrhythmia, weight loss)			

page 2 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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HEALTH CARE FINA... 3 ADMINISTRATION

OMB No. 0938-...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(5) F 117	CFR 405.1124(c) and 442.338 KAR 28-39-87 (f)(8)(B) One resident with 3 decubiti was observed on 6/1/87 with fecal material on the dressing to the coccyx area and had no dressing on 2 areas (coccyx and at hip) on 6/2/87. Two residents with decubiti did not have areas cleansed prior to application of ointments. One of these residents had feces on buttocks and Foley catheter at time of treatment on 6/2/87.			
(6) F 120	CFR 405.1124(c) and 442.338 KAR 28-39-87(a) Residents with Foley catheters did not always receive proper care. Four residents were observed laying on the catheters and/or tubing. Two residents were observed with the catheter tubing dragging the floor, one had feces on the catheter. One resident had a physician order to remove catheter on 6/2/86 in one week but was not removed until 6/17/86. Fluid intake and output was not recorded for one resident with a Foley catheter in May and inconsistently recorded for one other resident with a catheter.			

page 3 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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DEPARTMENT OF HEA[illegible] AND HUMAN SERVICES
HEALTH CARE FINANC[illegible] ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F121	CFR 405.1124(c) KAR 28-39-87(a)(h)(3) One skilled patient receiving naso-gastric tube feedings lacked a record of feedings to verify compliance with physicians orders. The physician order did not include amount of water to be administered via NG tube and the amount of feedings recorded varied each day.			
F123	CFR 405.1124(c) and 442.338 KAR 28-39-98(a) and 89(a.) Proper techniques were not followed in medication administration because: a) Good handwashing was not always practiced between residents. b) Four residents had medications crushed that were contraindicated (Ferrous sulfate, Motrin, Micro K caps). c) The treatment cart, containing multiple bottles of betadine, hydrogen peroxide, and biologicals, was left unattended in the hall and accessible to residents while the treatment nurse			

page 4 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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DEPARTMENT OF HEA[illegible] HEALTH CARE FINANC[illegible] | ND HUMAN SERVICES [illegible]DMINISTRATION | Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5-89

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
[redacted]	continued - - - - was inside resident rooms performing treatments.			
1) F155 F158 F159	CFR 405.1124(e) and 442.338 and 442.343(b) KAR 28-39-87 (1)(1)(2)(3) and (6)(8)(E) Rehabilitative nursing services were not adequate to meet resident needs because of the following reasons: targeted. a) One resident lacked application of a wrist splint on all days of the survey as ordered by physician b) One indepth resident was receiving no assistance with ambulation as ordered c) Three of 13 targeted residents and one other observed lacked supportive devices to prevent foot drop. d) No heel protectors were provided as indicated for 4 of 13 residents. e) Bowel and/or bladder retraining programs initiated for 7 residents were not properly implemented. Records did not indicate these residents were taken		a) b) c) d) e) 7-15-89 page 5 of 14	

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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HEALTH CARE FINANC ... DMINISTRATION

OMB No 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDE... NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COM... ED
[redacted]	A. BUILDING _____ B. WING _____	6/.-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
[redacted]	continued to the bathroom, every 2 hours, after fluids furnished, or daily response to the program. f) Restorative nursing services were not consistently recorded as provided or planned. Documentation stated restorative aide was pulled to floor duty, not provided in complete days, or restorative aide absent on 26 of 41 records reviewed.			
0	~~F165 CFR 405.1124 (f) and 442.339 KAR 28-39-87 (4)(3)~~ delete per			
F172	CFR 405.1124(h)(g), 442.334(a).			
F173	CFR 442.341 and 442.342			
F174	KAR 28-39-89 (6)(4)			
F209	Medications were not administered in accordance with physicians orders as follows: a) Three residents were observed during drug pass and 1 indigent resident received did not receive medications			

page 6 of 17

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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FORM APPROVED
OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
[redacted]	Continued			
	as ordered by the physician because the Medication was not available (Quinaretic, synthroid, inderal) Furosemide was borrowed from another resident.			
	b) One resident had an antibiotic ordered 5/5/87 but was not administered until 5/12/87. Only 17 of the 30 doses ordered were recorded as administered.			
(11)	c) One resident lacked documentation of insulin injection 10 times in May, 1987			
F179	CFR 405.1125(c)(2), 442.332(b)(1)(2)			
F180	KAR 28-39-92 (a)(d)(1)(g)(1)			
F182	The nutritional needs of each resident were not met because:			
F187	a) Diabetic residents were served 2% milk rather than skim milk and one diabetic resident was given sugar by a nurse aide at breakfast 6/2/87			
F188	b) One resident had a physician order for poly can to increase calories but was not provided because it was not available. (Unknown)			
F189	c) Plates of food were placed on tables before residents arrived in the dining room and were cold before			

PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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FORM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page ___ of ___

DEPARTMENT OF H... HEALTH CARE FINA... | H AND HUMAN SERVICES 3 ADMINISTRATION | FORM APPROVED OMB No. 0938-0...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
[redacted]	continued . . . residents arrived. Two meal trays were observed standing in an unheated cart for 25 minutes prior to being served to residents in feeder area at breakfast meal 6/2/87. A taste test of food directly from the steam table at breakfast and lunch 6/2/87, verified that food was not served hot. d) All foods were prepared without salt at breakfast meal 6/2/87 and no salt was provided to residents in the feeder area of the dining room.			
2) F240	CFR 405.1124 (d), 442.341 KAR 28-39-84 (d)(4) ~~Review of all care plans reviewed~~ Reviews of all care plans did not address all problems and reflect changes in patient condition. Reviews of several problems were reflected in only one general statement.			

page 8 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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FORM HCFA-2567 (10-84) If continuation sheet Page ... of

HEALTH CARE FIN/ G ADMINISTRATION

OMB No 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	BUILDING _____ B WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--- (15)	KAR 28-39-85 (c)(2)(3)(4) Six employees, hired since the last survey that have worked longer than 10 days, lacked a physical exam signed by a physician.			
--- (16)	KAR 28-39-78(a)(3) The facility admission financial agreement stated 5 days notice would be given in advance of transfer or discharge rather than 15 days as required in 7 of 13 in depth residents reviewed.			
--- (17)	KAR 28-39-89(f)(1) Insulin was documented as administered to one resident by a CNA at 5 PM on 6/1 and 6/2/87.			

page 1 of 14

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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DEPARTMENT OF H[illegible] AND HUMAN SERVICES
HEALTH CARE FINA[illegible] ADMINISTRATION

FORM APPROVED
OMB No 0938-0[illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6/1-5/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
---	KAR 28-31-101(d)			
(18)	Resident care equipment was not maintained in a safe and sanitary manner as follows:			
	a) Floor cleaner (Sundance) in unlabeled janitors closet hall 4 6/1/87			
	b) a gallon pail-wash and stainless spray in resident bathroom 415 6/1/87			
	c) aloe Vesta, with warning label, in room 412 and hall 1 mens shower room 6/1/87.			
	d) alcohol on dresser in room 405			
	e) foam pads in wheelchairs unsecured			
	~~f) [illegible] (sitting) in shower hall 4~~			
	g) 3 soiled brushes and 1 soiled comb were observed unidentified in the whirlpool room hall 1 on 6/1/87.			
(19) ---	KAR 28-39-87(g)(5)			
	A "no smoking" sign was not posted on the corridor side of the door in room 409 where a resident was receiving Oxygen as needed on 6/1 thru 6/5/87.			

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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HEALTH CARE FINA... 3 ADMINISTRATION

FORM APPR... OMB No ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	6-8-87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F342 F345	(1) CFR 405.1135(d) Linens were not handled, processed, and transported in such a manner as to prevent the spread of infection as evidenced by: (2) KAR 28-39-99(e) & KAR 28-39-104(K) Soiled laundry was usually sorted on the floor, as adequate bins or tables were not provided. (3) KAR 28-39-104(K) After five hours of work by the laundry staff, the quantity of soiled laundry was so great as to nearly prohibit passage through the sorting area. One of only two washing machines shook so badly during spin cycles that it was eventually shut down. (4) KAR 28-39-100(e) Hot water supplied to the washing machines measured 150°F, rather than the required 160°F. Note: Change of Ownership Deficiencies corrected with the exception of item (3) (Item 39 on KDHE Letter of 9-26-86)			

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In The Matter Of The Correction Order
Against [redacted]

Case No. 87-ACF-85

CITATION

Now on this 26th day of August, 1987, Stanley C. Grant, Ph.D., Secretary, Kansas Department of Health and Environment, reviews the file on this matter and after consultation with his staff finds that a Citation should be issued pursuant to KSA 39-946.

The Secretary finds that a Correction Order was issued on July 15, 1987, stating that the above-entitled facility was in violation of KAR 28-39-78(a)(7), KAR 28-39-87(e), KAR 28-39-87(a), KAR 28-39-87(f)(8)(B), KAR 28-39-87(h)(3), KAR 28-39-98(a), KAR 28-39-89(a), KAR 28-39-87(i)(1), KAR 28-39-87(i)(2), KAR 28-39-87(i)(3), KAR 28-39-89(f), KAR 28-39-92(d)(1), KAR 28-39-89(f)(1), KAR 28-39-97, KAR 28-39-101(e), and KAR 28-39-109(m) and that the facility was to correct these immediately upon receipt of that order.

The Secretary finds that on July 16, 1987, a representative from [redacted] and on July 22, 1987, [redacted] signed the receipts for the Correction Order on behalf of [redacted]

The Secretary finds that [redacted] was revisited on July 29 and 30, 1987, by [redacted] Attached as Exhibit A and incorporated herein is a copy of the deficiency reports setting forth the factual basis for this order.

The Secretary further finds that as a result of the July 29 and 30, 1987 inspection, the following items were deemed not to be corrected.

KAR 28-39-78(a)(7) and KAR 28-39-87(e) -- One resident lacked a physicians order for the use of physical restraints. Residents were not released from physical restraints every 2 hours for exercise or change of position. Five residents were observed restrained for periods ranging from 2½ to 4½ hours before release.

KAR 28-39-87(a) -- One resident did not have TED hose applied on July 29, 1987, because none was available. Blood pressure readings were not available as prescribed or planned for 4 of 5 residents and the other resident had a daily blood pressure reading ordered and the physician was to be notified if above 165 systolic and 105 diastolic. This resident had a blood pressure reading recorded 180/100 on July 7, 1987, and 168/108 on July 15, 1987, but there was no evidence the physician was notified.

KAR 28-39-87(a) and KAR 28-39-(f)(8)(B) -- Treatments were not documented or administered as ordered for 8 of 8 residents reviewed. The treatment nurse scheduled to provide treatments on the day shift observed July 29, 1987, did not have time to complete all treatments on the day tour of duty.

KAR 28-39-87(a) — Proper catheter care was not provided because 2 residents were observed lying on the catheter tubing, 2 were observed with feces on the catheter, and 2 residents were observed with catheter tubing and drainage bags dragging the floor while up in wheelchair.

KAR 28-39-87(h)(3) -- Food and fluid was not recorded consistently for meals or for residents with Foley catheters. Intake was not recorded for one resident receiving tube feedings, one resident for fluid restrictions, and one resident with poor fluid and food intakes.

KAR 28-39-89(a) and KAR 28-39-98(a) -- Proper techniques of good handwashing was not practiced between residents. Two residents were not observed by the medication nurse while taking the drug. Ten of 14 residents did not received medications at the right time. The medication nurse on Hall 1 and 2 had worked only 5 days in the facility and was still passing 9:00 am medications at 12:00 noon and 1:00 pm medications at 3:00 pm.

KAR 28-39-87(i)(1)(2) -- Only 30 of 128 residents were on a restorative nursing service program. Residents were identified in need of restorative services but were not receiving this service. Three residents had daily orders for services but were not provided on weekends. Supportive duties to prevent foot drop were not available as indicated nor were heel protectors provided. Cones were not provided to all residents with contractural hands. The bowel and bladder retraining program had been attempted but not consistently provided and not recorded daily.

One restorative aide was absent on June 23 and 25, 1987, and was pulled to floor duty and June 29 and July 2, 1987 and therapy services were not provided during these days. The other aide was absent on July 7, 1987, and services were not provided.

KAR 28-39-89(f) -- One resident observed during drug pass on July 29, 1987, did not have the medication available and was not administered. Another resident did not have insulin recorded as given on June 29, 1987 and the order for insulin in the pm on this date was not given according to physicians order (10 units given rather then 5 units as ordered).

KAR 28-39-92(d)(1) -- Therapeutic diets were not served as ordered and planned on the menu. Two resident diet orders did not agree with the tray/plate diet order card. Diabetic residents were served whole milk on July 29, 1987, rather than non-fat milk because non-fat milk was not available and one diabetic resident was served whole milk on July 30, 1987. One resident did not receive polycase on food at breakfast July 29, 1987, because none was available. There was no salt seasoning in food for regular diets at breakfast meals observed.

KAR 28-39-97 and KAR 28-39-101(e) -- An unidentified chemical was stored in an unlocked cabinet in Hall 3 soiled workroom. Brights Washroom cleaner and Respond Spray Buff were in unlocked area of Hall 3 soiled utility room.

KAR 28-39-109(m) -- The facility did not provide a laundry service to meet the needs of the residents. On July 30, 1987, laundry was observed being sorted on the floor. Two bags of dish towels from dietary were on the floor in the laundry on July 29, 1987, and 2 large laundry bins of soiled linens were stored approximately 4 feet above the level of cart, uncovered, in the holding room and 1 bin in the washer room and there were 9 barrels of soiled linen in the holding room. There were insufficent linens (blankets, sheets, incontinent pads, wash cloths) on the halls to care for residents. Nurse aides had to leave resident care and go to the laundry to obtain clean linen in order to change beds and care for incontinent residents. One resident was crying "I'm cold." The aide said no blankets were available. There were only 2 #50 capacity washers in use. Residents and resident families were complaining that clothing had been lost in the laundry.

The Secretary finds that the uncorrected deficiencies set forth above have an endangering relationship to the health, safety, nutrition, or sanitation of the adult care home residents.

Failure to correct the deficiencies set out above may result in the assessment of a penalty not to exceed $100.00 per day per deficiency for each day subsequent to the day following issuance of this Citation that the deficiencies have not been corrected - the maximum assessment not to exceed $500.00.

The Secretary orders, adjudges, and decrees that a Citation be issued pursuant to KSA 39-946, against [redacted] for the above violations.

Dated this 20th day of August, 1987.

Stanley C. Grant, Ph.D., Secretary
Kansas Department of Health and Environment

CERTIFICATE OF MAILING

I hereby certify that on the 26th day of August, 1987, a true and correct copy of the foregoing Citation was mailed to: [redacted] depositing the same in a properly addressed envelope, postage prepaid, certified mail, return receipt requested in the U.S. mail.

[redacted]
Staff Member

Certified Mail # 518644966

Certified Mail # 518644967

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Correction Order 7/29, 30/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--- 1)	KAR 28-39-78(a)(7) and 87(a) Not Corrected One resident lacked a physicians order for the use of physical restraints. Residents were not released from physical restraints every 2 hours for exercise or change of position. Five residents were observed restrained for periods ranging from 2½ to 4½ hours before release.			
---	KAR 28-39-87(a) Not corrected a) One resident did not have TED hose applied on 7/29/87 because none was available. b) Blood pressure readings were not available as prescribed or planned for 4 of 5 residents and the other resident had a daily blood pressure reading ordered and the physician was to be notified if and the physician was to be notified if above 165 systolic or 105 diastolic. This resident had a blood pressure reading recorded 180/100 on 7/7/87 and 168/108 on 7/15 but there was no evidence the physician was notified. c) corrected weights were recorded in residents nursing as ordered.			

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	page 1 of 7	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See these for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED [illegible]

FORM HCFA-2567 (10-84) [illegible] HCFA REGIONAL OFFICE [illegible] If continuation sheet Page

CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ WING _____	Correction Order 7/29, 30/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
---	KAR 28-39-87(a) and (f)(8)(B Not Corrected			
(3)	Treatments were not documented as			
	administered as ordered for 8 of 8			
	residents reviewed. The treatment			
	nurse scheduled to provide treatments			
	on the day shift observed 7/29/87 did			
	not have time to complete all treatments			
	on the day tour of duty.			
---	KAR 28-39-87(a) Not Corrected			
	Proper catheter care was not provided			
	because 2 residents were observed lying			
	on the catheter tubing, 2 were observed			

	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
VED BY STATE CERTIFYING AGENCY ☐				
ROVED BY STATE CERTIFYING AGENCY ☐				
ED BY DHHS REGIONAL OFFICE ☐	REVIEWED BY (INITIALS)	DATE	TITLE	
OVED BY DHHS REGIONAL OFFICE (ONLY FACILITIES REQUIRE USE IN THIS BLOCK) ☐				

ficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting it is determined that other safeguards provide sufficient protection to the patients.
verse for further instructions.)

FORM CMS-2567(11-92)

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued .... with feces on the catheter, 2 residents were observed with catheter tubing and drainage bags dragging the floor while up in wheelchair.			
---	KAR 28-39-87(4)(3) Not corrected Food and fluid was not recorded consistently for meals or for residents with foley catheters. Intake was not recorded for one resident receiving tube feedings, one resident for fluid restriction, one resident with poor fluid and food intake.			
--- (6)	KAR 28-39-89(a) and 98(a) Not corrected Proper technique of good handwashing was not practiced between residents. Two residents were not observed by the medication nurse while taking the drug. 10 of 14 residents did not receive medications at the right time. The medication nurse on hall 1 and 2 had worked only 5 days in the facility and was still passing 9 AM meds at 12 noon and 9 PM meds at 8 pm.			

PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

page 3 of 7

* A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Complaint Order 7/29-30/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO[redacted]
[redacted]	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--- D	KAR 28.39-87(i)(1)(2) Not Corrected Only 35% 128 residents were on a restorative nursing service program. Residents were identified in need of restorative service but were not receiving this service. Three residents had daily orders for service but were not provided on week-ends. Supportive devices to prevent foot drop were not available as indicated nor were bed protectors provided. Cones were not provided to all residents with contractured hands. The bowel and bladder retraining program had been attempted but not consistently provided and not recorded daily. One restorative aide was absent on 6/23+25 and was pulled to floor duty on 6/29-7/2/87 and therapy service were not provided during these days. The other aide was absent on 7/3/87 and service were not provided.			

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	[illegible]	

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See ...ce for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to ...ued program participation.

...CFA-...37 (10-84)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Complete Oral 7/29-30/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--- (8)	KAR 28-39-89(f) Not corrected One resident observed during drug pass on 7/29/87 did not have the medication available and was not administered. Another resident did not have insulin ordered as given in AM on 6/29/87 and the order for insulin in the PM on this date was not given according to physician order. (10 units given rather than 5 units as ordered)			
--- (9)	KAR 28-39-92(d)(1) Not corrected Therapeutic diets were not served as ordered and planned on the menu. Two residents diet order did not agree with the tray/plate diet order card. Diabetic residents were served whole milk on 7/29/87 rather than non-fat milk because non-fat milk was not available and one diabetic resident was served whole milk on 7/30/87. One resident did not receive polyunsaturated fat at breakfast 7/29/87 because none was available. There was no substitute given in food for required diets at breakfast			

PROVIDER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	page 1 of 7	

►Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (see reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required as a condition of continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: [redacted]

(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____

(X3) DATE SURVEY COMPLETED: Correction Order 7/29-30/87

NAME OF PROVIDER OR SUPPLIER: [redacted]

STREET ADDRESS, CITY, STATE, ZIP CODE: [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(9)	Continued .... Meals observed.			
---	KAR 28-39-89 (f)(1) Corrected			
(10)	Insulin was documented as administered by licensed nurses.			
---	KAR 28-39-97 and 101(e) not corrected			
(11)	An unidentified chemical was stored in an unlocked cabinet in hall 3 soiled workroom. Bright & Washroom cleaner and Respond Spray bags were in unlocked area of hall 3 soiled utility room.			
---	KAR 28-39-109(m) Not corrected.			
(12)	The facility did not provide a laundry service to meet the needs of the residents. On 7/30/87, laundry was observed being sorted on the floor. Two bags of dish towels from dietary were on the floor in the laundry on 7/29/87 and 2 large laundry bins of soiled linens were stored approximately 4 feet above the level of			

PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

page 6 of 7

►Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM HCFA-2567 (10-84)

If continuation sheet Page ___ of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Complaint 6-6 7/29-30/8/

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(12)	Continued Cont, uncovered, in the holding room and I bin in the washer room and there were 9 barrels of soiled linen in the holding room. There were insufficient linens (blankets, sheets, incontinent pads, wash cloths) on the halls to care for residents. Nurse aides had to leave resident care and go to the laundry to obtain clean linen in order to change beds and care for incontinent residents. One resident was crying "I'm cold". The aide said no blankets were available. There were only 2 - 50# capacity washers in use. Residents and resident families were complaining that clothing had been lost in the laundry. The water temperature was in compliance (160°) on this visit.			

PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Page 7 of 7

►Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In The Matter Of The Correction Order
Against [redacted]

Case No. 87-ACF-85

NOTICE OF ASSESSMENT

Now on this 25th day of September, 1987, Stanley C. Grant, Ph.D., Secretary, Kansas Department of Health and Environment, reviews the file on this matter and finds that a fining order should be issued pursuant to KSA 39-946.

The Secretary finds that a Citation was issued to this facility on August 26, 1987, for violation of KAR 28-39-78(a)(7), KAR 28-39-87(e), KAR 28-39-87(a), KAR 28-39-87(f)(8)(B), KAR 28-39-87(h)(3), KAR 28-39-89(a), KAR 28-39-98(a), KAR 28-39-87(i)(1)(2), KAR 28-39-89(f), KAR 28-39-92(d)(1), KAR 28-39-97, KAR 28-39-101(e), and KAR 28-39-109(m). The Secretary finds that the Citation was issued a result of a July 29 and 30, 1987 inspection.

The Secretary further finds that [redacted] received the Citation on August 28, 1987.

The Secretary further finds that a Correction Order was issued against the facility on July 15, 1987, for violation of KAR 28-39-78(a)(7), KAR 28-39-87(e), KAR 28-39-87(a), KAR 28-39-87(f)(8)(B), KAR 28-39-87(h)(3), KAR 28-39-98(a), KAR 28-39-89(a), KAR 28-39-87(i)(1), KAR 28-39-87(i)(2), KAR 28-39-87(i)(3), KAR 28-39-89(f), KAR 28-39-92(d)(1), KAR 28-39-89(f)(1), KAR 28-39-97, KAR 28-39-101(e), and KAR 28-39-109(m). The Secretary finds that the order was received on July 16, 1987.

The Secretary finds that [redacted] was visited on September 2 and 3, 1987.

The Secretary finds that as a result of the September 2 and 3, 1987 visit, that KAR 28-39-78(a)(7), KAR 28-39-87(e), KAR 28-39-87(a), KAR 28-39-87(f)(8)(B), KAR 28-39-89(a), and KAR 28-39-98(a) were not in compliance.

The Secretary finds that the facility did not release residents from restraints at least every two hours as required by KAR 28-39-78 (a)(7) and KAR 28-39-87(e).

The Secretary finds that the facility did not provide treatment for skin conditions as required by KAR 28-39-87(a) and KAR 28-87 (f)(8)(B).

The Secretary finds that medications were not being given at the proper time as required by KAR 28-39-89(a) and KAR 28-39-98(a).

The Secretary finds that a civil penalty in the amount of $100.00 per day per deficiency should be issued against [redacted] Kansas, for being out of compliance with the above-listed regulations on September 1, 2, and 3, 1987. The Secretary finds that a maximum fine of $500.00 should be assessed.

The fine is due and payable within ten days after the receipt of this Assessment. If the fine is not paid within ten days, the Secretary may file a certified copy of the Notice of Assessment with the Clerk of the District Court of [redacted]unty and the Assessment can be enforced in that court.

The Assessment may be appealed by filing a written notice of appeal with the Secretary within ten days of receipt of this Notice of Assessment, in which case, a hearing will be conducted pursuant to the Kansas Administrative Procedure Act. The penalty must be paid as set out above regardless of whether this Assessment is appealed. If the appeal is sustained, the Assessment will be refunded pursuant to Statutes KSA 39-946 and KSA 39-948.

Therefore, the Secretary orders that an Assessment be issued pursuant to KSA 39-946, against [redacted] for the maximum fine of $500.00 for the above violations.

IT IS SO ORDERED

Dated this 25th day of September, 1987.

Stanley C. Grant, Ph.D., Secretary
Kansas Department of Health and Environment

CERTIFICATE OF MAILING

I hereby certify that on the 25th day of September, 1987, a true and correct copy of the foregoing Notice of Assessment was mailed to:

[redacted] by depositing the same in a properly addressed envelope, postage prepaid, certified mail, return receipt requested in the U.S. mail.

[redacted]
Staff Member

Certified Mail # 518577028

Certified Mail # 518577027

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OMB NO. 43

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Citation 9/2-3/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
- - - (4)	KAR 28-39-87(a) Corrected Cathetar care was improved significantly as observed during this visit			
- - - (5)	KAR 28.39-87(4)(3) Corrected Acceptance of meals was now recorded and intake and output was available for residents as indicated by condition			
- - - (6)	KAR 28-39-89(a) and 98(a) Not Corrected Good handwashing was practiced. and residents were observed while taking medications but 8 Am medications were still being administered at 10 Am.			
- - - (7)	KAR 28-39-87(i)(1)(2) Considered Corrected The facility had hired a physical therapist on 8/1/87. Services were now provided to 46 residents. Heel protectors and canes were utilized for residents as needed. Bladder and bowel retraining was started in the initial phase and recommendations for better documentation was given to staff during this visit			

		REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY	☐				
DISAPPROVED BY STATE CERTIFYING AGENCY	☐				
APPROVED BY DHHS REGIONAL OFFICE	☐	REVIEWED BY (INITIALS)	DATE	TITLE	
DISAPPROVED BY DHHS REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK)	☐				

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA 2567 (11-83)

HEALTH CARE FINANC ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
[redacted]	A. BUILDING _____ B. WING _____	Citation B 9/2,3/87

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETE DATE
--- (1)	KAR 28-39-78(a)(7) and 87(2) Not corrected Two of five restrained residents observed were not released from restraints at least every 2 hours as per facility policy and as required. These residents were physically restrained for 3 hours before release and opportunity for exercise or change of position.			
--- (2)	KAR 28-39-87(a) Not corrected ~~One resident with orders for BP for~~ ~~four months~~ Six of twenty residents lacked a record of blood pressure readings as prescribed or planned.			
--- (3)	KAR 28-39-87(a), KAR 28-39-87(f)(8)(B) Not corrected Four of nine residents surveyed with physician orders for treatment to skin conditions did not have treatment provided as ordered. When a staff member was not assigned to do treatments, specifically, all treatments were not able to be completed.			

		REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY STATE CERTIFYING AGENCY	☐				
DISAPPROVED BY STATE CERTIFYING AGENCY	☐				
APPROVED BY DHHS REGIONAL OFFICE	☐	REVIEWED BY (INITIALS)	DATE	TITLE	
DISAPPROVED BY DHHS REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK)	☐				

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA 2567 (11-82)

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Position Statement on AIDS

The Kansas Medical Society recognizes the impact that virally transmitted AIDS and AIDS-related complex have on our state and country. Projected medical and economic concerns increase daily, reflecting the growing number of cases reported to the Centers for Disease Control.

Consistent with KMS policy that all patients should have competent and humane medical care, no patient should be discriminated against or denied medical care on the basis of a known or suspected diagnosis. All physicians and surgeons, nurses, other health care professionals, and hospitals should either render services to patients with AIDS or AIDS-related complex, or promptly refer to another physician who is competent to care for such patients.

In the area of professional and public education, the Kansas Medical Society will strive to keep its members informed by disseminating information on AIDS in a timely manner, to reprint information about AIDS in KANSAS MEDICINE, and to promote continuing education on AIDS to KMS members.

Additionally, KMS will help establish a speakers bureau for health care professionals that can help educate both professionals and lay people concerning AIDS. The Kansas Medical Society also supports appropriate educational efforts which will enable all citizens of Kansas to become informed about AIDS.

In the area of HIV testing, the KMS suggests that testing be: 1) voluntary and with informed consent; 2) that a positive ELISA test be confirmed with a Western Blot test; and 3) that testing be administered only if trained personnel are available for pre- and post-test counselling.

The KMS also adopts by reference the guidelines and recommendations contained in the following Center for Disease Control publications:

1. CDC Recommendations for Control of AIDS and for the Protection of Health Care Workers and Their Patients.

2. CDC Perspectives in Disease Prevention and Health Promotion.

3. CDC Guidelines for the Control of Perinatal Tranmission of HIV.

4. CDC Revision of CDC Surveillance Case Definition for AIDS of August, 1987.

Finally, KMS endorses the recommendations, findings and guidelines for physicians contained in the following AMA reports: 1) AMA Board of Trustees Report YY (A-87); and 2) Council on Ethical and Judicial Affairs Report A (I-87).

Attm. #8
3-24-8
Attn.

REPORT OF THE BOARD OF TRUSTEES

Report: YY
(A-87)

Subject: Prevention and Control of AIDS - An Interim Report

Presented by: Alan R. Nelson, M.D., Chairman

Referred to: Reference Committee E (Alfred J. Clementi, M.D., Chairman)

Introduction

Responding sensitively, intelligently, and effectively to the growing AIDS crisis is one of the crucial public health problems facing the nation. Prevention and control of the disease must be an essential part of that response because there is, at present, no known cure for AIDS patients.

Recommendations in this report have as their foundation an overriding concern for a judicious balance between the well-being of HIV positive patients and the protection of the public health. These recommendations are based upon the best information and data available at present. The AMA will continuously monitor and analyze developments in AIDS and update AMA policy and recommendations as dictated by advances in knowledge.

Education continues to be the major weapon against spread of HIV infection. Physicians should assume the leadership role in educating themselves, their patients and the public. Individuals in society also must assume responsibility for being well-informed and for actions that affect their own health and the health of others. In developing this report, the Board emphasizes the need for concerted and cooperative efforts by all members of society in the fight against AIDS. The recommendations outlined below are designed to help in successfully confronting this challenge to society's well-being.

I. Background

A. The Current Climate

It is estimated that five to ten million people are infected with HIV virus worldwide. AIDS has been reported in more than one hundred countries. In the United States HIV-infected individuals may number one and one-half (1.5) million, approximately 35,000 of whom have been reported to suffer from AIDS and more than 20,000 of whom are dead.

The U.S. Public Health Service has projected that by 1991 there may be 323,000 reported patients with AIDS and as many as 200,000 of them may be dead by that time. In addition, conversion rates of seropositive people to AIDS status now appear to be higher than early preliminary estimates. Originally under 20% were thought to convert. It now appears that, without treatment advances, a much higher percentage will develop the disease.

Seventeen percent of the AIDS cases have been intravenous drug abusers; 66% have been homosexual/bisexual men; 8% have been homosexual male IV drug users; female, heterosexual male, and pediatric victims infected by the transfusion of blood or blood products, sexual contact, or prenatally in the case of infants, account for the bulk of the balance.

Polls indicate that AIDS has become the highest priority health concern of the American public, ahead of heart disease and cancer. It has already caused changes in a variety of public attitudes. Sexual abstinence, monogamous relationships, and the use of condoms are being widely promoted in the media by public officials and many private organizations. IV drug abusers are being counseled to use clean needles and to avoid sharing needles. Education on the sexual transmission of the AIDS virus is being extended to school children. The nation is more sensitive to the rights of those afflicted with the disease to be free from discrimination, regardless of the manner by which they became infected.

B. Historical Control Measures for Infectious Diseases

A primary mode of transmission of AIDS is through sexual contact, and the control efforts for sexually transmitted diseases (STD) that have been instituted in the past are sources of analogies for prevention and control of AIDS. National programs to control STDs were established during the beginning of World War I. For the following 50 years the focus was almost exclusively on the control of syphilis and its complications. During World War II rapid treatment centers for syphilis and gonorrhea were established. Public health officials instituted limited contact-tracing, had the authority to close sex bars and clubs, to order tests for prostitutes, and, most importantly, had effective therapy to offer. Widespread availability of penicillin led to the dissolution of the rapid treatment centers and of the clinical speciality, syphilology. Every state in the Union at one time required all persons seeking marriage licenses to be tested for syphilis. During the 1950s and 1960s federal assistance programs continued to support contact-tracing, serological screening, and patient education.

In the late 1960s public health officials were concerned about the rapidly escalating cases of gonorrhea, and projects were instituted to increase case-finding and contact-tracing. In 1972

financial assistance for STD control by the federal government was dramatically increased and by 1982 gonorrhea accounted for nearly three-fourths of the federal STD dollar. During the 1970s gonorrhea control efforts evolved through overlapping phases that included objectives to lower disease incidence and the occurrence of drug-resistant bacteria, focused screening on high-risk patients, intensified follow-up of treatment failures, and used patient counseling as a means of increasing compliance with therapy and improving contact-tracing. The latter was deemed especially important since the large numbers of gonorrhea cases precluded the intensive follow-up of each infected case that had been characteristic of the syphilis era.

In 1982 the World Health Organization/Pan American Health Organization (WHO/PAHO)identified the following key objectives for intervention to reduce STDs:

1. To minimize disease exposure by reducing sexual intercourse with persons who have a high probability of infection.

2. To prevent infection by increasing the use of condoms or other prophylactic barriers.

3. To detect and cure disease by implementing screening programs, providing effective diagnostic and treatment facilities, and promoting health-seeking behaviors.

4. To limit complications of infections by providing early treatment to symptomatic and asymptomatic infected individuals.

5. To limit disease transmission within the community through the above efforts.

These objectives were used as a framework for the current United States program regarding STDs, which consists of the following components:

1. Health education and promotion.

2. Disease detection through testing and other means.

3. Appropriate treatment.

4. Contact tracing and patient counseling.

5. Clinical services.

6. Training.

7. Research.

C. The Challenge of AIDS Control

It might seem reasonable to extend the experience in preventing the spread of other STD infections to AIDS. The objectives established by WHO/PAHO and the components of the current national STD program are certainly applicable to AIDS. However, AIDS presents a much different social problem than other STD infections. Since there is no cure for AIDS and no protection beyond avoiding or making safer intimate contact with infected individuals, those infected with the virus must be sexually isolated from uninfected persons. A condom barrier offers some but not complete protection. Avoidance of sexual contact and use of shared needles are the only sure protections.

Further, the stigma that accompanies a diagnosis of AIDS, based on fear and society's attitude toward IV drug abusers and homosexuals, presents a factor beyond the control of the infected individual or medicine. An HIV-seropositive individual who might live five years or much longer with no overt health problems, once identified in a community, may be subject to many and varied discriminations--by family and loved ones, by neighbors and friends, by employers and fellow employees, and by other providers of services.

