STATE OF MINNESOTA

HIV ISSUES TEAM

Report of

1988 Activities

January 1989

Pursuant to 1988 laws, ch 689
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STATE OF MINNESOTA

HIV ISSUES TEAM

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I. INTRODUCTION

The AIDS Issues Team was established by the Executive Branch in late 1985, to provide AIDS-related analysis and coordination of activities between state agencies. The Issues Team was originally comprised of 14 state agencies. It was asked to identify and prioritize issues related to AIDS and to develop policies, plans, and proposals to respond to these issues. In addition, the group was to assure consistency between agencies and avoid duplication of effort. The Issues Team completed a report in November 1986, which outlined issues and recommendations in the areas of public health, education, financing, employment, human rights, corrections, state-operated and licensed facilities, law enforcement, and data privacy.

The Issues Team was reactivated in 1988, and 25 agencies were asked to participate. The current charge for the Team is as follows:

> **The AIDS Issues Team will review the status of AIDS issues in each agency's area of responsibility since November 1986, and identify policies and plans that need updating as well as new AIDS issues to be addressed. The AIDS Issues Team will serve as the mechanism by which the State will attempt to achieve consistency and avoid duplication among its agencies as they deal with the AIDS crisis.**

The group recently changed its name to the "HIV Issues Team" to emphasize the need to consider issues posed by human immunodeficiency virus (HIV) infection as well as clinically defined AIDS. Early in 1988, the issues most relevant to each agency were identified. Related issues were grouped and subgroups on (1) higher education; (2) issues related to communities of color; (3) primary/secondary education, (4) training and public education; and (5) direct care were established to allow for a focused discussion of the issues. Three of the five subgroups have served primarily to facilitate coordination between participating state agencies, while the other two have developed recommendations to address unresolved issues.

II. SUBGROUP REPORTS AND ISSUES TEAM RECOMMENDATIONS

The following sections describe the issues addressed by each subgroup in 1988, the steps taken to address these issues, and in some cases, the recommendations adopted by the Issues Team.

A. Issues in Higher Education

Issues Team members from the Higher Education Coordinating Board, University of Minnesota, State University System, Community College System, and Vocational Technical Education System sat on this subgroup. In addition, representatives of the Private College Council and private two-year institutions participated in their meetings.

This subgroup has assisted state higher education institutions in developing formal policies relating to HIV infection. The role of higher education systems in teaching students about HIV infection, and institutional responses to HIV-infected students and staff were issues of particular relevance. The subgroup has actively worked to coordinate the responses of, and facilitate information sharing between, the various higher education systems in Minnesota.

B. Issues Related to Communities of Color

Four legislatively-mandated minority councils are charged to serve as liaisons to the state government for citizens and organizations of the communities of color; and to advise the governor and the legislature of administrative, legislative, and programmatic changes necessary to ensure that their constituencies have access to benefits and services.

This subgroup - which consists of the directors of the Council on Black Minnesotans, the Council on Asian-Pacific Minnesotans, the Indian Affairs Council, and the Spanish Speaking Affairs Council - has provided a vehicle for the council directors and the Minnesota Department of Health (MDH) to share information and coordinate the HIV-related functions of each council.

Acting as a conduit to the MDH on behalf of their respective communities, the council directors are organizing the combined efforts of their communities and those of the MDH to address the AIDS epidemic. Each community of color now has an active AIDS task force (consisting of community leaders, service providers, and other interested parties) that meets regularly to discuss pertinent issues, and to plan AIDS community education events and activities.

The MDH will continue to routinely interact with council leadership in 1989. The Issues Team will be used as needed to provide a forum for state agencies to discuss AIDS-related issues pertaining to communities of color.

C. Primary/Secondary Education Issues

This subgroup was created to provide the opportunity for the Department of Education and the MDH to coordinate efforts regarding a legislative funding proposal in the area of education and to review the HIV policies developed by school districts.

In May 1988, the Minnesota Legislature appropriated $900,000 for AIDS education within the schools and adopted new legislation which stipulates that every Minnesota school district must provide an AIDS curriculum. The Department of Education and the MDH will continue to work collaboratively in the areas of policy development, instruction, counseling/support, and community education.

D. Direct Care Issues

The direct care subgroup was established to examine some of the many issues that HIV raises for state agencies which provide direct care services. Members of this subgroup include individuals from the Departments of Human Services, Health, Corrections, and Labor and Industry, Corrections Ombudsman, Mental Health/Mental Retardation Ombudsman, and the Veteran's Home. The subgroup identified seven issues to be addressed. The recommendations adopted by the Issues Team are presented below.

1. Assessment/Testing

The direct care subgroup considered the type of policies that should be established pertaining to counseling and risk assessment for individuals admitted to state-operated correctional or human service facilities. The Issues Team has adopted the following recommendations regarding assessment and testing:

a) **State direct care providers should complete HIV risk assessments for all inmates/residents at the time of the initial medical examination upon entry into the program or facility.** [Attachments I(a) and I(b) are samples of HIV risk assessment forms.] **Any inmate/resident assessed to be at risk of, or who has signs and/or symptoms of, HIV infection should be encouraged to be tested for the HIV antibody. Information should be provided which explains the benefits of testing to the inmate/resident.**

b) **Informed consent should be obtained in writing and care should be taken to assure that individuals are not coerced into testing.**

c) **Testing should include a screening test such as EIA and, if positive, a confirmatory test such as Western blot. Laboratories utilized by facilities for testing must assure high quality test results.**

d) **Pre- and post-test counseling should be provided to those individuals tested by staff trained according to MDH protocols** [Attachment II].