As with prevention and control of all contagious diseases, prevention and control of AIDS involves two, sometimes competing, concerns. First, the person who is afflicted with the disease needs compassionate treatment, and both those who have the disease and those who have been infected with the virus should not be subjected to irrational discrimination based on fear, prejudice or stereotype. Second, and of critical importance, the uninfected must be protected; those individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them.

II. The Need for a National Policy on Aids

Given the growing dimensions of the crisis and given limited national resources, it is imperative that a national policy be developed jointly by the public and private sectors. Such a policy must seek, in a cost-effective way, to achieve fundamental national goals: prevention, treatment, and cure — and adequate research in all three areas. A coherent national approach to this modern killer is needed: a comprehensive blue print for a national response, not piecemeal solutions. Knowledge of the disease is now more than six years old and the growing magnitude of the problem has been apparent for nearly that long.

Such a national policy must have certain characteristics:

- The policy must be comprehensive, proceeding simultaneously on the fronts of prevention, treatment, and research.

- The policy must be coordinated between public and private sectors and between the different levels of government. A national policy does not necessarily mean a federal policy: there are important roles at all levels of the health care systems and at all levels of government. Nor does it necessarily mean uniformity: on certain issues different approaches should be tried to determine efficacy.

- The policy must be carefully balanced. For example, concern for the person with the disease must be balanced with concern for those who do not have the disease but who may become infected. Similarly, careful consideration must be given to directing scarce resources to increased prevention, even as increasingly large resources are necessarily devoted to research and treatment.

- The policy must be based on scientific information and medical judgments. Although policy choices must inevitably be made, they should be formed on the best available information and on the extensive public health experience in dealing both with AIDS and with other contagious diseases.

- The policy should be nonpartisan. Although it may be tempting to play on fears and prejudices, public figures and officials both inside and outside the health community should avoid exploiting the crisis for partisan political advantage.

- The policy should be capable of continuous review and modification as more and better information becomes available.

RECOMMENDATION 1:

A Commission, modeled after the commission which made recommendations on the problems of Social Security financing in the early 1980s, should be constituted with representatives from the Executive branch of the federal government, the Congress, state and local government, and the private sector and directed to develop a consensus position for consideration by the Congress, the Executive, state and local governments and private associations and institutions. The presidential commission announced, but not yet

appointed, by the Administration could be broadened to implement this recommendation. A high-level body with representatives from the different branches and levels of government, but operating to the side of the more formal political processes, may have the best chance of forging the necessary national consensus which can then become the basis for concerted and coordinated action by both the public and private sectors.

III. The Special Role of Physicians and Other Health Care Counselors

Because there is no cure for AIDS, effective preventive techniques are vital. This involves both those who are infected and those who are not. Those who are infected must be identified so that they will not unknowingly transmit the disease to others. Many who are not infected will need to change their behavior substantially to minimize their risk of infection by the AIDS virus.

The key to changed behavior is public education coupled with counseling which must be given by physicians and other health care counselors.

A. Public Awareness

The public is well aware of AIDS in a general sense. The attention of the media has been intensively focused on the disease. Translating general awareness into modifications of behavior is the challenge.

The groups that are most at risk for AIDS, e.g., IV drug abusers, homosexuals, bisexuals, and prostitutes, have reason to know they are at risk. Their contacts, however, may not know they are at risk and hence spouses, unborn babies, and premarital and extramarital sexual partners may become infected. Education and counseling aimed at the high-risk groups must be the first priority. The education should urge immediate counseling with a physician or other health care counselor about the risk of AIDS, the uses of antibody testing and preventive measures.

Also, it must be recognized that persons in these groups may not respond to education and counseling and, when they do not, more aggressive programs—such as expanded methadone maintenance programs or penalties for knowingly exposing others--must be considered.

Education aimed at the more general population is difficult for at least two reasons. First, reaching all Americans with an effective message can be expensive and not all people respond in the same way or to the same method of learning. Messages must therefore be tailored to the target audience in question. Second, preventive messages must necessarily deal with controversial subject matter. Widespread use of the electronic media — especially television --

appears to be the most effective way to reach the general public. Accordingly, public service advertising on the electronic media must be greatly increased and these announcements must be shown at times and in places where they will be viewed by those who need the message most.

The AMA will continue its efforts to place its own public service ads on national television. AMA's Tony Danza public service advertisement (PSA) directed at teenagers about abstinence and condoms, and other PSAs which the networks have agreed to use, are significant first steps. But, more must be done and it must be nationally coordinated.

RECOMMENDATION 2:

The communications industry must develop voluntary guidelines for public service advertising regarding AIDS in consultation with the health care community and government officials. The AMA intends to be a catalyst in this effort to immediately bring the communications and health care communities together.

B. Counseling--And Educating Counselors

Perhaps the greatest need at the present time is effective counseling of both low-risk and high-risk populations by physicians or other health care counselors. A massive education effort for physicians and other counselors is necessary as a first step. Complete and accurate information on the disease, the modes of transmission, the appropriate application of antibody testing, and effective ways to change behavior must be understood by counselors if it is to be properly communicated to patients. In conjunction with face-to-face counseling, printed materials--like the Surgeon General's recent 36-page report on AIDS--should be widely disseminated.

Even more challenging than preparing physicians and others for generic counseling on AIDS is preparing these counselors to assist those who test positive and are infected with the virus. It is at that time that a change of behavior on the part of the person infected is most critical, and it is then that the most sophisticated counseling is required due to the emotional impact of the test results. There is no higher prevention priority than ensuring that the community of individuals who provide health care counseling be given adequate tools to be effective. And the AMA, as the largest organization of physicians in the world, must take a leading role in this undertaking.

RECOMMENDATION 3:

A conference should be immediately held between the AMA, other

physician organizations and public health officials at all levels of government to determine:

1. The types of education and training that are necessary for effective counseling.

2. The people in the health care community who should receive this education and training.

3. The current resources available for such education and training.

4. Recommendations for providing additional resources, including consideration of the respective roles of medical associations and government at all levels.

5. Recommendations on how to update information continually as new scientific data are developed.

6. Recommendations as to alternative measures to prevent the spread of AIDS where education and counseling are not likely to be effective, particularly among IV drug users, through such programs as expanded methadone maintenance.

The AMA will promptly and widely report on the conference findings and assist in the implementation of the conference recommendations.

C. Voluntary and Mandatory Testing

Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling (and when offered in the context of appropriate anti-discrimination and confidentiality protections discussed below), serves the important public health purpose of providing impetus for behavior changes that minimize the risk of transmitting the AIDS virus.

Clearly, the need for HIV-antibody testing has expanded beyond its original purpose, the screening of blood donors. Guidelines for the appropriate use of HIV-antibody testing must center on the following justifications:

1. To identify infected persons and to offer treatment where possible and to protect uninfected third parties.

2. To offer education and counseling that would modify high risk behavior.

3. To solicit patient cooperation for locating and referring sex partners.

4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

In addition, in considering the merits of voluntary versus mandatory testing, these facts about AIDS must be kept in mind:

1. AIDS is caused by an infectious agent, and therefore is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.

2. The extent to which the AIDS virus already has spread into the general population is not completely understood. Current projections are based on a number of unverified assumptions.

3. The transmission of the AIDS virus does not occur through casual contacts. Sexual contact, septic intravenous equipment, and the administration of infected blood and blood products are the main modes of transmission.

4. Heterosexual transmission of the AIDS virus, especially from males to females, does occur.

5. Seropositive pregnant females will transmit the virus to their babies in a high percentage of cases.

6. Health care workers, especially those who perform invasive surgical procedures, and emergency room and laboratory personnel, are at some risk when caring for AIDS patients.

7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.

8. The disease, not its victims, is the threat from which society must be protected.

9. The confidentiality of the doctor-patient relationship is vitally important but not absolute.

10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

All of these considerations guided the Board of Trustees as it considered the issues that have been raised by the wide variety of proposals for HIV-antibody testing that are being discussed in society.

General Conclusions

Except for individuals in the limited categories listed in Recommendation 5 below (blood, organ and semen donors, immigrants, military personnel, prison inmates) with regard to whom testing serves well-established and well-accepted protection goals, mandatory national testing should not, at present, be broadly extended.

Military personnel have traditionally been subject to mandatory immunizations and our defense forces, of course, must be as strong as possible. Prison inmates, because they are confined and have a higher incidence of high-risk individuals than the general population, require special protection. Immigrants should be tested so that we can focus on the AIDS problem already here, and the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs and semen has never been questioned.

Public health authorities have advanced a plausible premise for their opposition to mandatory testing of homosexuals and drug abusers: such testing will only drive people underground and away from the health care system. Public health authorities also have advanced a premise for not requiring mandatory testing of large segments of the general population, such as all those seeking marriage licenses or all those admitted to hospitals: such testing in low prevalence populations would result in a high proportion of false positives, and would not be cost-effective, given the demand for voluntary testing and the shortage of testing and counseling resources for those who want them voluntarily or who will want them following effective public awareness campaigns.

Until those premises are shown by superior studies to be incorrect, a policy regarding mandatory testing which has been rejected by the vast majority of public health officials, including the Centers for Disease Control and the Surgeon General, cannot be recommended.

But certain high risk groups should be regularly tested, with a right to informed consent and to refuse the test. Those groups are defined in Recommendation 6.

In addition, physicians and other hospital personnel involved in invasive surgical procedures who necessarily and unavoidably come in contact with the blood of patients, need to be aware of their risks. Limited regular testing of patients will assure that the CDC

guidelines for the protection of hospital personnel are followed rigorously and will further assure that all patients receive prompt and full treatment. The Board emphasizes here that physicians have a long and honored tradition of tending to patients afflicted with infectious diseases with compassion and courage. That tradition must and will be continued throughout the AIDS epidemic.

Because the risk to health care personnel will be slight in most areas, any effort at mandatory testing of certain kinds of patients should be instituted after voluntary testing has failed and where a variety of factors, e.g. the costs and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high risk patient population, weigh in favor of mandatory testing.

The AMA does not believe it appropriate at this time to extend regularly offered testing to persons other than those listed, e.g., recommended testing should not be extended to all individuals anywhere who are considering marriage or to all persons in hospitals. Decisions about whether there should be generally recommended testing to other types of individuals should, at this time, be left to the decision of the local community depending on its own circumstances and the judgments of its own public health officials.

At present, each case of AIDS must be reported by the individual physician to state public health authorities either by name or identifier. Anonymous, or if carefully implemented, confidential reporting should also be extended to all confirmed instances of persons infected with AIDS virus but not afflicted with ARC or AIDS. Individuals who are seropositive for the HIV antibody are infected with the virus and can spread the disease as certainly as those with symptoms of AIDS. A sound epidemiologic understanding of the potential impact of AIDS on society requires the reporting of those who are confirmed as testing positive for the antibody to the AIDS virus.

Testing Recommendations

RECOMMENDATION 4:

Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

RECOMMENDATION 5:

Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or invitro fertilization, for

immigrants to the United States, for inmates in federal and state prisons and for military personnel.

RECOMMENDATION 6:

Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

1. Patients at sexually transmitted disease clinics.

2. Patients at drug abuse clinics.

3. Pregnant women in high risk areas in the first trimester of pregnancy.

4. Individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior seeking family planning services.

5. Patients who are from areas with a high incidence of AIDS or who engage in high risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

RECOMMENDATION 7:

As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

RECOMMENDATION 8:

Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

RECOMMENDATION 9:

Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

RECOMMENDATION 10:

Physicians should counsel their patients who are found to be seropositive regarding (a) responsible behavior to prevent the spread of the disease, (b) strategies for health protection with a

compromised immune system, and (c) the necessity of alerting sexual contacts, past (5-10 years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

RECOMMENDATION 11:

Patients should knowingly and willingly give consent before a voluntary test is conducted.

IV. Resources

Only recently has Congress and the Administration begun to seriously consider the vast resources needed to deal effectively with AIDS. Federal funding for 1988 is expected to reach $1 billion. But that amount will not be enough. The AMA endorses the bill introduced by Congressman Waxman to increase resources for testing and counseling.

Testing for the HIV virus in America will require substantially more resources than are currently being made available. Trained counselors, materials for counseling, and research on effective counseling approaches, for the variety of population groups that need these services, are urgently required. Also, dependable testing facilities with sufficient capacity to respond to the epidemic are needed now. In addition, funds for research and care must be increased to fully exploit the nation's capacity to respond effectively to this crisis.

The key premise of a prevention strategy, when there is no vaccine, is behavioral change on the part of those infected and those at risk of infection by AIDS virus. It is therefore crucial that there be immediate and systematic studies conducted of how behavior of affected groups may have changed in recent years, and if possible, what factors caused the changes. Most particularly, it is necessary to study and evaluate the types of counseling that have been effective so that the techniques may be replicated widely. There can be little question that in a free society suasion and voluntary change, if effective, are far preferable to compulsion.

RECOMMENDATION 12:

Public funding must be provided in an amount sufficient (1) to promptly and efficiently counsel and test for AIDS (2) to conduct the research necessary to find a cure and develop an effective vaccine, (3) to perform studies to evaluate the efficiency of counseling and education programs on changing behavior and (4) to assist in the care of AIDS patients who cannot afford proper care or who cannot find appropriate facilities for treatment and care.

V. Protection Against Discrimination

A. Anti-Discrimination

The AMA believes strongly that AIDS victims and those who test positively for the antibody to the AIDS virus should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives. Last year, the AMA filed a friend of the court brief in School Board of Nassau County v. Arline, a case before the Supreme Court which addressed the question of how the federal handicapped anti-discrimination laws should apply to persons afflicted with contagious diseases. The AMA set forth a framework for the application of the law which the Supreme Court adopted, quoting verbatim from the AMA brief in its key holding.

A sound anti-discrimination approach does not allow reflexive discrimination against AIDS victims based on fear or stereotype or prejudice. Nor does it require that all employers or other federal fund recipients automatically accommodate a person afflicted with a communicable disease. Instead, based on an individualized analysis of the nature and duration of the handicap and the nature and duration of the communicability, a federal fund recipient must make a reasonable accommodation based on reasonable medical judgments, given the state of medical knowledge at the time. This sound framework for carefully balancing the two competing concerns -- the right of the victim to be free from irrational acts of prejudice and the right of others to be protected against an unreasonable risk from disease -- should also guide state anti-discrimination efforts.

A key question left open by the Supreme Court is whether a person who is not afflicted with AIDS or AIDS Related Complex, but who nonetheless tests positive for the antibody, is protected by the federal anti-discrimination law.

In order to encourage people to seek counseling, and testing if necessary, the AMA strongly urges that anti-discrimination laws at both the federal and state levels be clarified either by regulatory interpretation or statutory amendment to cover those who test HIV antibody positive. Allowing irrational discrimination against those who test positive serves no useful purpose: it only has the destructive effect of removing those who are otherwise productive members of society from the work force or otherwise denying them access to an important aspect of normal life. While the federal law should continue to apply only to federal fund recipients, state laws should be sought to prevent irrational discrimination by entities or individuals within those jurisdictions.

RECOMMENDATION 13:

Anti-discrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus.

B. Confidentiality

The ability of the health care community to maintain the confidentiality of patient information and restrict its use to only those purposes essential for maintenance of health is, like clarification of anti-discrimination laws, vital to an effective program of preventing and controlling AIDS. Even if anti-discrimination laws were completely effective, which unfortunately is not likely, persons who test positive (such as those with ARC or AIDS), will suffer stigma. Thus, confidentiality is crucial.

The basic principle should be that access to patient information should be limited only to health care personnel who have a legitimate need to have access to the information in order to assist the patient or to protect the health of others closely associated with the patient.

As with anti-discrimination laws, laws protecting the confidentiality of patient information should be on both federal and state agendas.

RECOMMENDATION 14:

Model confidentiality laws must be drafted which can be adopted at all levels of government to encourage as much uniformity as possible in protecting the identity of AIDS patients and carriers, except where the public health requires otherwise.

V. Questions for the Future

As the national debate on prevention and control of AIDS continues, other important issues will need to be addressed.

A. Research and Data

There is an urgent and critical need for more scientifically sound data on the prevalence and spread of virus in the general population. At the present time only those cases that meet the current CDC surveillance definition of AIDS are reported to that institution. Since AIDS is the terminal and fatal stage of HIV-infection, it represents only the tip of the huge HIV-infection iceberg. There are protean manifestations of HIV-infection ranging from infected asymptomatic to full-blown AIDS. How large the base of that iceberg really is—that is, how many people are actually infected--can only be estimated from the number of reported AIDS cases. That has been done by using a multiple (50 to 100 times the number of AIDS cases) that has been extracted largely from surveys done in high-prevalence areas. Yet this same multiple has been used to estimate the number of current and potential HIV-infected persons in low-prevalence areas and for that matter the entire country and even the world. The CDC itself is unsure about the accuracy of its

estimates. Yet if economic and medical plans are to be made for the future, reliable projections must be available. How sufficient or exaggerated these plans may be depends upon the accuracy of current and future estimates of HIV-infected persons, particularly as to the extent of its spread into the low-risk heterosexual population.

Not only are accurate estimates of HIV-infected persons needed, but so too are reliable data on the rate conversion of asymptomatic seropositive persons to clinical illness, including AIDS, that requires increased medical care. This information is important for the formulation of plans for the future cases of potentially hospitalizable patients and the economic consideration thereof. HIV-infection has protean manifestations and death can result not only from AIDS itself, but from severe ARC or progressive CNS disease as well. In order to obtain accurate information in HIV infected persons on the rate of conversion from asymptomatic to clinically severe illness, baseline data on their serologic status must be obtained as early as possible--not after clinically manifest disease is present. The presence of HIV antibodies indicates not only current infection with the virus, but also that the patient is potentially capable of transmitting the disease. This follows from the fact that HIV integrates its genome into the host cell genome with the result that once infected, the patient remains infected for life and is, therefore, capable of life-long transmission of the agent. The earlier the infected person is detected, the earlier he or she may be advised of this contagious state and counseled on how to avoid further transmission of this lethal virus.

RECOMMENDATION 15:

Consistent with the proposal by the Secretary of Health and Human Services, a national study in various areas of the country must be immediately undertaken to determine the prevalence and conversion rate of the virus in the United States population, and the study must be repeated at appropriate intervals to gauge the spread of the disease.

B. Warning to Third Parties

One of the more difficult issues for society is how to warn unsuspecting spouses or sexual partners of persons who test HIV positive. Such a warning would allow the third party to practice "safer" sex or to abstain from sexual relations with the infected person altogether. Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning.

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn

the unsuspecting sexual partner should then reside in the public health authorities as well as the infected person and not in the physician to the infected person.

The AMA believes that mechanisms, analogous to those used by public health authorities to warn sexual partners about other sexually transmitted diseases, should be put in place to warn unsuspecting third parties about an infected sexual partner. Such warning may be appropriate whether the infected person is bisexual, heterosexual or homosexual.

This problem raises the general question of whether anonymous reporting should continue to be the standard for persons who test seropositive. Our recommendation at this time is limited to situations where physicians or health officials already know the identity of the AIDS carrier and have reason to believe a risk to third parties exists.

RECOMMENDATION 16:

Specific statutes must be drafted which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method for warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but (c) establish clear standards for when a physician should inform the public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.

C. Sanctions for Reckless Disregard for the Safety of Others

A related question which must be explored is whether an infected person, who knows he or she is infected and who knowingly fails to warn a sexual partner of the infection, should be subject not just to tort suits, but to a proceeding brought by state authorities to sanction the individual.

RECOMMENDATION 17:

Given the risk of infection being transmitted sexually, and given the dire potential consequences of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently finds out about a partner's infection and brings a complaint to the attention of authorities. Pre-emptive sanctions are not being endorsed by this recommendation.

CONCLUSION

The Board intends to review its evaluation of the developing AIDS epidemic on a constant basis. Modifications of the AMA's positions will be made as the situation warrants.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report: A
(I-87)

Subject: Ethical Issues Involved in the Growing AIDS Crisis

Presented by: John H. Burkhart, M.D., Chairman

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Julius Michaelson, M.D., Chairman)

The Council on Ethical and Judicial Affairs of the American Medical Association recognizes the growing AIDS crisis as a crucial health problem involving the physician's ethical responsibility to his patients and to society. The House of Delegates adopted Report YY (A-87) of the Board of Trustees which provides excellent guidance for a responsible public policy. As stated therein, AIDS patients are entitled to competent medical service with compassion and respect for human dignity and to the safeguard of their confidences within the constraints of the law. Those persons who are afflicted with the disease or who are seropositive have the right to be free from discrimination.

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. The tradition of the American Medical Association, since its organization in 1847, is that: "when an epidemic prevails, a physician must continue his labors without regard to the risk to his own health." (See Principles of Medical Ethics, 1847, 1903, 1912, 1947, 1955). That tradition must be maintained. A person who is afflicted with AIDS needs competent, compassionate treatment. Neither those who have the disease nor those who have been infected with the virus should be subjected to discrimination based on fear or prejudice, least of all by members of the health care community. Physicians should respond to the best of their abilities in cases of emergency where first aid treatment is essential, and physicians should not abandon patients whose care they have undertaken. (See Section 8.10 of Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, 1986).

Principle VI of the 1980 Principles of Medical Ethics states that "A physician shall in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services." The Council has always interpreted this Principle as not

supporting illegal or invidious discrimination. (See Section 9.11 of Current Opinions, 1986). Thus, it is the view of the Council that Principle VI does not permit categorical discrimination against a patient based solely on his or her seropositivity. A physician who is not able to provide the services required by persons with AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services.

At its 1987 Annual Meeting, the House of Delegates adopted Substitute Resolution 18 which asked the Council on Ethical and Judicial Affairs to address "the patient confidentiality and ethical issues raised by known HIV antibody positive patients who refuse to inform their sexual partners or modify their behavior." Physicians have a responsibility to prevent the spread of contagious diseases, as well as an ethical obligation to recognize the rights to privacy and to confidentiality of the AIDS victim. These rights are absolute until they infringe in a material way on the safety of another person or persons. Those who are not infected with the virus are entitled to protection from transmission of the disease. Thus, the societal need for accurate information and public health surveillance must also be respected. As the Board of Trustees stated in Report YY (A-87), "A sound epidemiologic understanding of the potential impact of AIDS on society requires the reporting [on an anonymous or confidential basis to public health authorities] of those who are confirmed as testing positive for the antibody to the AIDS virus."

In those jurisdictions in which the reporting of individuals infected with the AIDS virus to public health authorities is not mandated, a physician who knows that a seropositive patient is endangering a third party faces a dilemma. The physician should attempt to persuade the infected individual to refrain from activities that might result in further transmission of the disease. When rational persuasion fails, authorities should be notified so that they can take appropriate measures to protect third parties. Ordinarily, this action will fulfill the physician's duty to warn third parties; in unusual circumstances when all else fails, a physician may have a common law duty to warn endangered third parties. However, notification of any third party, including public health authorities without the consent of the patient may be precluded by statutes in certain states. Therefore, the Council reiterates and strongly endorses Recommendations 16 and 17 of Board Report YY (A-87). They are:

RECOMMENDATION 16:

Specific statutes must be drafted which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method for warning unsuspecting sexual

> partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but, (c) establish clear standards for when a physician should inform the public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.
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> RECOMMENDATION 17:
>
> Given the risk of infection being transmitted sexually, and given the dire potential consequences of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently finds out about a partner's infection and brings a complaint to the attention of authorities. Pre-emptive sanctions are not being endorsed by this recommendation.

The civil rights and liberties of those who are infected with the AIDS virus, as well as those who are not, are entitled to protection. The ethical challenge to the medical profession is to maintain a judicious balance in this regard, including the issue of whether physicians who are HIV-infected must inform their patients or whether they may continue in patient care at all. The Council's new opinion on PHYSICIANS AND INFECTIOUS DISEASES is:

> A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others.

In the context of the AIDS crisis, the application of the Council's opinion depends on the activity in which the physician wishes to engage.

The Council on Ethical and Judicial Affairs reiterates and reaffirms the AMA's strong belief that AIDS victims and those who are seropositive should not be treated unfairly or suffer from discrimination. However, in the special context of the provision of medical care, the Council believes that if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.

The Council recommends that the afflicted physician disclose his or her condition to colleagues who can assist in the individual assessment of whether the physician's medical condition or the proposed activity poses any risk to patients. There may be an occasion when a patient who is fully informed of the physician's condition and the risks that condition presents may choose to continue his or her care with the seropositive physician. Great care must be exercised to assure that true informed consent is obtained.

In summary, the Council on Ethical and Judicial Affairs believes that:

- A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

- Physicians are dedicated to providing competent medical service with compassion and respect for human dignity.

- Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services.

- Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and seropositive individuals.

- Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should: (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.

- A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others.

- A physician who has AIDS or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

The Council on Ethical and Judicial Affairs requests that this report be filed.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Recommendations for Prevention of HIV Transmission in Health-Care Settings

U. S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

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Recommendations for Prevention of HIV Transmission in Health-Care Settings

Introduction

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (*1*) and precautions for health-care workers and allied professionals (*2*); recommendations for preventing HIV transmission in the workplace (*3*) and during invasive procedures (*4*); recommendations for preventing possible transmission of HIV from tears (*5*); and recommendations for providing dialysis treatment for HIV-infected patients (*6*). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (*7*) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (*8*). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons—representing 5.6% of the U.S. labor force—were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (*9*). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had only a convalescent-phase serum sample obtained and tested ≥90 days post-exposure, one—for whom heterosexual transmission could not be ruled out—was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351

with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (*10*). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (*11*). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (*12*).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (*13-15*). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (*16,17*). The other three were health-care workers with non-needlestick exposures to blood from infected patients (*18*). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (*19*).

Precautions To Prevent Transmission of HIV

Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients. This approach, previously recommended by CDC (*3,4*), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of all patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (*20*).

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC (7) for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [7]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

Precautions for Invasive Procedures

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery

room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.
2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Precautions for Dentistry*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (*8*).

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

Precautions for Dialysis

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions (*21*). Universal blood and body-fluid precautions should be used when dialyzing all patients.

Strategies for disinfecting the dialysis fluid pathways of the hemodialysis machine are targeted to control bacterial contamination and generally consist of using 500-750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30-40 minutes or 1.5%-2.0% formaldehyde overnight. In addition, several chemical germicides formulated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients. The type of dialysis treatment (i.e., hemodialysis or peritoneal dialysis) should be based on the needs of the patient. The dialyzer may be discarded after each use. Alternatively, centers that reuse dialyzers—i.e., a specific single-use dialyzer is issued to a specific patient, removed, cleaned, disinfected, and reused several times on the same patient only—may include HIV-infected patients in the dialyzer-reuse program. An individual dialyzer must never be used on more than one patient.

Precautions for Laboratories[†]

Blood and other body fluids from all patients should be considered infective. To supplement the universal blood and body-fluid precautions listed above, the following precautions are recommended for health-care workers in clinical laboratories.

[†]Additional precautions for research and industrial laboratories are addressed elsewhere (*22,23*).

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.
2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.
5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.
6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste (*24*).
8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infective.

Environmental Considerations for HIV Transmission

No environmentally mediated mode of HIV transmission has been documented. Nevertheless, the precautions described below should be taken routinely in the care of all patients.

Sterilization and Disinfection

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use (*25,26*) in a variety of health-care settings—including hospitals, medical and dental clinics and offices, hemodialysis centers, emergency-care facilities, and long-term nursing-care facilities—are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV (*21,23*).

Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection, a procedure that kills vegetative organisms and viruses but not necessarily large numbers of bacterial spores. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as "sterilants" may be used either for sterilization or for high-level disinfection depending on contact time.

Contact lenses used in trial fittings should be disinfected after each fitting by using a hydrogen peroxide contact lens disinfecting system or, if compatible, with heat (78 C-80 C [172.4 F-176.0 F]) for 10 minutes.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specifications for compatibility of the medical device with chemical germicides be closely followed. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, SW, Washington, D.C. 20460.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice (*27-30*). Embalming fluids are similar to the types of chemical germicides that have been tested and found to completely inactivate HIV. In addition to commercially available chemical germicides, a solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective germicide. Concentrations ranging from approximately 500 ppm (1:100 dilution of household bleach) sodium hypochlorite to 5,000 ppm (1:10 dilution of household bleach) are effective depending on the amount of organic material (e.g., blood, mucus) present on the surface to be cleaned and disinfected. Commercially available chemical germicides may be more compatible with certain medical devices that might be corroded by repeated exposure to sodium hypochlorite, especially to the 1:10 dilution.

Survival of HIV in the Environment

The most extensive study on the survival of HIV after drying involved greatly concentrated HIV samples, i.e., 10 million tissue-culture infectious doses per milliliter (*31*). This concentration is at least 100,000 times greater than that typically found in the blood or serum of patients with HIV infection. HIV was detectable by tissue-culture techniques 1-3 days after drying, but the rate of inactivation was rapid. Studies performed at CDC have also shown that drying HIV causes a rapid (within several hours) 1-2 log (90%-99%) reduction in HIV concentration. In tissue-culture fluid, cell-free HIV could be detected up to 15 days at room temperature, up to 11 days at 37 C (98.6 F), and up to 1 day if the HIV was cell-associated.

When considered in the context of environmental conditions in health-care facilities, these results do not require any changes in currently recommended sterilization, disinfection, or housekeeping strategies. When medical devices are contaminated with blood or other body fluids, existing recommendations include the cleaning of these instruments, followed by disinfection or sterilization, depending on the type of medical device. These protocols assume "worst-case" conditions of

extreme virologic and microbiologic contamination, and whether viruses have been inactivated after drying plays no role in formulating these strategies. Consequently, no changes in published procedures for cleaning, disinfecting, or sterilizing need to be made.

Housekeeping

Environmental surfaces such as walls, floors, and other surfaces are not associated with transmission of infections to patients or health-care workers. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary. However, cleaning and removal of soil should be done routinely.

Cleaning schedules and methods vary according to the area of the hospital or institution, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (e.g., bedside tables and hard-surfaced flooring) in patient-care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged. Cleaning of walls, blinds, and curtains is recommended only if they are visibly soiled. Disinfectant fogging is an unsatisfactory method of decontaminating air and surfaces and is not recommended.

Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used. Therefore, cost, safety, and acceptability by housekeepers can be the main criteria for selecting any such registered agent. The manufacturers' instructions for appropriate use should be followed.

Cleaning and Decontaminating Spills of Blood or Other Body Fluids

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body fluids. Strategies for decontaminating spills of blood and other body fluids in a patient-care setting are different than for spills of cultures or other materials in clinical, public health, or research laboratories. In patient-care areas, visible material should first be removed and then the area should be decontaminated. With large spills of cultured or concentrated infectious agents in the laboratory, the contaminated area should be flooded with a liquid germicide before cleaning, then decontaminated with fresh germicidal chemical. In both settings, gloves should be worn during the cleaning and decontaminating procedures.

Laundry

Although soiled linen has been identified as a source of large numbers of certain pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended (*26*). Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in patient-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed

with detergent in water at least 71 C (160 F) for 25 minutes. If low-temperature(≤70 C [158 F]) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.

Infective Waste

There is no epidemiologic evidence to suggest that most hospital waste is any more infective than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission. The most practical approach to the management of infective waste is to identify those wastes with the potential for causing infection during handling and disposal and for which some special precautions appear prudent. Hospital wastes for which special precautions appear prudent include microbiology laboratory waste, pathology waste, and blood specimens or blood products. While any item that has had contact with blood, exudates, or secretions may be potentially infective, it is not usually considered practical or necessary to treat all such waste as infective (*23,26*). Infective waste, in general, should either be incinerated or should be autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer.

Implementation of Recommended Precautions

Employers of health-care workers should ensure that policies exist for:

1. Initial orientation and continuing education and training of all health-care workers—including students and trainees—on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal blood and body-fluid precautions for all patients.
2. Provision of equipment and supplies necessary to minimize the risk of infection with HIV and other blood-borne pathogens.
3. Monitoring adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, counseling, education, and/or re-training should be provided, and, if necessary, appropriate disciplinary action should be considered.

Professional associations and labor organizations, through continuing education efforts, should emphasize the need for health-care workers to follow recommended precautions.

Serologic Testing for HIV Infection

Background

A person is identified as infected with HIV when a sequence of tests, starting with repeated enzyme immunoassays (EIA) and including a Western blot or similar, more specific assay, are repeatedly reactive. Persons infected with HIV usually develop antibody against the virus within 6-12 weeks after infection.

The sensitivity of the currently licensed EIA tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for ≥12 weeks. Optimal laboratory conditions include the use of reliable reagents, provision of continuing education of personnel, quality control of procedures, and participation in performance-evaluation programs. Given this performance, the probability of a false-negative test is remote except during the first several weeks after infection, before detectable antibody is present. The proportion of infected persons with a false-negative test attributed to absence of antibody in the early stages of infection is dependent on both the incidence and prevalence of HIV infection in a population (Table 1).

The specificity of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of initially reactive specimens by EIA is required to reduce the likelihood of laboratory error. To increase further the specificity of serologic tests, laboratories must use a supplemental test, most often the Western blot, to validate repeatedly reactive EIA results. Under optimal laboratory conditions, the sensitivity of the Western blot test is comparable to or greater than that of a repeatedly reactive EIA, and the Western blot is highly specific when strict criteria are used to interpret the test results. The testing sequence of a repeatedly reactive EIA and a positive Western blot test is highly predictive of HIV infection, even in a population with a low prevalence of infection (Table 2). If the Western blot test result is indeterminant, the testing sequence is considered equivocal for HIV infection.

TABLE 1. Estimated annual number of patients infected with HIV not detected by HIV-antibody testing in a hypothetical hospital with 10,000 admissions/year*

Beginning prevalence of HIV infection	Annual incidence of HIV infection	Approximate number of HIV-infected patients	Approximate number of HIV-infected patients not detected
5.0%	1.0%	550	17-18
5.0%	0.5%	525	11-12
1.0%	0.2%	110	3-4
1.0%	0.1%	105	2-3
0.1%	0.02%	11	0-1
0.1%	0.01%	11	0-1

*The estimates are based on the following assumptions: 1) the sensitivity of the screening test is 99% (i.e., 99% of HIV-infected persons with antibody will be detected); 2) persons infected with HIV will not develop detectable antibody (seroconvert) until 6 weeks (1.5 months) after infection; 3) new infections occur at an equal rate throughout the year; 4) calculations of the number of HIV-infected persons in the patient population are based on the mid-year prevalence, which is the beginning prevalence plus half the annual incidence of infections.