This recommendation is consistent with the MDH recommendations regarding risk assessment, counseling, and testing. The MDH has recommended that counseling and risk assessment take place in a variety of settings throughout the state, including sexually transmitted disease, tuberculosis, and family planning clinics; chemical dependency treatment facilities; and general medical practice serving individuals who are sexually active. Recommendations for counseling and testing can be made based upon an intake risk assessment which evaluates, for an individual, behaviors that may have placed the individual at risk for HIV infection.

2. Prevention and Risk Reduction

There are presently individuals in state institutions who are HIV-infected. Because behaviors which can transmit HIV do occur in these settings, there exists a need to develop and implement programs to prevent transmission among inmates or patients. In a few cases, institutionalized individuals who are HIV-infected may be unwilling or unable to refrain from behaviors that place others at risk.

The Issues Team adopted two recommendations intended to prevent transmission of HIV within regional treatment centers and state correctional facilities.

a) **Planning should be undertaken immediately for behavior management of HIV-infected individuals who are noncompliant and individuals whose behavior may place them at risk of infection so that appropriate options are available for both housing and behavior management for these individuals and for providing safe environments for others.**

A procedure has been developed to deal with these individuals within the general community, but the special situations that exist within state institutions may necessitate different practices. The Federal Bureau of Prisons has developed regulations for "controlled housing" of inmates whose behavior places others at risk of infection. These regulations include due process safeguards for inmates [Attachment III]. The Department of Corrections has developed draft policies covering this topic.

b) **Information on HIV transmission and prevention should be provided to all inmates/residents in all state-operated programs and facilities. Prevention and risk reduction topics should be integrated into ongoing activities of daily living, human sexuality programs, and other programs designed to train or habilitate inmates/residents in order to maximize opportunities for learning, which will facilitate behavior change.**

Prevention activities developed for state institutions can, in some cases, serve as models for community-based facilities which may face similar problems.

3. Universal Precautions

There is evidence of some degree of uncertainty about the exact situations in which universal blood and body fluid precautions should be applied within state institutions. To clarify this matter the Issues Team recommends the following:

a) **Universal precautions, as currently defined by the Centers for Disease Control, should be adopted in facilities in which there is risk of transmission of HIV through exchange of blood and body fluids** [Attachments IV(a) and IV(b)].

Current workers' compensation death benefit costs are estimated at approximately $900,000 for each case in which a fatality results. Given the statutory amendment (Minnesota Statutes 176.011, Subd. 15) which presumes workers' compensation eligibility for health care-related workers providing emergency medical care who develop illness following documented exposure to infectious agents in the work setting, the expense of universal precautions may actually be a cost savings.

4. Staff Training

The direct care subgroup discussed whether the state should require mandatory and regular training for all staff in regional treatment centers and correctional institutions, and if so, what topics should be included in this type of training. To ensure that state employees are well equipped to deal with HIV in these workplace settings, the Issues Team recommends the following:

a) **All staff assigned to state-operated facilities and programs should be required to participate in regular and ongoing training which address issues related to HIV infection.**

b) **Training topics should include modes of transmission, prevention, client rights and data privacy, and the impact of universal precautions on their duties.**

c) **Following initial training, additional information on HIV infection prevention should be integrated into ongoing training on related topics such as infection control, safety, and cardiopulmonary resuscitation, which are required for staff.**

The Minnesota Right-to-Know Act (Minnesota Statutes 182.653) requires that information and training be provided to employees in health care facilities. In addition, the Occupational Safety and Health Act General Duty Clause [Attachment V] extends that requirement to all employees who might be exposed to HIV in their workplaces. This latter clause also applies to all facilities and programs in which there is a known risk of transmission to employees.

5. Vulnerable Adult Issues

The direct care subgroup examined the way in which vulnerable adult status affects prevention efforts, particularly among those individuals who are not capable of consenting to sexual activity. Because these issues were found to need further clarification, the Issues Team recommends that the following actions be taken:

a) **A task force should be convened by the Department of Human Services to study issues related to HIV prevention activities in programs and facilities covered by the Vulnerable Adults Act. This task force should be comprised of professionals in the areas of HIV transmission, treatment and habilitation of vulnerable adults, and rights protection as well as advocates and representatives of consumer organizations.**

b) **The task force should recommend any statutory or rule changes necessary for facilities and programs covered by the Vulnerable Adults Act to provide appropriate prevention activities while protecting the rights of these persons. The task force should consider whether issues of vulnerability to HIV transmission should be addressed in individual abuse prevention plans, requiring a rule change; or whether these should be addressed through Individual Care Plans, which could be required by the Department of Human Services in its facilities, without rule changes.**

Minnesota Statutes 626.557 [Attachment VI] defines adults residing in facilities, or receiving services from programs, licensed by the Department of Human Services as vulnerable adults. Programs and facilities are legally required to develop facility abuse prevention plans which examine the environment in which services will be provided. In addition, individual abuse prevention plans must be developed for each adult residing in, or receiving services from, facilities or programs.

If the vulnerable adult is sexually active and able to consent to sexual activity, then the abuse prevention plan must not interfere with that individual's choice to engage in that activity. However, if the vulnerable person in the judgment of an interdisciplinary team defined in Minnesota Rules 9555.8000-9555.8500 determines that the individual is mentally impaired to the degree that ability to consent to sexual activity is limited or non-existent, then the abuse prevention plan must address the need to prevent sexual contact with others. Any individual, including another vulnerable adult able to consent to sexual activity, found to

have had sexual contact with a vulnerable adult unable to consent is guilty of criminal sexual contact. A facility or program which did not prevent such activity could be found guilty of neglect.