When this occurs, the Western blot test should be repeated on the same serum sample, and, if still indeterminant, the testing sequence should be repeated on a sample collected 3-6 months later. Use of other supplemental tests may aid in interpreting of results on samples that are persistently indeterminant by Western blot.

Testing of Patients

Previous CDC recommendations have emphasized the value of HIV serologic testing of patients for: 1) management of parenteral or mucous-membrane exposures of health-care workers, 2) patient diagnosis and management, and 3) counseling and serologic testing to prevent and control HIV transmission in the community. In addition, more recent recommendations have stated that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at highest risk of infection (*32*).

Adherence to universal blood and body-fluid precautions recommended for the care of all patients will minimize the risk of transmission of HIV and other blood-borne pathogens from patients to health-care workers. The utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. Results of such testing may not be available in emergency or outpatient settings. In addition, some recently infected patients will not have detectable antibody to HIV (Table 1).

Personnel in some hospitals have advocated serologic testing of patients in settings in which exposure of health-care workers to large amounts of patients' blood may be anticipated. Specific patients for whom serologic testing has been advocated include those undergoing major operative procedures and those undergoing treatment in critical-care units, especially if they have conditions involving uncontrolled bleeding. Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions. In addition, when deemed appropriate, testing of individual patients may be performed on agreement between the patient and the physician providing care.

In addition to the universal precautions recommended for all patients, certain additional precautions for the care of HIV-infected patients undergoing major surgical operations have been proposed by personnel in some hospitals. For example, surgical procedures on an HIV-infected patient might be altered so that hand-to-hand passing of sharp instruments would be eliminated; stapling instruments rather than

TABLE 2. Predictive value of positive HIV-antibody tests in hypothetical populations with different prevalences of infection

	Prevalence of infection	Predictive value of positive test*
Repeatedly reactive enzyme immunoassay (EIA)†	0.2%	28.41%
	2.0%	80.16%
	20.0%	98.02%
Repeatedly reactive EIA followed by positive Western blot (WB)§	0.2%	99.75%
	2.0%	99.97%
	20.0%	99.99%

*Proportion of persons with positive test results who are actually infected with HIV.
†Assumes EIA sensitivity of 99.0% and specificity of 99.5%.
§Assumes WB sensitivity of 99.0% and specificity of 99.9%.

hand-suturing equipment might be used to perform tissue approximation; electrocautery devices rather than scalpels might be used as cutting instruments; and, even though uncomfortable, gowns that totally prevent seepage of blood onto the skin of members of the operative team might be worn. While such modifications might further minimize the risk of HIV infection for members of the operative team, some of these techniques could result in prolongation of operative time and could potentially have an adverse effect on the patient.

Testing programs, if developed, should include the following principles:

- Obtaining consent for testing.
- Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
- Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
- Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
- Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.

Testing of Health-Care Workers

Although transmission of HIV from infected health-care workers to patients has not been reported, transmission during invasive procedures remains a possibility. Transmission of hepatitis B virus (HBV)—a blood-borne agent with a considerably greater potential for nosocomial spread—from health-care workers to patients has been documented. Such transmission has occurred in situations (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (*33,34*).

The hepatitis B experience indicates that only those health-care workers who perform certain types of invasive procedures have transmitted HBV to patients. Adherence to recommendations in this document will minimize the risk of transmission of HIV and other blood-borne pathogens from health-care workers to patients during invasive procedures. Since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed. If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results—as previously outlined for testing programs for patients—must be addressed.

Management of Infected Health-Care Workers

Health-care workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., measles, varicella). Any health-care worker with an impaired immune system should be counseled about the potential risk associated with taking care of patients with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (*7,35*). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating health-care workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV—especially those who perform invasive procedures—can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Management of Exposures

If a health-care worker has a parenteral (e.g., needlestick or cut) or mucous-membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood—especially when the exposed skin is chapped, abraded, or afflicted with dermatitis—the source patient should be informed of the incident and tested for serologic evidence of HIV infection after consent is obtained. Policies should be developed for testing source patients in situations in which consent cannot be obtained (e.g., an unconscious patient).

If the source patient has AIDS, is positive for HIV antibody, or refuses the test, the health-care worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. The health-care worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness—particularly one characterized by fever, rash, or lymphadenopathy—may be indicative of recent HIV infection. Seronegative health-care workers should be retested 6 weeks post-exposure and on a periodic basis thereafter (e.g., 12 weeks and 6 months after exposure) to determine whether transmission has occurred. During this follow-up period—especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert—exposed health-care workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (*36,37*).

No further follow-up of a health-care worker exposed to infection as described above is necessary if the source patient is seronegative unless the source patient is at high risk of HIV infection. In the latter case, a subsequent specimen (e.g., 12 weeks following exposure) may be obtained from the health-care worker for antibody

testing. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

If a patient has a parenteral or mucous-membrane exposure to blood or other body fluid of a health-care worker, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source health-care worker and the exposed patient.

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MORBIDITY AND MORTALITY WEEKLY REPORT

Perspectives in Disease Prevention and Health Promotion

Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS

These guidelines are the outgrowth of the 1986 recommendations published in the *MMWR* (*1*); the report on the February 24-25, 1987, Conference on Counseling and Testing (*2*); and a series of meetings with representatives from the Association of State and Territorial Health Officials, the Association of State and Territorial Public Health Laboratory Directors, the Council of State and Territorial Epidemiologists, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the National Association of State Alcohol and Drug Abuse Directors.

Human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS) and related clinical manifestations, has been shown to be spread by sexual contact; by parenteral exposure to blood (most often through intravenous [IV] drug abuse) and, rarely, by other exposures to blood; and from an infected woman to her fetus or infant.

Persons exposed to HIV usually develop detectable levels of antibody against the virus within 6-12 weeks of infection. The presence of antibody indicates current infection, though many infected persons may have minimal or no clinical evidence of disease for years. Counseling and testing persons who are infected or at risk for acquiring HIV infection is an important component of prevention strategy (*1*). Most of the estimated 1.0 to 1.5 million infected persons in the United States are unaware that they are infected with HIV. The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others.

Along with the potential personal, medical, and public health benefits of testing for HIV antibody, public health agencies must be concerned about actions that will discourage the use of counseling and testing facilities, most notably the unauthorized disclosure of personal information and the possibility of inappropriate discrimination.

Guidelines – Continued

Priorities for public health counseling and testing should be based upon providing ready access to persons who are most likely to be infected or who practice high-risk behaviors, thereby helping to reduce further spread of infection. There are other considerations for determining testing priorities, including the likely effectiveness of preventing the spread of infection among persons who would not otherwise realize that they are at risk. Knowledge of the prevalence of HIV infection in different populations is useful in determining the most efficient and effective locations providing such services. For example, programs that offer counseling and testing to homosexual men, IV-drug abusers, persons with hemophilia, sexual and/or needle-sharing partners of these persons, and patients of sexually transmitted disease clinics may be most effective since persons in these groups are at high risk for infection. After counseling and testing are effectively implemented in settings of high and moderate prevalence, consideration should be given to establishing programs in settings of lower prevalence.

Interpretation of HIV-Antibody Test Results

A test for HIV antibody is considered positive when a sequence of tests, starting with a repeatedly reactive enzyme immunoassay (EIA) and including an additional, more specific assay, such as a Western blot, are consistently reactive.

The *sensitivity* of the currently licensed EIA tests is 99% or greater when performed under optimal laboratory conditions. Given this performance, the probability of a false-negative test result is remote, except during the first weeks after infection, before antibody is detectable.

The *specificity* of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of specimens initially reactive by EIA is required to reduce the likelihood of false-positive test results due to laboratory error. To further increase the specificity of the testing process, laboratories must use a supplemental test—most often the Western blot test—to validate repeatedly reactive EIA results. The sensitivity of the licensed Western blot test is comparable to that of the EIA, and it is highly specific when strict criteria are used for interpretation. Under ideal circumstances, the probability that a testing sequence will be falsely positive in a population with a low rate of infection ranges from less than 1 in 100,000 (Minnesota Department of Health, unpublished data) to an estimated 5 in 100,000 (*3,4*). Laboratories using different Western blot reagents or other tests or using less stringent interpretive criteria may experience higher rates of false-positive results.

Laboratories should carefully guard against human errors, which are likely to be the most common source of false-positive test results. All laboratories should anticipate the need for assuring quality performance of tests for HIV antibody by training personnel, establishing quality controls, and participating in performance evaluation systems. Health department laboratories should facilitate the quality assurance of the performance of laboratories in their jurisdiction.

Guidelines — Continued

Guidelines for Counseling and Testing for HIV Antibody

These guidelines are based on public health considerations for HIV testing, including the principles of counseling before and after testing, confidentiality of personal information, and the understanding that a person may decline to be tested without being denied health care or other services, except where testing is required by law (*5*). Counseling before testing may not be practical when screening for HIV antibody is required. This is true for donors of blood, organs, and tissue; prisoners; and immigrants for whom testing is a Federal requirement as well as for persons admitted to state correctional institutions in states that require testing. When there is no counseling before testing, persons should be informed that testing for HIV antibody will be performed, that individual results will be kept confidential to the extent permitted by law, and that appropriate counseling will be offered. Individual counseling of those who are either HIV-antibody positive or at continuing risk for HIV infection is critical for reducing further transmission and for ensuring timely medical care.

Specific recommendations follow:

1. *Persons who may have sexually transmitted disease.* All persons seeking treatment for a sexually transmitted disease, in all health-care settings including the offices of private physicians, should be routinely* counseled and tested for HIV antibody.
2. *IV-drug abusers.* All persons seeking treatment for IV-drug abuse or having a history of IV-drug abuse should be routinely counseled and tested for HIV antibody. Medical professionals in all health-care settings, including prison clinics, should seek a history of IV-drug abuse from patients and should be aware of its implications for HIV infection. In addition, state and ~~local~~ health policy makers should address the following issues:
   - Treatment programs for IV-drug abusers should be sufficiently available to allow persons seeking assistance to enter promptly and be encouraged to alter the behavior that places them and others at risk for HIV infection.
   - Outreach programs for IV-drug abusers should be undertaken to increase their knowledge of AIDS and of ways to prevent HIV infection, to encourage them to obtain counseling and testing for HIV antibody, and to persuade them to be treated for substance abuse.
3. *Persons who consider themselves at risk.* All persons who consider themselves at risk for HIV infection should be counseled and offered testing for HIV antibody.

*"Routine counseling and testing" is defined as a policy to provide these services to all clients after informing them that testing will be done. Except where testing is required by law, individuals have the right to decline to be tested without being denied health care or other services.

Guidelines – Continued

4. *Women of childbearing age.* All women of childbearing age with identifiable risks for HIV infection should be routinely counseled and tested for HIV antibody, regardless of the health-care setting. Each encounter between a health-care provider and a woman at risk and/or her sexual partners is an opportunity to reach them with information and education about AIDS and prevention of HIV infection. Women are at risk for HIV infection if they:
   - Have used IV drugs.
   - Have engaged in prostitution.
   - Have had sexual partners who are infected or are at risk for infection because they are bisexual or are IV-drug abusers or hemophiliacs.
   - Are living in communities or were born in countries where there is a known or suspected high prevalence of infection among women.
   - Received a transfusion before blood was being screened for HIV antibody but after HIV infection occurred in the United States (e.g., between 1978 and 1985).

   Educating and testing these women before they become pregnant allows them to avoid pregnancy and subsequent intrauterine perinatal infection of their infants (30%-50% of the infants born to HIV-infected women will also be infected).

   All pregnant women at risk for HIV infection should be routinely counseled and tested for HIV antibody. Identifying pregnant women with HIV infection as early in pregnancy as possible is important for ensuring appropriate medical care for these women; for planning medical care for their infants; and for providing counseling on family planning, future pregnancies, and the risk of sexual transmission of HIV to others.

   All women who seek family planning services and who are at risk for HIV infection should be routinely counseled about AIDS and HIV infection and tested for HIV antibody. Decisions about the need for counseling and testing programs in a community should be based on the best available estimates of the prevalence of HIV infection and the demographic variables of infection.

5. *Persons planning marriage.* All persons considering marriage should be given information about AIDS, HIV infection, and the availability of counseling and testing for HIV antibody. Decisions about instituting routine or mandatory premarital testing for HIV antibody should take into account the prevalence of HIV infection in the area and/or population group as well as other factors and should be based upon the likely cost-effectiveness of such testing in preventing further spread of infection. Premarital testing in an area with a prevalence of HIV infection as low as 0.1% may be justified if reaching an infected person through testing can prevent subsequent transmission to the spouse or prevent pregnancy in a woman who is infected.

Guidelines – Continued

6. *Persons undergoing medical evaluation or treatment.* Testing for HIV antibody is a useful diagnostic tool for evaluating patients with selected clinical signs and symptoms such as generalized lymphadenopathy; unexplained dementia; chronic, unexplained fever or diarrhea; unexplained weight loss; or diseases such as tuberculosis as well as sexually transmitted diseases, generalized herpes, and chronic candidiasis.

   Since persons infected with both HIV and the tubercle bacillus are at high risk for severe clinical tuberculosis, all patients with tuberculosis should be routinely counseled and tested for HIV antibody (*6*). Guidelines for managing patients with both HIV and tuberculous infection have been published (*7*).

   The risk of HIV infection from transfusions of blood or blood components from 1978-1985 was greatest for persons receiving large numbers of units of blood collected from areas with high incidences of AIDS. Persons who have this increased risk should be counseled about the potential risk of HIV infection and should be offered antibody testing (*8*).

7. *Persons admitted to hospitals.* Hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infections in the age groups at highest risk for infection. Consideration should be given to routine testing in those age groups deemed to have a high prevalence of HIV infection.

8. *Persons in correctional systems.* Correctional systems should study the best means of implementing programs for counseling inmates about HIV infection and for testing them for such infection at admission and discharge from the system. In particular, they should examine the usefulness of these programs in preventing further transmission of HIV infection and the impact of the testing programs on both the inmates and the correctional system (*9*). Federal prisons have been instructed to test all prisoners when they enter and leave the prison system.

9. *Prostitutes.* Male and female prostitutes should be counseled and tested and made aware of the risks of HIV infection to themselves and others. Particularly prostitutes who are HIV-antibody positive should be instructed to discontinue the practice of prostitution. Local or state jurisdictions should adopt procedures to assure that these instructions are followed.

Partner Notification/Contact Tracing

Sexual partners and those who share needles with HIV-infected persons are at risk for HIV infection and should be routinely counseled and tested for HIV antibody. Persons who are HIV-antibody positive should be instructed in how to notify their partners and to refer them for counseling and testing. If they are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, physicians or health department personnel should use confidential procedures to assure that the partners are notified.

Guidelines — Continued

Confidentiality and Antidiscrimination Considerations

The ability of health departments, hospitals, and other health-care providers and institutions to assure confidentiality of patient information and the public's confidence in that ability are crucial to efforts to increase the number of persons being counseled and tested for HIV infection. Moreover, to assure broad participation in the counseling and testing programs, it is of equal or greater importance that the public perceive that persons found to be positive will not be subject to inappropriate discrimination.

Every reasonable effort should be made to improve confidentiality of test results. The confidentiality of related records can be improved by a careful review of actual record-keeping practices and by assessing the degree to which these records can be protected under applicable state laws. State laws should be examined and strengthened when found necessary. Because of the wide scope of "need-to-know" situations, because of the possibility of inappropriate disclosures, and because of established authorization procedures for releasing records, it is recognized that there is no perfect solution to confidentiality problems in all situations. Whether disclosures of HIV-testing information are deliberate, inadvertent, or simply unavoidable, public health policy needs to carefully consider ways to reduce the harmful impact of such disclosures.

Public health prevention policy to reduce the transmission of HIV infection can be furthered by an expanded program of counseling and testing for HIV antibody, but the extent to which these programs are successful depends on the level of participation. Persons are more likely to participate in counseling and testing programs if they believe that they will not experience negative consequences in areas such as employment, school admission, housing, and medical services should they test positive. There is no known medical reason to avoid an infected person in these and ordinary social situations since the cumulative evidence is strong that HIV infection is not spread through casual contact. It is essential to the success of counseling and testing programs that persons who are tested for HIV are not subjected to inappropriate discrimination.

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Guidelines — Continued

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Special Article

Guidelines for the Control of Perinatally Transmitted Human Immunodeficiency Virus Infection and Care of Infected Mothers, Infants and Children

GEORGE W. RUTHERFORD, MD; GERALDINE E. OLIVA, MD, MPH; MOSES GROSSMAN, MD; JAMES R. GREEN, MD; DIANE W. WARA, MD; NANCY S. SHAW, PhD; DEAN F. ECHENBERG, MD, PhD; CONSTANCE B. WOFSY, MD; DANIEL H. WEINSTEIN, LLB; FLORENCE STROUD, MSN, MPH; EDWIN S. SARSFIELD, MSW, *and* DAVID WERDEGAR, MD, MPH, *San Francisco*

The transmission of the human immunodeficiency virus (HIV) from infected mothers to infants, either in utero or perinatally, has been well established.[1-10] Infection in these infants can be asymptomatic or cause a variety of clinical syndromes including the acquired immunodeficiency syndrome (AIDS).[11] It is not, however, conclusively known what proportion of infants exposed in utero or perinatally will become infected and in what proportion of infected infants clinical disease will develop.[12] As of December 1, 1985, there were 217 cases of pediatric AIDS reported to the Centers for Disease Control (CDC) (unpublished data). Of these children, 48% were born to intravenous-drug-using mothers, 17% to Haitians and 10% to mothers who either had AIDS or were sexual partners of men with AIDS or at risk for AIDS. An additional 39 (18%) children were infected through transfusions of infected blood or blood products, and 13 (6%) had unknown sources of infection. Thus, 165 (76%) of the cases had been exposed to HIV in utero or perinatally.