Current law does not provide guidance on how facilities can prevent sexual contact, especially given that some facility residents are able to consent to sexual activity. Statutes do not provide clear advice to facilities and programs regarding the parameters in which activities aimed at preventing HIV transmission could occur. It does not address contact between two individuals, both of whom are legally unable to provide consent. Nor does the statute address the liabilities assumed by care providers who fail to prevent sexual contact in which HIV transmission occurs, whether that transmission occurs between vulnerable adults able to consent or not.

6. Duty to Warn*

Even when an institutionalized individual is capable of consenting to sexual activity, issues related to the duty to warn may exist. Duty to warn refers to circumstances where the duty to protect an unsuspecting third party from harm can override confidentiality considerations. To clarify the procedures that are needed to comply with duty to warn obligations in state institutions where an identifiable individual is put at risk by the behavior of a source case infected with HIV, the Issues Team recommends the following:

a) **Procedures addressing duty to warn issues should be developed for employees in state-operated facilities in consultation with attorneys from the Attorney General's Office representing the Departments of Corrections, Human Services, Health, and Veteran's Affairs. These procedures should address when client confidentiality with respect to HIV transmission may be breached in order to protect the safety of another person. They should also address training of both client/inmate and staff and appropriate controls of providing warning to persons at risk.**

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*Duty to warn in this context does not refer to the "duty to warn" established by Minnesota Statutes 148.975. In this context, it refers to the management of situations where one person's activity presents a risk of infection to others.

7. State-Regulated Facilities

Community corrections and human service facilities will face many of the same HIV-related issues as state-operated facilities, in such areas as infection control, prevention, and behavior management. Therefore, the Issues Team recommends that:

a) **A special subcommittee of the HIV Issues Team should be convened to study issues related to HIV transmission in state-regulated or licensed facilities or programs, as distinct from those programs and facilities which are state-operated.**

E. Training and Public Education

The training and public education subgroup consisted of representatives from the Departments of Agriculture, Employee Relations, Administration, Labor and Industry, and State Planning, and the Council on Black Minnesotans. This group was asked to discuss issues related to HIV in both public and private sector workplaces, and make recommendations in the areas of employee training and the ability of Minnesota employers -- including the state -- to deal with HIV infection in the workplace. The Issues Team has adopted several recommendations related to training and public education.

1. **The personnel directors in each state agency should continue to be the contact point for administration of the State of Minnesota policy on AIDS in the workplace.**

   The HIV Issues Team understands that the role of the personnel director is to: (1) implement the AIDS policy; (2) provide information to managers and employees on the policy; (3) counsel individuals about AIDS in the workplace; (4) refer employees to other information sources; and (5) facilitate training appropriate to individual agency needs.

   This recommendation is intended to affirm the important role that personnel directors play in implementing state policy on AIDS in the workplace.

2. **State employees who may have direct contact with HIV-infected persons, as well as supervisors and managers should receive mandatory training regarding HIV. All other state employees should receive one hour of mandatory education about HIV by the end of 1991. The Issues Team adopts the training proposal entitled: Proposal for Implementation of AIDS Education for Minnesota State Employees** [Attachment VII].

The subgroup originally recommended that information on AIDS be disseminated to every state employee along with their payroll check. However, after subsequent discussion, the Issues Team voted to adopt the more comprehensive recommendation stated above. In addition to furthering the overall goal of HIV prevention among state employees, this measure can provide an example for other employers in Minnesota, facilitate infection control procedures in state employment settings, and may also decrease the potential for costly lawsuits based on improper handling of HIV infection among state employees.

The implementation proposal adopted by the Issues Team outlines a three-hour training course for managers and supervisors during which they would receive general HIV information, a copy of the state AIDS policy, information on legal issues, information on resource materials, and

procedures for policy implementation. A one-hour educational session would be mandatory for the majority of state employees, with additional information on available resources and a copy of the state policy on AIDS in the workplace.

At this time, the Department of Employee Relations plans to distribute written information on AIDS to all state employees, as originally proposed by the training and public education subgroup. A brochure on HIV infection and an information sheet outlining the state AIDS policy will be received by all state employees along with their payroll checks.

3. **The state should develop a program that provides private industry with assistance in the development of their individual AIDS policy. Suggested areas of assistance are:**

   a) **Provide packets of AIDS informational materials.**
   b) **Provide a list of additional informational material and their sources.**
   c) **Provide instructions for the development and implementation of an AIDS workplace policy.**
   d) **Provide speakers for industry meetings.**
   e) **Provide resource persons to assist on the development of policy statements or to review policy statements.**

This recommendation is to be implemented through the public health system. In 1987, the Commissioner of Health asked each Community Health Board in Minnesota to appoint an HIV resource person for each county under their jurisdiction. This person is to provide education and assistance to individuals and organizations in their county, including employers. In addition, Community Health Boards were asked to take a leadership role in assuring that there is

appropriate and sufficient community education including establishing a representative community task force on HIV; to stimulate and coordinate the development of local resources for dealing with HIV-related situations; to lead the community in understanding the real and present danger posed by the HIV epidemic; and to develop and adopt sound personnel and other related policies dealing with HIV infection.

Each county in Minnesota now has one resource person who is available to provide the types of assistance outlined in recommendation four. These individuals receive ongoing training and technical assistance from the MDH.

To implement part a) of the above recommendation, the training subgroup proposed distributing a two-part informational packet to the approximately 80,000 places of employment in Minnesota in order to reach the approximately 2 million persons employed in the state. This packet would consist of a letter to the employer and a one-page informational piece for the employee. In the letter, the employer would be asked to duplicate the second information sheet and pass it on to each employee.