HIV Infection in Women of Child-Bearing Age

In the United States, approximately 7% of adult cases of AIDS are women. Nearly 53% of these women are intravenous drug users, 15% are sexual partners of men in risk groups (primarily heterosexual intravenous drug users) and 9% have received infected blood or blood products. In all, 80% are between 20 and 49 years old, 22% of these women are white, 55% black and 23% Latino (CDC, unpublished data). In San Francisco, as of January 31, 1986, there had been ten cases of AIDS reported in adult women. Three of these women were intravenous drug users, one was a sexual partner of a man in a high-prevalence group, four had received transfusions and two had no identified risk. Four were between 20 and 49 years old; two of these were white, one black and one Asian.

HIV Transmission in Households

None of the identified cases of HIV infection in the United States are known to have been transmitted in school, day-care or foster-care settings or through casual person-to-person contact.[13] Other than sexual partners of HIV-infected patients, infants born to infected mothers or a single case involving nosocomial transmission from a child to a mother providing nursing care,[14] none of the family members of the more than 17,000 AIDS patients reported to CDC have had the development of AIDS. Five studies of family members of patients with HIV infection have failed to show HIV transmission to adults who are not sexual contacts of the infected patients or to children who are not already infected perinatally.[15-19] If, however, casual person-to-person transmission of HIV infection does exist, it should theoretically be greatest among young children. This theoretic transmission would most likely involve exposure of open skin lesions of mucous membranes to blood and possibly other body fluids of an infected person. We emphasize that there is no evidence of this type of transmission occurring in any setting at this time.

General Recommendations

Education

Risk-reducing education. All sexually active homosexual, bisexual and heterosexual adults with multiple sexual partners since 1979 should be aware that they are potentially at risk of HIV infection, and sexually active women with multiple sexual partners since 1979 should understand that, if they have been infected, they are at risk of transmitting HIV perinatally. To this end, widespread health education campaigns should address the risk of infection and the ways to prevent sexual transmission among heterosexuals and, more specifically, to women of child-bearing age. Additionally, women in recognized risk groups (Table 1) should be the target of more intensified educational campaigns and, if indicated, special educational programs to decrease their ongoing risk of parenterally or sexually acquiring HIV infection, such as referral for substance abuse or sexual risk-reducing counseling. These campaigns should be culturally and linguistically appropriate for these risk groups.

Provider education. To provide a high standard of care for HIV-infected women, infants and children, obstetricians, pediatricians, foster parents and agencies and other providers

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From the Departments of Public Health (Drs Rutherford, Oliva, Echenberg and Werdegar and Ms Stroud) and Social Services (Mr Sarsfield), and the Superior Court (Judge Weinstein), City and County of San Francisco; the Departments of Pediatrics (Dr Grossman), Obstetrics, Gynecology and Reproductive Services (Dr Green), and Medicine, AIDS Activities Unit (Dr Wofsy), San Francisco General Hospital and Medical Center; the Department of Pediatrics, University of California, San Francisco, School of Medicine (Dr Wara), and the San Francisco AIDS Foundation (Dr Shaw).

Reprint requests to George W. Rutherford, MD, AIDS Program, Department of Public Health, 1111 Market St, 4th Floor, San Francisco, CA 94103.

ABBREVIATIONS USED IN TEXT

AIDS = acquired immunodeficiency syndrome
ARC = AIDS-related complex
CDC = Centers for Disease Control
ELISA = enzyme-linked immunosorbent assay
HIV = human immunodeficiency virus

need to be educated about the virus, its modes of transmission, its prevention and the special issues of confidentiality and counseling surrounding the infection. Focus should be placed on educating and training those providers serving patients at highest risk of infection. We recommend that providers assess each patient's history of potential exposure to HIV and not assume that membership in a risk group implies de facto infection and, conversely, that nonmembership implies noninfection.

Laboratory Testing

We recommend that more than one method of anti-HIV antibody determination be used for testing pregnant women, women in risk groups and children of women in risk groups for HIV infection. Such methods include enzyme-linked immunosorbent assay (ELISA), indirect fluorescent antibody and Western blot. Because of a possible increased incidence of false-positive ELISA results during pregnancy, especially among intravenous-drug-using women, laboratory testing should be done in a single reliable and experienced facility. Submission of specimens identified only by code number to this laboratory will greatly decrease the chances of unintentional disclosure.

Preconception Recommendations

Whenever possible, women infected with HIV should be confidentially identified and educated about the risks of perinatal transmission. Infected women should be advised to postpone pregnancy until more is known about the specific risks of perinatal transmission. Detailed contraceptive counseling should be offered to these women. Infected women should also be counseled to avoid unsafe sexual practices and to inform previous and prospective sexual partners about their possible exposure. Regardless of other contraceptive methods used, they should use barrier methods of contraception—such as a condom or a condom plus a diaphragm with a nonoxynol-9-containing spermicide—during intercourse to diminish the chances both of transmitting HIV to their sexual partners and of being reinfected with it.

We recommend that women who believe themselves to be at high risk for HIV infection (Table 1) be confidentially or anonymously tested for anti-HIV antibody if they are planning to become pregnant. Testing can be offered through private physicians, alternate test sites or through clinics, especially those used by women in risk groups, such as family planning clinics, drug treatment programs and sexually transmitted disease clinics. Testing of these women, although strongly recommended, must be voluntary and confidential. We do not recommend that women who are not in risk groups be tested at this time. Because of possible sexual contact with men in high-incidence groups, however, it may be prudent for women with multiple sexual partners in areas with a high incidence of AIDS to consider themselves at risk and to obtain preconception counseling and testing if indicated. Regardless of test results, women and their children should continue to have access to all health and social services for which they are eligible.

TABLE 1.—*Women in Whom Human Immunodeficiency Virus Infection Has Been Reported*

Mode of Transmission	*Group*
Sexual	Sexual contacts of AIDS patients or men in risk groups*
	Artificially inseminated women (donor insemination) between January 1, 1979, and June 1, 1985
Parenteral	Intravenous drug users
	Recipients of blood or blood products between January 1, 1979, and June 1, 1985
Either	Mothers of perinatally infected children

AIDS = acquired immunodeficiency virus

*Women with multiple sexual partners in areas with high incidences of AIDS should possibly consider themselves in this category.

Recommendations for Mothers

Identification of Infected Pregnant Women

Routine histories taken at clinical facilities serving women potentially at high risk for HIV infection should include confidential questions designed to elucidate their risk of infection. Such clinics include physicians' offices, family planning clinics, sexually transmitted disease clinics, drug treatment clinics, women, infants and children clinics and prenatal clinics. Written or audiovisual materials, or both, regarding HIV infection should be available at all sites where these women are seen.

We recommend that women in risk groups be educated about HIV infection and that women determined to be at risk be tested at the time they present for prenatal care. Such testing must be voluntary and confidential. We do not recommend routine testing of all pregnant women. High-risk women who are seronegative in the first or second trimester should be retested in the late third trimester to rule out intercurrent HIV infection. Because quality obstetric care requires that the obstetrical provider know if an individual patient is infected, we recommend that, whenever possible, the test be obtained through the provider. Before such testing occurs, however, each provider should institute procedures that guarantee patient confidentiality. A release-of-information form authorizing the newborn's medical provider access to the mother's test result should also be obtained at this time. Because of the unique potential for exposure of health care workers to large amounts of possibly infectious blood and amniotic fluid during the course of labor and delivery, we recommend that labor and delivery personnel be notified of the need for appropriate infection control procedures on a strictly controlled basis. Ideally this information should be transmitted directly to labor and delivery personnel and through a mechanism other than the permanent medical record.

Care of Infected Pregnant Women

These recommendations apply specifically to women who are known to be infected. Guidelines for women at high risk of infection who have not been tested for HIV infection are found under "Special Considerations" below.

Prenatal care. We recommend that any seropositive woman be retested using two different anti-HIV antibody determinations to ensure accuracy. We recommend that women confirmed to be seropositive be carefully counseled regarding the risk of perinatal HIV infection and the options open to

them. Such options include continuing the pregnancy or terminating it if early enough in gestation. Infected women should also be specifically counseled to postpone subsequent pregnancies until more is known about the perinatal transmission of the virus. They should be medically evaluated to rule out any incipient opportunistic infection or malignancy. Specifically, the possibility of infection with *Mycobacterium tuberculosis* should be evaluated by chest x-ray film and purified protein-derivative test, and chronic infection with hepatitis B virus, cytomegalovirus and herpes simplex virus should be excluded. The use of teratogenic drugs, including trimethoprim and most antivirals, should be avoided except in the face of a life-threatening maternal illness.

Intrapartum care. We recommend that hospitals review their procedures for infection control during the intrapartum period and that hospital personnel exercise caution when dealing with any potentially infectious body fluid. For HIV these fluids include blood of either maternal or fetal origin, amniotic fluid and the placenta and membranes. Grossly contaminated linens and disposables, as well as blood and amniotic fluid specimens, should be handled according to the hospital infection control procedures. The choice of location for delivery—delivery room versus labor room—may be dictated by circumstance, but consideration should be given to a labor room delivery to minimize the need for disinfection of two locations. All personnel expected to have direct contact with an infected mother or newborn during delivery should wear gloves and gowns. Those exposed to the possibility of a splash of infectious materials should strongly consider wearing a mask and protective eyewear during the delivery itself. Disposal of all materials should follow hospital infection control procedures. The labor room, delivery room and all instruments should be disinfected with a 1:10 sodium hypochlorite solution. The placenta of a seropositive woman or of a high-risk woman of unknown status should be labeled with "Blood Precautions" or the equivalent before routing for pathologic examination or disposal.

Postpartum care. In the postpartum period, regular hospital infection control procedures for HIV infection should be followed. Isolation of asymptomatic seropositive women is not recommended. Mothers should be given full access to their infants unless they have untreated pulmonary tuberculosis. Until more is known about the possible transmission of virus in breast milk, mothers known to be infected should not breast-feed their infants. Because the potential for exposure to large amounts of infectious material decreases substantially after delivery, information regarding the woman's antibody status should not be transmitted beyond the labor and delivery area, including to social work, law enforcement or correctional personnel.

Special Considerations

Women at high risk of infection who are not tested. We recommend that women at high risk of HIV infection who have not been tested during pregnancy be presumed to be positive for purposes of intrapartum infection control procedures. As the benefits of breast-feeding may outweigh the possible risk of postnatal transmission of the virus, however, breast-feeding by mothers at risk of infection who have not been tested is not absolutely contraindicated. Rather, recommendations regarding the safety of breast-feeding should be individualized and based on a mother's estimated risk of infection.

Intravenous-drug-using mothers. To prevent further parenteral transmission of HIV through needle sharing and further perinatal transmission, we recommend that women in this group be specially targeted for substance abuse treatment and risk-reducing education.

Recommendations for Infants and Children

Identifying Exposed Infants

We recommend that identification of HIV-exposed infants begin in utero. If women in high-incidence groups are not tested during pregnancy, we recommend that for medical reasons their infants be tested as early as possible—such as testing the cord blood—and definitely before 2 months of age. Such testing should be done confidentially and with the voluntary consent of the child's parent or guardian.

Identifying Infected Infants

Infants of seropositive mothers. Infants born to mothers who are known to have been infected during pregnancy should be retested for anti-HIV antibody at about 1 year of age when passively acquired maternal antibody has disappeared. Infants presenting before 1 year of age with symptoms suggestive of HIV infection should be retested at that time. If facilities are available, peripheral mononuclear cells should be cultured for HIV to definitely establish a diagnosis of HIV infection.

Infants and children of high-risk mothers with unknown serologic status. Infants born to mothers at high risk of HIV infection whose prenatal anti-HIV antibody status is not known should be tested before 2 months of age for exposure to HIV and retested at 1 year of age or earlier if clinically indicated. Older children who were born on or after January 1, 1979, and whose mothers were at risk of HIV infection should be tested only if they have not completed a primary series of oral polio vaccine and have not received a measles-mumps-rubella vaccination or if clinically indicated. Because of possible complications of live virus vaccines, we recommend that older high-risk children be tested for HIV exposure or infection before receiving live virus vaccines. In the event that the parent or guardian refuses testing, the infant or child should not receive live virus vaccines.

Infants and children at risk for parenterally acquired infection. Infants and children at risk for parenterally acquired HIV infection should be tested only if they received blood or blood products from a donor identified as HIV-infected and will receive live virus vaccines, or if they were transfused with non-heat-treated factor VIII and will receive live virus vaccines or if clinically indicated.

Infants and children of non-high-risk mothers. Infants and children born to mothers not at high risk of HIV infection and not at risk for parenterally acquired HIV infection should not be tested.

Care of Exposed and Infected Infants and Children

Nursery and in-hospital care. Regular hospital infection control procedures for HIV infection and regular hospital procedures for inpatient care of immunosuppressed patients should be followed in the nursery and during subsequent inpatient admissions. To prevent possible portals of entry for infection, circumcision of exposed male infants should be strongly discouraged and only done with informed consent. Umbilical stumps should be meticulously cleaned daily until they are evulsed.

Routine home care. Care-givers who are exposed to the body fluids and excrement of exposed infants and infected children should be aware of the potential for infection and the modes of HIV transmission. Good handwashing after exposure to body fluids and excrement should be observed and any open lesions, either on care-givers' hands or on children, should be covered.

Medical care. Exposed infants who remain anti-HIV positive beyond 1 year of age or who have documented positive HIV cultures at any age should be considered at risk for the development of AIDS or AIDS-related complex (ARC) and, therefore, potentially immunodeficient. Infants and children either at risk for the development of AIDS or ARC or who have clinical AIDS or ARC should be assumed to have a secondary combined immunodeficiency, be followed closely for problems with growth and development and be given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella and measles.

Exposed infants and infected children should not receive live virus vaccines or bacille Calmette Guérin until more is known about vaccinating HIV-infected persons. Inactivated vaccines, including *Hemophilus influenzae* type b and pertussis vaccines and diphtheria and tetanus toxoids, are not contraindicated and should be given as regularly scheduled. Inactivated polio vaccine should be substituted for oral polio vaccine and be given in conjunction with diphtheria and tetanus toxoids and pertussis vaccine at 2, 4, 6 and 18 months and 4 to 6 years of age. Measles, mumps and rubella vaccine should not be administered to these children at the present time.

Infants or children with clinical AIDS or ARC should be evaluated and cared for as if they have combined immunodeficiency disease. Because these children potentially have a significant cellular immunodeficiency, all blood products should be irradiated to avoid graft-versus-host disease. Until more is known about the natural history of disease in infants who remain anti-HIV positive beyond 1 year of age, the immune status of these children should be sequentially evaluated with the consultation of a pediatrician experienced in the care of HIV-infected children. The increased risk of *Pneumocystis carinii* pneumonia in these children may be modified by the prophylactic use of trimethoprim-sulfamethoxazole. As these children do not make normal specific antibodies to new antigens, their increased risk of infection with bacterial agents may be altered by monthly administration of immune globulin, either intramuscularly or intravenously.

Special Considerations

Foster care. In each decision involving foster-care placement, a mother's history of possible exposure to HIV infection should be individually assessed to determine if she and her child are truly at risk of infection. In San Francisco these decisions can be made in consultation with a designated perinatal coordinator within the Department of Public Health or, if necessary, with the Perinatal and Pediatric AIDS Advisory Committee. For the purposes of foster-care decisions, the committee in San Francisco also includes consumer advocates representative of ethnic and socioeconomic populations at high risk for perinatally transmitted infection. (For a list of the committee members, see footnote at end of article.)

If a child whose mother has been tested for HIV infection comes to foster care, we recommend that the social worker assigned to the case request that the mother's obstetrical provider release the results of her test to the perinatal coordinator with the mother's consent. Based on the results of these tests, the perinatal coordinator will specify if the infant will need medical foster-care placement or routine foster-care placement. Medical placement will be required for infants of mothers with a positive anti-HIV antibody test and in San Francisco entails review of the placement decision by the Perinatal and Pediatric AIDS Advisory Committee. Routine placement will require that a mother be seronegative. The perinatal coordinator will inform the social worker assigned to follow the child of the reasons for medical placement and will also be responsible, in conjunction with the social worker, for informing the foster family and the child's pediatrician of the reasons for medical placement. Additional authorizations to release information will be required for each of these subsequent disclosures.

Children younger than 3 years currently in foster care and children entering foster care in the future whose mothers were not tested for HIV infection prenatally should be tested for HIV infection only if their mothers have been determined to be at risk of infection. Testing in these cases is indicated on medical grounds alone and should be done with the consent of the mother. In San Francisco, if a mother refuses to consent to testing or refuses to release the results of her test, we recommend that the case be reviewed by the Perinatal and Pediatric AIDS Advisory Committee and, if indicated, confidential testing of the child and release of the test results be done as part of dependency proceedings. Once results of the test are available, they will be released by the child's provider to the perinatal coordinator in the case of voluntary testing or reported directly by the laboratory to the perinatal coordinator in the case of court-ordered testing. The perinatal coordinator will then indicate whether the child is in need of medical placement or routine placement. If the child is in need of medical placement, the perinatal coordinator will follow procedures as outlined above. If, for whatever reason, the child is not tested; the mother's exposure history will be reviewed and appropriate placement recommended by the perinatal and pediatric AIDS advisory committee.

Children in foster care 3 years of age and older, born after January 1, 1979, and born to a mother determined to be at risk of HIV infection should be tested only if they have significant neurodevelopmental delay and lack control of their body secretions or display aggressive behavior, such as biting, or who have uncoverable, oozing lesions. Such testing should occur only after careful medical review by a perinatal and pediatric AIDS advisory committee to determine if such conditions truly increase the theoretic risk of casual HIV transmission. Again, the consent of the child's mother should be obtained for testing and release of information, or, if consent is not available, testing and release of information should be ordered by the court if indicated. We feel that all prenatal testing should be done on a voluntary basis and that the mother should freely consent both to being tested and to release the test results (required by law in California[20]) to assure better medical care of her children. In the event, however, that a mother determined to be at significant risk of infection has not been tested prenatally, refuses to be tested prenatally or refuses to consent to release the results of her prenatal test, as it is our opinion that testing of high-risk children for HIV infection is medically indicated, we recommend that, if these children are to be placed in foster homes, such testing be done and, if necessary, be specifically ordered by the court having

jurisdiction over the child. Before any court-ordered testing, however, the case must be reviewed by the Perinatal and Pediatric AIDS Advisory Committee to determine if testing is indeed indicated.

Adoption. We recommend that infants and children whose mothers were at high risk of HIV infection, who were born on or after January 1, 1979, and who have not been previously tested be tested for HIV infection before placement. We recommend that the HIV status of all children at high risk of infection be made available to adopting parents before final placement so that they can consider the possible social and psychological effects on their families.

Conclusions

The information and recommendations contained in this report were developed and compiled by the Perinatal and Pediatric AIDS Advisory Committee, a special task force of the Department of Public Health, City and County of San Francisco, which included representatives of the Departments of Obstetrics, Gynecology and Reproductive Sciences, Medicine and Pediatrics and the AIDS Activities Unit, San Francisco General Hospital; the Department of Pediatrics, University of California, San Francisco; the San Francisco Medical Society; the American Academy of Pediatrics; the San Francisco Gynecologic Society; the San Francisco AIDS Foundation; Bay Area Addiction Research and Treatment, Inc, and the Department of Social Services, the City Attorney's Office and the Superior Court of the City and County of San Francisco.*

These recommendations apply to all infants, children and women of child-bearing age known to be infected or at high risk of being infected with HIV. This includes persons with CDC-defined acquired immunodeficiency syndrome, persons with lesser clinical manifestations of HIV infection such as ARC and persons with asymptomatic HIV infection. They are intended to supplement previously published national guidelines for the foster care and adoption of HIV-infected children and for the prevention of perinatal HIV infection.

We reemphasize that these are interim guidelines that will need to be reviewed as more information becomes available on perinatal transmission, the natural history of HIV infection in pregnancy and childhood and household transmission and also as vaccine and definitive antiviral therapy become available. Finally, it should be clearly stated that all evidence suggests that there is no risk of casual transmission of HIV and that the primary intent of these guidelines is to assure appropriate medical care for infected pregnant women, infants and children.

*Members of the committee were Moses Grossman, MD, chair; Jeffery W. Amory, Arthur F. Back, DrPH; Paul E. Barnes; Martin C. Carr, MD; Wayne W. Clark, PhD; Daniel E. Collins, JD; Nancy G. Corser, RN, FNP; Dean F. Echenberg, MD, PhD; James R. Green, MD; Marty Jessup, RN, MS; Alan C. Johnson, MD; Ron Kletter, PhD; Craig M. McCabe, JD; Larry Meredith, PhD; Glenn Molyneaux, MD; Geraldine F. Oliva, MD, MPH; Ann O'Reilly, MSW; Nancy H. Rubin, MSW; George W. Rutherford, MD; Edwin S. Sarsfield, MSW; Janet Shalwitz, MD; Nancy S. Shaw, PhD; Florence M. Stroud, MSN, MPH; Joan R. Vera, MSW; Diane W. Wara, MD; Daniel H. Weinstein, LLB; David Werdegar, MD, MPH; Constance B. Wofsy, MD; Donald F. Wong, MD, and Mark M. Young, MA.

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Supplement

Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

AIDS Program
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Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

Reported by
Council of State and Territorial Epidemiologists;
AIDS Program, Center for Infectious Diseases, CDC

INTRODUCTION

The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists. The Council of State and Territorial Epidemiologists (CSTE) has officially recommended adoption of the revised definition for national reporting of AIDS. The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human immunodeficiency virus (HIV) (including HIV-1 and HIV-2); b) to simplify reporting of AIDS cases; c) to increase the sensitivity and specificity of the definition through greater diagnostic application of laboratory evidence for HIV infection; and d) to be consistent with current diagnostic practice, which in some cases includes presumptive, i.e., without confirmatory laboratory evidence, diagnosis of AIDS-indicative diseases (e.g., *Pneumocystis carinii* pneumonia, Kaposi's sarcoma).

The definition is organized into three sections that depend on the status of laboratory evidence of HIV infection (e.g., HIV antibody) (Figure 1). The major proposed changes apply to patients with laboratory evidence for HIV infection: a) inclusion of HIV encephalopathy, HIV wasting syndrome, and a broader range of specific AIDS-indicative diseases (Section II.A); b) inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section II.B); and c) elimination of exclusions due to other causes of immunodeficiency (Section I.A).

Application of the definition for children differs from that for adults in two ways. First, multiple or recurrent serious bacterial infections and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia are accepted as indicative of AIDS among children but not among adults. Second, for children<15 months of age whose mothers are thought to have had HIV infection during the child's perinatal period, the laboratory criteria for HIV infection are more stringent, since the presence of HIV antibody in the child is, by itself, insufficient evidence for HIV infection because of the persistence of passively acquired maternal antibodies < 15 months after birth.

The new definition is effective immediately. State and local health departments are requested to apply the new definition henceforth to patients reported to them. The initiation of the actual reporting of cases that meet the new definition is targeted for September 1, 1987, when modified computer software and report forms should be in place to accommodate the changes. CSTE has recommended retrospective application of the revised definition to patients already reported to health departments. The new definition follows:

1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (*See* Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (*See* Appendix II).

A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection

1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy ≤3 months before the onset of the indicator disease
2. any of the following diseases diagnosed ≤3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy
3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia

B. Indicator diseases diagnosed definitively (*See* Appendix II)

1. candidiasis of the esophagus, trachea, bronchi, or lungs
2. cryptococcosis, extrapulmonary
3. cryptosporidiosis with diarrhea persisting >1 month
4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
6. Kaposi's sarcoma affecting a patient < 60 years of age
7. lymphoma of the brain (primary) affecting a patient < 60 years of age
8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
9. *Mycobacterium avium* complex or *M. kansasii* disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. *Pneumocystis carinii* pneumonia
11. progressive multifocal leukoencephalopathy
12. toxoplasmosis of the brain affecting a patient >1 month of age

I. With Laboratory Evidence for HIV Infection

Regardless of the presence of other causes of immunodeficiency (I.A), in the presence of laboratory evidence for HIV infection (*See* Appendix I), any disease listed

case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (*4,5*).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (*6,7*). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection.

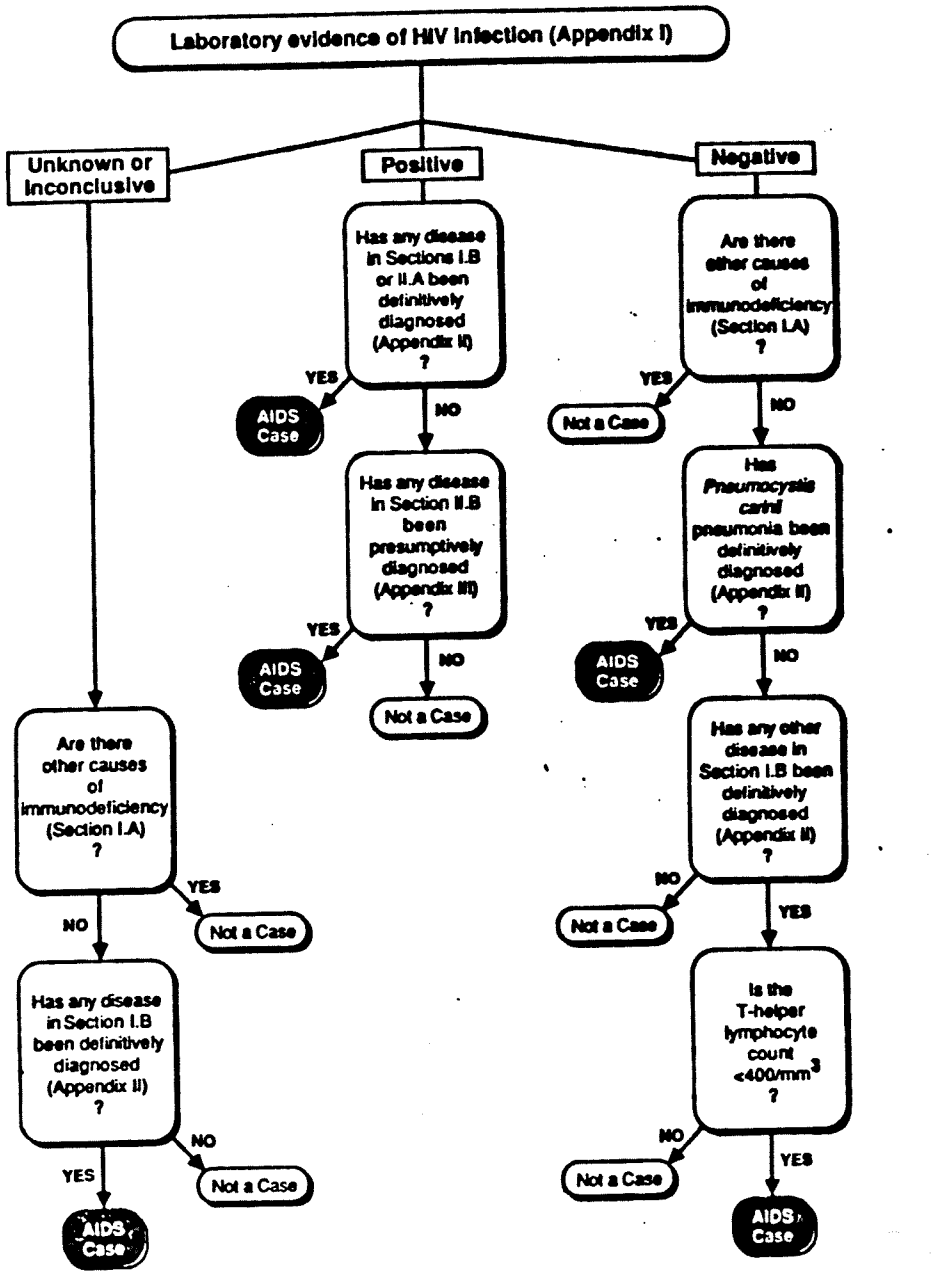
The effectiveness of the revision will depend on how extensively HIV-antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, < 7% have been reported with HIV-antibody test results, compared with > 60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV-antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV-antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counselling to prevent transmission of HIV.

FIGURE I. Flow diagram for revised CDC case definition of AIDS, September 1, 19



HIV encephalopathy* (dementia)	clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioral developmental milestones affecting a child, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.
HIV wasting syndrome*	findings of profound involuntary weight loss >10% of baseline body weight plus either chronic diarrhea (at least two loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis).

*For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive, but are sufficiently rigorous for surveillance purposes.

APPENDIX III

Suggested Guidelines for Presumptive Diagnosis of Diseases Indicative of AIDS

Diseases	Presumptive Diagnostic Criteria
candidiasis of esophagus	a. recent onset of retrosternal pain on swallowing; AND b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.
cytomegalovirus retinitis	a characteristic appearance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, hemorrhage, and necrosis). Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling.
mycobacteriosis	microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, skin cervical or hilar lymph nodes, showing acid-fast bacilli of a species not identified by culture.
Kaposi's sarcoma	a characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane. (Note: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.)
lymphoid interstitial pneumonia	bilateral reticulonodular interstitial pulmonary infiltrates present on chest X ray for ≥2 months with no pathogen identified and no response to antibiotic treatment.
Pneumocystis carinii pneumonia	a. a history of dyspnea on exertion or nonproductive cough of recent onset (within the past 3 months); AND b. chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; AND c. arterial blood gas analysis showing an arterial pO_2 of <70 mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; AND d. no evidence of a bacterial pneumonia.
toxoplasmosis of the brain	a. recent onset of a focal neurologic abnormality consistent with intracranial disease or a reduced level of consciousness; AND b. brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; AND c. serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

Patient's Name _____ Telephone No.: (___) _____

Address _____

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) PEDIATRIC CONFIDENTIAL CASE REPORT

(Patients <13 years of age at time of diagnosis)

Physician's Name: _____ Telephone No.: (___) _____

Hospital _____ Medical Record No.: _____

Person Completing Form: _____ Telephone No.: (___) _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AIDS PROGRAM, CID, ATLANTA, GEORGIA 30333

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
PEDIATRIC CONFIDENTIAL CASE REPORT
(Patients <13 years of age at time of diagnosis)

FORM APPROVED
OMB NO. 0920-0009

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of AIDS. Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on the reverse of the form, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 308 (d) of the Public Health Service Act (42 USC 242m).

DATE FORM COMPLETED: Mo ___ Day ___ Year ___

CDC PATIENT NUMBER: _____

HEALTH DEPARTMENT USE ONLY

SOUNDEX NAME CODE: _____

STATUS OF THIS REPORT: [1] New Case [2] Update Report

REPORTING HEALTH DEPARTMENT: State _____ City/County _____

STATE PATIENT NUMBER: _____

CITY/COUNTY PATIENT NUMBER: _____

I. BASIC PATIENT INFORMATION

DATE OF BIRTH: Mo ___ Day ___ Year ___

AGE AT DIAGNOSIS OF AIDS: Years ___ Mos ___

CURRENT STATUS: [1] Alive [2] Dead [9] Unknown

DATE OF DEATH: Mo ___ Day ___ Year ___

SEX: [1] Male [2] Female

RACE/ETHNICITY: [1] White (not Hispanic) [2] Black (not Hispanic) [3] Hispanic [4] Asian/Pacific Islander [5] American Indian/Alaskan Native [9] Not Specified

COUNTRY OF BIRTH: [1] US [2] Canada [3] Dominican Republic [4] Haiti [5] Mexico [8] Other (specify) _____

RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS:
City _____ County _____ Zip Code _____
State/Country _____

HOSPITAL WHERE DIAGNOSIS OF AIDS ESTABLISHED:
Name _____
City _____ State/Country _____

II. SOCIAL AND RISK FACTORS

AFTER 1977 AND PRECEDING THE DIAGNOSIS OF AIDS, HAS THIS CHILD: (check all that apply)

	Yes	No	Unk
• Received any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	[1]	[0]	[9]
• If yes, specify disorder: [1] Hemophilia A (factor VIII) [2] Hemophilia B (factor IX) [8] Other, specify: _____			
• Received a transfusion of blood/blood components?	[1]	[0]	[9]
• If yes, and this is only risk factor, give date of first and last transfusion: First Mo ___ Yr ___ Last Mo ___ Yr ___			

AFTER 1977, HAS THIS CHILD'S MOTHER: (check all that apply)

	Yes	No	Unk
• Used needles for self injection of drugs not prescribed by a physician?	[1]	[0]	[9]
• Received any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	[1]	[0]	[9]
• If yes, specify disorder: [1] Hemophilia A (factor VIII) [2] Hemophilia B (factor IX) [8] Other, specify: _____			
• Received a transfusion of blood/blood components?	[1]	[0]	[9]
• Been diagnosed as having AIDS, ARC, or documented HIV infection?	[1]	[0]	[9]
• Had heterosexual relations with any of the following (check all that apply)			
• I.V. drug abuser	[1]	[0]	[9]
• Bisexual man	[1]	[0]	[9]
• Man with hemophilia/coagulation disorder	[1]	[0]	[9]
• Blood transfusion recipient with AIDS or documented HIV infection	[1]	[0]	[9]
• Man with unknown risk factors, but has AIDS, ARC, or documented HIV infection	[1]	[0]	[9]
• Man born in a country where heterosexual transmission predominates, (e.g., African or Caribbean country) Specify country: _____	[1]	[0]	[9]

MOTHER WAS BORN IN: [1] US [2] Canada [3] Dominican Republic [4] Haiti [5] Mexico [8] Other (specify) _____

FATHER WAS BORN IN: [1] US [2] Canada [3] Dominican Republic [4] Haiti [5] Mexico [8] Other (specify) _____

III. DISEASES INDICATIVE OF AIDS (check all that apply)

DISEASE	DIAGNOSIS Definitive*	DIAGNOSIS Presumptive
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	[1]	NA
Candidiasis, bronchi, trachea, or lungs	[1]	NA
Candidiasis, esophageal	[1]	[2]
Coccidioidomycosis, disseminated or extrapulmonary	[1]	NA
Cryptococcosis, extrapulmonary	[1]	NA
Cryptosporidiosis, chronic intestinal	[1]	NA
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	[1]	NA
Cytomegalovirus retinitis (with loss of vision)	[1]	[2]
HIV encephalopathy	[1]	NA
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or pneumonitis or esophagitis onset at >1 mo. of age	[1]	NA
Histoplasmosis, disseminated or extrapulmonary	[1]	NA
Isosporiasis, chronic intestinal (>1 mo. duration)	[1]	NA

DISEASE	DIAGNOSIS Definitive*	DIAGNOSIS Presumptive
Kaposi's sarcoma	[1]	[2]
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	[1]	[2]
Lymphoma, Burkitt's (or equivalent term)	[1]	NA
Lymphoma, immunoblastic (or equivalent term)	[1]	NA
Lymphoma, primary in brain	[1]	NA
Mycobacterium avium complex or *M. kansasii*, disseminated or extrapulmonary	[1]	[2]
M. tuberculosis, disseminated or extrapulmonary	[1]	[2]
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	[1]	[2]
Pneumocystis carinii pneumonia	[1]	[2]
Progressive multifocal leukoencephalopathy	[1]	NA
Toxoplasmosis of brain, onset at >1 mo. of age	[1]	[2]
Wasting syndrome due to HIV	[1]	NA

*Refer to instructions on back for definition of definitive diagnosis.