However, because every household in the United States has received an informational mailing sent out by the United States Surgeon General, and because survey data indicate that high levels of knowledge about AIDS presently exist within the general public, present efforts will focus on providing technical assistance and education at the local level to supplement the already-existing base of knowledge.

ASSESSMENT: AIDS High Risk Behaviors
This information is to be completely anonymous. Do not write your name.

Please answer each question. Check the circle below "YES" if your answer is yes, check the circle below "NO" if your answer is no, and check the circle below "DK" if you don't know or don't wish to answer that question.

YES	NO	DK	
O	O	O	1. Have you had more than three sex partners in the past year?
O	O	O	2. Have you had a blood test for antibody to the AIDS virus (an
O	O	O	3. IF YES, was the result positive?

This is an example of an assessment form; actual assessment forms will vary depending on the target population and the use to which they are put.

Since 1977, have you:

O	O	O	4. Had a sexually transmitted disease (such as syphillis, gono
O	O	O	5. Had anal sex (penis to rectum) without a condom?
O	O	O	6. Shared a needle to inject street drugs?
O	O	O	7. Exchanged sex for money (or drugs)?
O	O	O	8. Had sex with a person from Central Africa or Haiti?
O	O	O	9. Had a blood transfusion or an organ transplant?

Where?_____ When? _____
(City, State) (month, year)

It is important that you consider the behavior of your sex partners. These next questions apply to your <u>sex partners</u>, and <u>not to you</u>. Since 1977, have you had sex with someone who:

O	O	O	10. Had a bleeding disorder (hemophilia)?
O	O	O	11. Had a sexually transmitted disease (such as syphillis, gonorrhea, or chlamydia)?
O	O	O	12. Had sex with a prostitute?
O	O	O	13. Had sex with another man (ie. a bisexual man)?
O	O	O	14. Shared a needle to inject street drugs?
O	O	O	15. Had sex with someone who injected street drugs with a needle?
O	O	O	16. Has tested positive for antibody to the AIDS virus?

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17. **RACE**
___ White
___ Black
___ Asian/Pacific Islander
___ Native American
___ Hispanic
___ Other

18. **CURRENT MARITAL STATUS**
___ Never Married
___ Married
___ Widowed
___ Divorced
___ Separated

19. **YOUR AGE**_____

20. **HIGHEST GRADE COMPLETED** _____

Attachment I(b)

Agency _____ Date _____

Health Worker _____

AIDS RISK ASSESSMENT

is information is private. No names please! The questions can help you identify whether you may have been exposed to the AIDS virus. Your responses will be shared only with the counselor/nurse, and then will become part of an anonymous (no names) data base used to help us plan and evaluate health programs. Filling out the form is voluntary and will not be used to deny services.

CIRCLE ONE True - T False - F Don't Know - DK

T F DK 1. AIDS is an illness in which your body cannot fight off diseases.

T F DK 2. You can usually tell if you've been infected with the AIDS virus.

T F DK 3. If you are infected with the AIDS virus you can infect others.

T F DK 4. A person can get AIDS by sharing needles and syringes with an infected person.

T F DK 5. Anal intercourse may increase your chances of getting AIDS.

T F DK 6. Having sex with someone who has AIDS is one way of getting it.

T F DK 7. If a pregnant woman has AIDS she can give the virus to her unborn baby.

T F DK 8. Anybody can get AIDS.

T F DK 9. Condoms (rubbers) are 100% effective in preventing AIDS.

T F DK 10. There is a blood test available which can tell you if you have been infected with the AIDS virus.

11. List three ways to protect yourself and others from getting AIDS:
a._____ c._____

yes / no / unsure 12. Have you ... a blood transfusion between 1977 and ...

yes / no / unsure 13. Do you ... sexual partner have a bleeding disease ...

yes / no / unsure 14. Have you ... one person in the past six years?

15. Approxim... ...ers have you had during the past two years?
____10 or More ____5-9 ____2-4 ____1 ____None

16. Approximately how many sex partners have you had during the past three months?
____10 or More ____5-9 ____2-4 ____1 ____None

17. How often do you use rubbers when having vaginal sex?
____Always ____Sometimes ____Almost Never ____Never

18. If you don't like to use condoms, please say why you don't.

_____

This is an example of an assessment form; actual assessment forms will vary depending on the target population and the use to which they are put.

(OVER)

yes / no / unsure 19. Have you had anal sex (sex in the rectum)?

20. If you have had anal sex, did you use condoms?
____Yes ____No ____Not Applicable

yes / no / unsure 21. Have you ever had sexual contact with a person of the same sex?

yes / no / unsure 22. Have you, or a sex partner, had a sexually transmitted disease during the past six years?

yes / no / unsure 23. There have been many cases of AIDS in Central Africa and Haiti. Have you, or a sex partner, had sex or used street drugs injected by needles while in these countries or with someone who has lived in these countries?

yes / no / unsure 24. Have you, or any of your sex partners, had AIDS, AIDS symptoms, or a positive blood test for AIDS?

25. It is important to think about your sex partner's partners.

yes / no / unsure - Do you think any of your sex partners have had sex with other women?

yes / no / unsure - Do you think any of your sex partners have had sex with other men?

yes / no / unsure - Do you think any of your sex partners have had sex with both men and women?

yes / no / unsure - Do you think any of your sex partners have had sex with people who have used street drugs injected by a needle?

yes / no / unsure 26. Have you ever had unplanned sex because you were high? (Under the influence of alcohol or drugs such as cocaine, marijuana, speed, crack, etc.)

yes / no / unsure 27. Have you, or a sex partner, ever used street drugs injected by a needle?

28. How often do you use street drugs injected by a needle?
____Regularly ____Sometimes ____Once or Twice ____Never

Your Age____ Grade Completed____ Your Race: White____ American Indian____
Black____ Hispanic____
Male____ Female____ Asian/Pacific Islander____ Other ____

Marital Status: Never Married____ Married____ Widowed____ Divorced____ Separated____

Your main source of AIDS information: Friends____ Parents____
T.V./Newspaper____ Health Clinic____
School____

QUESTIONS OR CONCERNS ABOUT AIDS?

Minnesota AIDS Line: Twin Cities: (612)870-0700
Greater MN: 1-800-248-AIDS

Office Use Only:
At Risk ___Yes ___No
Test ___Yes ___No
Referred ___Yes ___No

Minneapolis Health Department
5/88

Attachment II

PROTOCOL FOR PROVIDING DISEASE PREVENTION AND RISK REDUCTION COUNSELING TO HUMAN IMMUNODEFICIENCY VIRUS (HIV)-INFECTED PERSONS REPORTED TO THE MINNESOTA DEPARTMENT OF HEALTH

Minnesota Department of Health
Acute Disease Epidemiology Section
AIDS Epidemiology Unit

February, 1987

I. INTRODUCTION

Risk reduction and disease prevention education remains the primary tool available to the public health community to limit and prevent the transmission of human immunodeficiency virus (HIV), and thus reduce the incidence of the acquired immunodeficiency syndrome (AIDS) and other HIV-associated diseases. Risk reduction and disease prevention messages are currently delivered to recognized groups at increased risk of exposure to HIV. These messages are also conveyed individually to persons at risk of exposure to this virus, primarily in health care settings.

At counseling and testing sites supported by the Minnesota Department of Health (MDH), persons seeking the HIV antibody test receive risk reduction and disease prevention messages as part of routine pre- and post-test counseling. Individualized risk reduction and disease prevention education in this setting has reached nearly 7,000 persons since these sites were first established in July, 1985 (unpublished data, MDH).

Despite the volume of HIV counseling and antibody testing occurring at CTS's, a greater number of persons are being tested for HIV antibody in the private medical sector. Data on non-donor HIV antibody testing in Minnesota indicate that between 1985 and May 1986, 75% of all such testing occurred in the clinical setting (1). In addition, the number of HIV-infected persons identified through HIV antibody testing in the clinical setting nearly equals the number identified at CTS's. As the need and demand for HIV antibody testing for screening and diagnostic purposes increases in the private medical community, so too will the number of HIV-infected persons identified in this setting.

The actual types and consistency with which risk reduction and disease prevention messages are delivered to private HIV-infected patients is not well known. However, at one large medical center in Minnesota, only 10% of

patients who were appropriately tested for HIV antibody were given risk reduction information (personal communication, Dr. Keith Henry, St. Paul Division of Public Health). In addition, it is not known to what extent HIV infected patients tested in the private medical community are encouraged to notify and refer current and past sexual and needlesharing partners--individuals most likely to be infected with HIV who may unknowingly be transmitting the virus to others.

To assure that all HIV-infected individuals receive risk reduction and disease prevention counseling, the MDH will provide an outreach service to private physician patients. This service will be one of the outreach programs in the MDH's statewide risk reduction and disease prevention plan (2, and Appendix I.) and is keeping with MDH recommendations concerning the use of the HIV antibody test in public health (3). In addition, MDH rules governing communicable diseases (M.S. 4605.7030) require that individuals who are HIV antibody positive and/or are diagnosed with AIDS shall be reported to the MDH.

The purpose of this protocol is to describe the methodology for assuring that all HIV-infected persons (asymtomatic and symptomatic HIV antibody positive persons and persons diagnosed with AIDS meeting the CDC case definition) reported to the MDH by private physicians and medical laboratories receive appropriate risk reduction and disease prevention education. This protocol also allows for the notification of sexual and needlesharing partners of HIV-infected patients, so that such persons can be informed of their at-risk status, counseled, and referred for HIV antibody testing and additional counseling services.

II. Objectives

A. To provide risk reduction and disease prevention counseling to all

HIV-infected patients who are reported to the MDH by physicians and medical laboratories.

B. To encourage and enable HIV-infected patients to notify and refer their own sexual and/or needlesharing partners.

C. To provide MDH assistance to those HIV-infected patients who choose not to notify their partners or prefer third party assistance in partner notification.

D. To locate and notify sexual and needlesharing partners identified by HIV-infected patients, when such service is needed.

E. To provide risk reduction and disease prevention information to notified contacts and encourage them to seek HIV antibody testing and further counseling.

III. Methods

A. Objective 1: To provide risk reduction and disease prevention counseling to all HIV-infected patients who are reported to the MDH by physicians and medical laboratories.

1. HIV-infected patients will be identified for counseling through reports received by the MDH AIDS Epidemiology Unit (AEU) from physicians, medical facilities, and laboratories. These reports are required according to MDH rules governing communicable diseases (M.S. 4605.7030). Reports of positive HIV antibody test results and AIDS cases received from physicians and laboratories are currently maintained by surveillance activity personnel in the AEU.

   a. Surveillance personnel will review reports of HIV antibody positive results received from medical laboratories for completeness of information. Complete laboratory reports will include at least the patient's name and/or an

identification number, the name of the physician (or medical facility) ordering the test, the date the specimen was collected, and the results of test. Surveillance personnel will contact individual laboratories to obtain any missing information.

b. Once complete information is obtained, surveillance personnel will transmit case and serology reports to the AEU disease investigation activity supervisor (formerly referred to as contact notification activity). Methods for the transfer of information are outlined in Appendix II.

c. Information contained in reports of HIV-infected individuals (asymptomatic and symptomatic HIV "carriers" and AIDS cases) received by surveillance personnel from physicians will be transmitted directly to the disease investigation activity supervisor.