Of diseases checked above, date first disease diagnosed: Mo ___ Yr ___

IV. LABORATORY DATA

1. HIV SERUM ANTIBODY TESTS:

	Pos	Neg	Inc*	Not Done	Test Date Mo	Test Date Yr
• ELISA	[1]	[0]	[8]	[9]		
• Western blot/immunofluorescence assay	[1]	[0]	[8]	[9]		
• Other (specify) _____	[1]	[0]	[8]	[9]		

*Inc = Inconclusive

2. HIV DETECTION TESTS: (Applicable only if serum antibody tests are not positive.)

	Pos	Neg	Inc*	Not Done
• Culture of HIV confirmed by both specific HIV antigen test and reverse transcriptase detection	[1]	[0]	[8]	[9]
• HIV serum antigen test	[1]	[0]	[8]	[9]
• Other HIV test (specify) _____	[1]	[0]	[8]	[9]

*Inc = Inconclusive

3. If HIV tests were not positive, were not done, or the patient is <15 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?

Yes	No	Unk
[1]	[0]	[9]

4. IMMUNOLOGIC LAB TEST: (If <15 months of age or if antibody negative at any age, has this patient had any of the following?)

	Yes	No	Unk
• Low lymphocyte count, (e.g., <1000 cells/mm^3)	[1]	[0]	[9]
• T-helper cell count <400 cells/mm^3	[1]	[0]	[9]
• Low T-helper/T-suppressor (e.g., <1.0)	[1]	[0]	[9]

• Total serum Immunoglobulins (mg/dl)
[1] <1500 [2] 1500 to 2500 [3] >2500
Test date of highest immunoglobulin level: Mo ___ Yr ___

V. ADDITIONAL INFORMATION OR COMMENTS

_____

_____

_____

CDC 50.42B (REV. 8-87)

COPY

Patient's Name: _____ Telephone No.: (___)_____

Address: _____

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) ADULT CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

Physician's Name: _____ Telephone No.: (___)_____

Hospital: _____ Medical Record No.: _____

Person Completing Form: _____ Telephone No.: (___)_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
AIDS PROGRAM, CID, ATLANTA, GEORGIA 30333

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
ADULT CONFIDENTIAL CASE REPORT
(Patients ≥13 years of age at time of diagnosis)

FORM APPROVED
OMB NO. 0920-0007

This report is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of AIDS. Information in the surveillance system that would permit identification of any individual or establishment is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on the reverse of the form, and will not otherwise be disclosed or released without the consent of the individual or the establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

DATE FORM COMPLETED Mo Day Year

CDC PATIENT NUMBER

HEALTH DEPARTMENT USE ONLY

SOUNDEX NAME CODE	STATUS OF THIS REPORT	REPORTING HEALTH DEPARTMENT	STATE PATIENT NUMBER
	[1] New Case [2] Update Report	State _____ City/ County _____	CITY/COUNTY PATIENT NUMBER

I. BASIC PATIENT INFORMATION

DATE OF BIRTH Mo Day Year

AGE AT DIAGNOSIS OF AIDS Years

CURRENT STATUS [1] Alive [2] Dead [9] Unknown

DATE OF DEATH Mo Day Year

SEX [1] Male [2] Female

RACE/ETHNICITY
[1] White (not Hispanic) [2] Black (not Hispanic) [3] Hispanic
[4] Asian/Pacific Islander [5] American Indian/ Alaskan Native [9] Not Specified

COUNTRY OF BIRTH
[1] U.S [2] Canada [3] Dominican Republic [4] Haiti
[5] Mexico [6] Other (specify)

RESIDENCE AT ONSET OF ILLNESS SUGGESTIVE OF AIDS:
City _____ County _____ Zip Code
State/ Country _____

HOSPITAL WHERE DIAGNOSIS OF AIDS ESTABLISHED
Name _____
City _____ State/ Country _____

II. SOCIAL AND RISK FACTORS

AFTER 1977 AND PRECEDING THE DIAGNOSIS OF AIDS, DID THIS PATIENT: (check all that apply)

	Yes	No	Unk
• Have sexual relations with a male partner?	[1]	[0]	[9]
• Have sexual relations with a female partner?	[1]	[0]	[9]
• Use needles for self-injection of drugs not prescribed by a physician?	[1]	[0]	[9]
• Receive any blood products (i.e., factor VIII or IX, cryoprecipitate, or fibrinogen) for the treatment of a coagulation disorder?	[1]	[0]	[9]
– If yes, specify disorder. [1] Hemophilia A (factor VIII) [2] Hemophilia B (factor IX) [8] Other, specify _____			
• Have heterosexual relations with any of the following: (check all that apply)			
– I.V. drug abuser	[1]	[0]	[9]
– Bisexual man	[1]	[0]	[9]
– Person with hemophilia/coagulation disorder	[1]	[0]	[9]
– Blood transfusion recipient with AIDS or documented HIV infection	[1]	[0]	[9]
– Person with AIDS or documented HIV infection	[1]	[0]	[9]
– Person born in a country where heterosexual transmission predominates, (e.g., African or Caribbean country) Specify country _____	[1]	[0]	[9]
• Has patient received a transfusion of blood/blood components?	[1]	[0]	[9]
– If yes, and this is only risk factor, give date of first and last transfusion: First Mo Yr Last Mo Yr			
• Work in a health-care or clinical laboratory setting?	[1]	[0]	[9]
– If yes, specify occupation _____			

III. DISEASES INDICATIVE OF AIDS (check all that apply)

DISEASE	DIAGNOSIS Definitive*	DIAGNOSIS Presumptive	DISEASE	DIAGNOSIS Definitive*	DIAGNOSIS Presumptive
Candidiasis, bronchi, trachea, or lungs	[1]	NA	Kaposi's sarcoma	[1]	[2]
Candidiasis, esophageal	[1]	[2]	Lymphoma, Burkitt's (or equivalent term)	[1]	NA
Coccidioidomycosis, disseminated or extrapulmonary	[1]	NA	Lymphoma, immunoblastic (or equivalent term)	[1]	NA
Cryptococcosis, extrapulmonary	[1]	NA	Lymphoma, primary in brain	[1]	NA
Cryptosporidiosis, chronic intestinal	[1]	NA	*Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary	[1]	[2]
Cytomegalovirus disease (other than in liver, spleen, or nodes)	[1]	NA	*M. tuberculosis*, disseminated or extrapulmonary	[1]	[2]
Cytomegalovirus retinitis (with loss of vision)	[1]	[2]	*Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary	[1]	[2]
HIV encephalopathy	[1]	NA	*Pneumocystis carinii* pneumonia	[1]	[2]
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis	[1]	NA	Progressive multifocal leukoencephalopathy	[1]	NA
Histoplasmosis, disseminated or extrapulmonary	[1]	NA	Salmonella septicemia, recurrent	[1]	NA
Isosporiasis, chronic intestinal (>1 mo. duration)	[1]	NA	Toxoplasmosis of brain	[1]	[2]
			Wasting syndrome due to HIV	[1]	NA

*Refer to instructions on back for definition of definitive diagnosis.

Of diseases checked above, date first disease diagnosed: Mo Yr

IV. LABORATORY DATA

	Pos	Neg	Inc*	Not Done
1. HIV SERUM ANTIBODY TESTS:				
• ELISA	[1]	[0]	[8]	[9]
• Western blot/immunofluorescence assay	[1]	[0]	[8]	[9]
• Other (specify) _____	[1]	[0]	[8]	[9]

*Inc = Inconclusive

	Pos	Neg	Inc*	Not Done
2. HIV DETECTION TESTS: (Applicable only if serum antibody tests are not positive.)				
• Culture of HIV confirmed by both specific HIV antigen test and reverse transcriptase detection	[1]	[0]	[8]	[9]
• HIV serum antigen test	[1]	[0]	[8]	[9]
• Other HIV test (specify) _____	[1]	[0]	[8]	[9]

*Inc = Inconclusive

	Yes	No	Unk
3. If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?	[1]	[0]	[9]

	Yes	No	Unk
4. IS ABSOLUTE T-HELPER LYMPHOCYTE COUNT <400 per mm^3? (Applicable only if tests results are negative for HIV infection.)	[1]	[0]	[9]

V. ADDITIONAL INFORMATION OR COMMENTS

WILLIAM E. WADE, D.O.
NANCY L. BELOHLAVEK, M.A.
FAMILY MEDICINE AND COUNSELING
SEXUALLY TRANSMITTED DISEASES

1115 WEST 10TH STREET, SUITE A
TOPEKA, KANSAS 66604
TELEPHONE 913/233-8268

March 24, 1988

REVISION RECOMMENDATIONS REGARDING SENATE BILL NO. 686

Dr. William E. Wade

Kansas AIDS Network, Inc.

Senate Bill No. 686 regarding legislation concerning Acquired Immunodeficiency Syndrome (AIDS) is a product of rational compromise which addresses the preservation of public health and the provision for confidentiality, but falls short in addressing the rights of individuals infected with the Human Immunodeficiency Virus (HIV), the causative agent of AIDS.

Whereas it is common for individuals to be infected with the Human Immunodeficiency Virus (HIV) for months to years, and whereas individuals infected with HIV may not experience deterioration of their immune system even after five years of infection; **individuals infected with HIV should be guaranteed protection under Kansas law to protect and preserve their civil rights including freedom from discrimination in employment, housing, health care, and physician-patient confidentiality.**

New Section 2 (a) provides for reporting to the secretary of

Attm. #9
3-24-8

health and environment the name and address of persons diagnosed as having AIDS, but also adds a very dangerous category of persons **suspected** of having AIDS. This week I received a call from a physician in a rural Kansas town who is convinced a mutual patient has AIDS. All my testing, examination, and history of this patient does not support this suspicion, the physician might be tempted to disclose the patient's name and address and compromise the person's expected confidentiality. There are very clear criteria established by the Centers for Disease Control (CDC) which outline diagnostic parameters for AIDS. Suspicion alone is not one of them. **I recommend the provision of persons suspected of having AIDS** (New Sec. 2 (a) line 0048-0049) **be amended out of the bill.**

This section also fails to address the need to monitor the incidence of HIV infection in the state. Reporting by initials and birthdate, without specific names, to the secretary of health any incident of HIV confirmed positive individuals would provide such epidemiologic data and not threaten loss of patient confidentiality.

New Section 4 (a) requires the disclosure of HIV testing results to "other health care personnel who. . . are subject to risk of exposure to HIV " (lines 0106-0116). This provision is not recommended by the Governor's Task Force on AIDS or the Centers for Disease Control, and undermines the recommendations to healthcare personnel to take universal precautions with all patients. There exists a small risk of exposure through injury

from needlesticks or other percutaneous exposure, according to the CDC. The determined occurrence of infection from these occupational exposures is less than 0.35% (0.0035)! If appropriate established precautions are utilized by healthcare personnel, the divulgence of a person's HIV testing status is unnecessary and may compromise his/her constitutional rights to privacy and his/her reasonable expectation of physician-patient confidentiality. **Deletion of this provision would be more consistent with the recommendations of the CDC and the Governor's Task Force on AIDS.** At least amending the bill from "shall disclose" to "may disclose" (line 0111) would leave such disclosure up to the discretion of the physician, depending upon individual circumstances.

New Section 8 (b) addresses HIV antibody testing for convicted individuals of "sex crimes". Victims of such crimes should be counseled about the risk of HIV exposure immediately, and should not have to wait for the test results of their perpetrator. Just as pregnancy may be a risk with rape, so might HIV exposure also be a risk. **Mandatory testing of convicted sex offenders does not affect the need for immediate counseling and personal testing of the survivors of these perpetrations.**

What If Both

502 children of mothers w/ AIDS are born w AIDS

New Section 8 (f) (line 0205-0206) stipulates a class A misdemeanor as the crime for breach of confidentiality throughout this section. Otherwise throughout the bill, the crime has been listed as a class C misdemeanor. **I recommend for consistency, all**

individuals who breach the confidentiality provided by this bill should be guilty of a class C misdemeanor.

New Section 9 should be deleted. Universal precautions pertain to funeral directors, embalmers, and others who might legally handle the body after death. **Specific provisions as outlined are inconsistent with the recommendations of the Centers of Disease Control and the Governor's Task Force on AIDS.** Equal protection at all times regardless of diagnosis must be strictly followed.

In summary, it is the responsibility of our legislators to assure the implementation of rational legislation regarding HIV reporting, disclosure, and testing. AIDS is very much an emotional issue confronting our society. The legislation enacted regarding AIDS and the Human Immunodeficiency Virus detection and reporting must not be allowed to circumvent intelligent time honored scrutiny and careful consideration of overwhelming medical information and fact. The changes in this bill which I have recommended address 1) the protection of the people who find themselves infected with a very frightening and socially unpopular virus, 2) the medically established requirements for accurate diagnosis of AIDS, 3) The provision of public health and welfare by allowing preservation of the physician-patient relationship while simultaneously providing needed epidemiologic data, 4) the need to counsel the victims and survivors of sex crimes of the possibility of HIV infection, 5) the guarantee of

confidentiality by stipulating the breach of confidentiality as being a class C misdemeanor, and 6) deleting the provision for labeling and tagging of deceased individuals based on diagnosis.

The bill which is before you will affect the health and well being of thousands of families in this state. Your signature deserves to be affixed to legislation which preserves human dignity, not threatens it; which addresses the public health and welfare of all of the citizens without malice or injury towards a few; and which provides for the overall good for humankind. The bill in front of you needs the revisions I have proposed if these goals are to be achieved.

TESTIMONY BEFORE THE HOUSE
PUBLIC HEALTH AND WELFARE COMMITTEE
REGARDING SB 686

My name is Darrel Newkirk and I'm the Director of the Kansas City, Kansas-Wyandotte County Health Department. I'm here today to testify in support of SB 686. However, there are two important areas not addressed in SB 686 that I feel need to be amended into the bill.

The first matter concerns the **reporting of HIV positive individuals** to the State Health Department by approved laboratories performing the HIV antibody test.

There are basically two reasons why we in public health need this provision concerning this very serious public health disease. First, we need to know the number of individuals who are infected with this virus so that we can do **rational public health planning**. Without accurate data of the population infected with the AIDS virus, we in public health and you in the legislature cannot make adequate plans to deal with this epidemic. Without this reporting information, we are really "shooting in the dark."

The second and most important reason we need this information reported is because **reporting is essential to preventing the transmission of this virus**. If we in public health don't know who is infected with this virus, how can we work with these individuals and their sex contacts to prevent the further spread of this virus?

REPORTING OF INFECTED INDIVIDUALS so that they can be counselled and worked with in a confidential manner is a basic, fundamental principle of communicable disease control that has worked successfully in controlling other infectious diseases. For example, reporting of positive syphilis tests by laboratories in our state has been extremely important in reducing the number of people infected with syphilis. Once we know a person is infected, we in public health, with the cooperation of the person's private doctor, counsel the patient privately, confidentially about his/her infection and what precautions should be taken to prevent the spread of syphilis to another person. Part of this process involves asking the patient to notify his/her sex partners that they may have been exposed to a sexually transmitted disease and advising them that they should come in for testing and counselling. With the patient's permission we contact their sex partners with this information (if the patient doesn't want to). In any event, being able to work with the sex partners of patients infected with syphilis has been extremely important in breaking the chain of transmission of syphilis and other sexually transmitted diseases.

The HIV infection is no different. The chain of transmission can be broken! The spread of the AIDS virus can be prevented if we use the same public health principles which have been followed in successfully controlling other infectious diseases. One of those principles is

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knowing who has the infection. If we don't know who has the infection, how can public health people in this state do their job to prevent the transmission of this virus? Without this information, we in public health, including you in the legislature, are like the boxer going into the ring blindfolded and with one hand tied behind his back. I ask you then for the good of all the people of Kansas--both those who are infected with the AIDS virus and particularly those who are not infected--to incorporate into SB 686 an amendment which requires confidential reporting of individuals who are infected with this virus so that public health in this state can do its job that it knows can be done and should be done to stop the spread of this deadly virus.

The other weakness in SB 686 presently is the lack of anti-discrimination provisions. Individuals who are infected with the AIDS virus and those who have been diagnosed as having ARC or the disease AIDS should be protected from discrimination in employment, education, housing, etc. The confidential reporting of individuals who have the disease AIDS or who are infected with the AIDS virus should be coupled hand in glove with provisions to prevent any discrimination against them because of this infection.

In conclusion, I urge you as representatives of the people of Kansas, to give the public health professionals in Kansas the ammunition we need to fight the spread of this deadly virus--SB 686 and these two important amendments.

Darrel D. Newkirk, MD, MPH
Director of Health
Kansas City, Kansas-Wyandotte Co. Health Dept.