2. The responsibility for actual follow-up with the patient will be delegated based on the residence of the patient, according to the following:

a. Patients residing in the seven-county Twin Cities metropolitan area will be followed-up by the MDH AEU disease investigation staff.

b. Patients who reside in a county in greater Minnesota will be followed-up by the MDH district epidemiologist assigned to that location. (Residents of St. Louis, Carlton, Cook, and Lake Counties will be followed-up by the communicable disease representative employed by St. Louis County, according to procedures outlined in this protocol.)

c. Patients residing in other states will be referred to appropriate state or city health department personnel depending upon available outreach counseling and partner notification and referral services. The availability of these services will be determined by contacting the respective state epidemiologist. If outreach services are not available in that state, no personally identifying information about the patient will be provided.

The MDH AEU disease investigator or district epidemiologist (MDH professional) responsible for patient follow-up will also be responsible for communicating with the physician who ordered the HIV antibody test and/or diagnosed the case, regardless of the location of the physician.

3. The objectives of the disease investigation activities are: 1) to identify risk factors for acquiring HIV infection and, 2) to limit transmission of the virus. Therefore, follow-up with physicians and patients will be conducted in order of the following priority:

   a. Women who have no identified risk of exposure to HIV.
   b. Women of childbearing age regardless of identified risk.
   c. Men with no identified risk.
   d. Men who are bisexuals.
   e. All other women, including those whose risks are known.
   f. All other men, including those whose risks are known.

4. Physicians will be informed of the purpose of the MDH outreach efforts directed at their patients. MDH personnel will:

   a. Notify the physician that his/her patients will be

contacted by the MDH;

b. Obtain complete identifying and locating information (full name, birthdate, race, marital status, current location - hospital/home - address, and phone number);

c. Obtain pertinent medical history information (HIV serology, history of possible risk(s) of exposure to HIV, any history of blood, body fluid, or tissue donation or receipt, pregnancy history, symptom history, and reasons(s) the HIV antibody test was performed or the patient sought HIV antibody testing or medical care);

d. Obtain information on the patient's current medical and mental condition (patient awareness and level of understanding about their HIV infection status, psychological and emotional status, and pregnancy status). Physicians who prefer to speak with their patients before they are contacted by MDH personnel will be asked that they or their patients provide direct and timely feedback to MDH about the patient's interest in counseling and/or contact notification services.

5. Patients whose phone numbers are available will be initially approached by telephone. This method is the least intrusive and most rapid way to reach the patient. Once a patient has been reached, MDH personnel will introduce themselves and confirm the identity of the patient based upon information provided by the physician (i.e. birthdate). Once personnel are reasonably assured that they are speaking with the correct person, and the person is in private, (s)he will be informed that the MDH

professional is calling in follow-up to the patient's care provided by "Dr. _____." The MDH professional will then arrange to meet with the patient at a time and place convenient and private for the patient.

6. The MDH professional will inform the patient that the purpose of the counseling is to assist the patient in protecting his/her health and the health of others as it relates to infection with HIV. Patients will also be informed that:

   a. Information requested from him/her will be used to assist the MDH professional in providing them with appropriate information concerning risk reduction and disease prevention. In addition, the information will be used to help protect the health of others, by allowing the rapid notification and referral of sexual and needlesharing partners and others at risk of exposure to HIV.

   b. Providing the information is voluntary. However, any requested information not provided by the patient may result in the patient not receiving appropriate recommendations and information important to protect their heatlh and the health of others.

   c. Those who have access or may have access to personallly identifying information obtained in counseling the patient will depend on individual circumstances. The patient may have access to information about him/herself which (s)he provided, but no other individual may receive information about the patient. In the rare event that there is a clear indication that the patient intends to expose unsuspecting

persons despite education and counseling, the Commissioner of Health, legal counsel acting on the Commissioner's behalf, and other persons within the justice system may have access to such data. The minimum amount of information needed to carry out the Commissioner's responsibilities to protect the public health would be disclosed only to those who may assist in limiting further transmission. In cases where the information is critical to an epidemiological investigation, the information may be accessible to other AEU staff on a professional and individual need-to-know basis. However, on a routine basis, only two MDH employees will have direct access to the data: the MDH disease investigation supervisor and MDH professional who is directly responsible for counseling the HIV-infected patient.

d. Health data collected as a part of counseling the patient cannot be disclosed even through subpeona or litigation without the patient's consent.

Patients will be encouraged to ask questions about issues of confidentiality.

7. The MDH professional will then provide individualized counseling to the patient. The counseling will include:

   a. A determination/affirmation of the patient's risk(s) of exposure to HIV.

   b. An assessment of the patient's knowledge about his/her HIV infection status: reinforcing correct information the patient knows, correcting any misinformation, and providing information that the patient lacks.

c. A discussion of the following risk reduction and disease prevention recommendations:

i. limit sexual partners and tell any future sexual partners that they are HIV-antibody positive.

ii. only engage in sexual activities which do not expose him/her or others to blood and/or body fluids.

iii. do not use illicit drugs; if drugs are used by needle, do not share needles with others.

iv. do not donate blood, plasma, body organs, other tissue, or semen.

v. avoid preganancy (for female patients of child-bearing age) (consult with a physician)

vi. inform physicians and dentists, who provide care, of his/her HIV infection status.

vii. obtain skin testing for past exposure to M. tuberculosis (with appropriate tests for anergy), and consult with their physician about receiving pneumococcal and influenza vaccines and other diagnostic tests, as appropriate.

viii. follow their physician's orders and see their physician if unusual symptoms develop.

8. During counseling, the MDH professional will elicit information about the patient's blood, body fluid, organ, other tissue, and semen donation history. If the patient gives any such history of donation, (s)he will be informed of the importance of notifying donation recipients of their at-risk status. Information will be elicited from the patient about the types of

donation, donation facility name(s) and location(s), and donation date(s) since 1977. (Respective donation facilities will then be notified by MDH personnel and follow-up will be conducted as outlined in the MDH protocol on follow-up of infected blood and blood component donors (4).

B. Objective 2. **To encourage and enable HIV-infected patients to notify and refer their own sexual and/or needlesharing partners.**

1. Patients will be informed of the need to notify their sexual and/needlesharing partners of their at-risk status and the need to provide referrals to those partners for counseling and HIV antibody testing. The format will be similar to that outlined in the protocol on Partner Outreach Services (POS) (5). MDH personnel will determine the length of time that the patient may have been likely to be infectious. This time period will be determined on an individual basis depending upon the patient's risk(s) of exposure to HIV and HIV serologic history, if any. In general, the previous 12-month period will be considered a likely time for potential exposure of partners.

2. The MDH professional will assess the patient's plan, if any, for notifying his/her partners. This assessment will explore when and how the patient plans to inform his/her partners and what information the patient plans to provide. In addition, the assessment will evaluate how the patient plans to respond to his/her partner's reactions. In instances where patients have already notified and provided referrals to partners, the MDH professional will review with the patient these partner

encounters. The content of the information provided to the partner(s) and their status will be assessed. It may be necessary for the patient and/or MDH professional to make further contact with a partner if additional information and recommendations need to be conveyed.

3. Patients who choose to undertake the entire process of notifying their partners will be instructed on how it can be accomplished as sensitively and effectively as possible. Patients will be advised to:

   a. Maintain the confidentiality of their partner(s).

   b. Inform partner(s) in private and, if feasible, in person.

   c. Not accuse any partner(s) of being the source of their infection.

   d. Anticipate that partner(s) may be upset or hostile.

   e. Tell their partner(s) to seek further counseling and testing as soon as possible.

   f. All patients will be given written material which will provide suggestions and guidance for partner notification and referral (Appendix III).

C. Objective 3: **To provide MDH assistance to those HIV-infected patients who choose not to notify their partners or prefer third party assistance in partner notification.**

1. Patients will be informed of the service provided by the MDH which will provide confidential third party notification and referral of all or some of their partners. If a patient chooses to use this service, (s)he will be informed that:

   a. His/her identity will not be revealed to partners or to anyone else.

   b. The exposure dates will not be revealed to partners.

c. The reason the partner is being located will not be revealed to anyone other than the partner.

d. Partners will be provided accurate risk reduction and disease prevention information, referrals for counseling and HIV antibody testing, and referrals for medical evaluation and psychosocial support, as appropriate.

2. The patient will be informed that to notify and refer his/her partners in a discreet and rapid manner, (s)he will have to provide detailed information about the partners. The MDH professional will then elicit the following information from the patient for each partner to be notified and referred:

a. the partner's full name and/or nickname;

b. locating information, such as home address and phone number, work location and phone number, and the name and location of someone familiar with the partner's whereabouts;

c. age, sex, race, marital status;

d. physical description including height, weight, hair color, facial hair, glasses, complexion, and other visual or speech characteristics;

e. the first and last dates of exposure and the frequency of exposure;

f. possible complicating factors such as living with spouse, lover, or roommate; and

g. the time and place judged by the patient to be best for obtaining a confidential encounter with the partner.

4. Patients will be informed that the MDH cannot guarantee the

notification of partners living in other states, as the types and extent of partner notification services will vary from state to state. Out-of-state partners will be handled on a case-by-case basis after communicating with the respective city or state health department. In addition, patients will be informed that they will not have access to any information concerning the outcome of partner notification undertaken by the MDH or other state or city health departments due to logistic and confidentiality constraints.

5. The responsibility of notifying and referring partners will be delegated based on the residence of the partner as described in III.A.2 above.

D. Objective 4: **To locate and notify sexual and needlesharing partners identified by HIV-infected patients, when such service is needed.**

1. Before the initial contact with the partner(s) is attempted, available telephone and address directories will be checked to confirm the locating information provided by the HIV-infected patient. Partners whose telephone numbers are available will be initially approached by telephone. Once a partner is reached by telephone, the MDH professional will introduce himself/herself and attempt to confirm the identity of the partner based upon information provided by the HIV infected patient (i.e., the partner's age, description, address, work location). Once the MDH professional is reasonably assured that (s)he is speaking with the correct person and the person is in private, the partner will be informed that the professional has important health information to discuss with him/her.

2. When logistically feasible, the MDH professional will request

that (s)/he and the partner meet in person to discuss the details of the health information. Such a meeting will take place at a time and place convenient and private for the partner. In instances where partners refuse to agree to meet in person or are unable to meet, the nature of the health information will be revealed to the partner by telephone.

3. Partners will be informed that they have been exposed (sexually and/or by use of a needle) to someone with an HIV infection. Partners will be given an opportunity to respond to the information and ask questions. The identity of the infected patient, dates of exposure, or location of exposure will not be revealed or acknowledged by the MDH professional.

E. Objective 6: **To provide risk reduction and disease prevention information to notified contacts and encourage them to seek HIV antibody testing and further counseling.**

1. Since this may be the only contact the the MDH professional has with the partner, it will be important that risk reduction and disease prevention information is conveyed to him/her. The meaning of the exposure will be discussed, as well as the actions the partner can take to reduce his/her risk of exposure in the future. Partners will be encouraged to seek further counseling and HIV antibody testing. Depending on their last at-risk exposure, partners will be advised to have a repeat HIV antibody test if their initial test is negative.

2. If a partner chooses to seek the HIV antibody test from his/her personal physician, the MDH professional will recommend that they be allowed to alert the physician to the circumstances of the partner's visit. If a partner agrees with this

recommendation, then the MDH professional will communicate directly with the physician and confirm that the physician has access to HIV antibody laboratory services and provide technical advice and assistance to the physician, if needed. Partners who choose to obtain testing at a CTS will be given appropriate information and encouraged to inform CTS personnel that they have been referred by MDH staff as a result of their exposure to someone confirmed as HIV-infected.

3. The MDH professional will conclude the encounter with the partner by addressing any quesitons (s)he has; by reaffirming any commitments made to seek testing and counseling services; and by encouraging the partner to call the MDH professional if additional questions arise, or if (s)he needs any other referrals (i.e., medical and psychosocial support services). Each partner notified will be told that there will likely be no further contact with them unless they initiate the contact.

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2. Minnesota Department of Health, Commissioner's Task Force on AIDS, Human Immunodeficiency Virus (HIV) in Minnesota: Statewide Risk Reduction and Disease Prevention Plan, July, 1986.

3. Minnesota Department of Health, Commissioner's Task Force on AIDS, Use of Human Immunodeficiency Virus (HIV) Antibody Testing in Public Helath, October,1986.

4. Minnesota Department of Health, Acute Disease Epidemiology Section, Protocol for Statewide Follow-up of Blood Donors Infected with the Human Immunodeficiency Virus (HIV) and Recipients of Blood or Blood Components Potentially Contaminated with HIV: Minnesota, November, 1986.

5. Gonsiorek JC, Elwood ND, Minnesota Department of Health, Acute Disease Epidemiology Section. Protocol for a Pilot Program of Partner Outreach Services (POS) for Sexual and Needlesharing Partners of Persons Infected wiht the Human Immunodeficiency Virus (HIV). (Unpublished) November, 1986.

DEPARTMENT OF JUSTICE

Bureau of Prisons

28 CFR Part 541

Control, Custody, Care, Treatment, and Instruction of Inmates

AGENCY: Bureau of Prisons, Justice.

ACTION: Interim rule.

SUMMARY: In this document, the Bureau of Prisons is publishing an interim rule on Procedures for Handling of HIV Positive Inmates Who Pose Danger to Others. This rule establishes the procedures to follow when an inmate who tests HIV positive indicates by his actions or verbally a disposition to engage in conduct which poses a significant threat to transmit the virus to another person. The rule is intended to remove from the general inmate population an inmate whose conduct poses a substantial health risk to others.

DATES: Effective October 9, 1987. Comments on the interim rule must be received on or before January 29, 1988.

ADDRESS: Office of General Counsel, Bureau of Prisons, Room 770, 320 1st Street, NW., Washington, DC 20534. Comments received will be available for examination by interested persons at the above address.

FOR FURTHER INFORMATION CONTACT: Hank Jacob, Office of General Counsel, Bureau of Prisons, phone 202/272-6874.

SUPPLEMENTARY INFORMATION: In this document, the Bureau of Prisons is publishing an interim rule on Procedures for Handling of HIV Positive Inmates Who Pose Danger to Others. The rule authorizes Bureau staff to place an inmate in controlled housing status when there is reliable evidence causing staff to believe that the inmate may engage in conduct posing a health risk to others. This evidence may be the inmate's behavior, or statements of the inmate, or other reliable evidence. The rule establishes procedures for referring an inmate for placement in controlled housing status, requires the inmate be afforded a hearing, and provides for regional review of the Hearing Administrator's recommendation. The rule specifies that the inmate, consistent with available resources and security needs of the institution, is to be considered for activities and privileges afforded the general inmate population. The rule requires the inmate to have his status reviewed regularly, and identifies the factors to be considered in evaluating an inmate's readiness for release from controlled housing status.

The scope of this rule is limited to the inmate who tests HIV positive and for whom there is reliable evidence that the inmate is engaged in, or may engage in, conduct posing a health risk to others (e.g., sexual predators). To prevent the spreading of the virus to others, the Bureau has engaged in an educational program for all its inmates and staff. A person who tests HIV positive is given counseling about the risks of his behavior. When, despite such education and counseling, a person engages or shows a disposition to engage in high-risk behavior, the Bureau believes it is necessary to immediately implement procedures for removing such inmates from the general inmate population. For this reason, the Bureau finds good cause for exempting the provisions of the Administrative Procedure Act (5 U.S.C. 553) requiring notice of proposed rulemaking, the opportunity for advance public comment, and delay in effective date. While the rule will become effective immediately, the Bureau is interested in receiving public comment on this rule and suggestions on how the rule may be further refined/modified. Accordingly, the Bureau has decided to publish its policy as an interim rule with public comment invited. Public comment received on or before January 29, 1988 will be considered before publication of the final rule.

The Bureau of Prisons has determined that this rule is not a major rule for the purpose of EO 12291. The Bureau of Prisons has determined that EO 12291 does not apply to this rule since the rule involves agency management. After review of the law and regulations, the Director, Bureau of Prisons, has certified that this rule, for the purpose of the Regulatory Flexibility Act (Pub. L. 96-354), does not have a significant impact on a substantial number of small entities.

List of Subjects in 28 CFR Part 541

Prisoners.

Conclusion

Accordingly, pursuant to the rulemaking authority vested in the Attorney General in 5 U.S.C. 552(a) and delegated to the Director, Bureau of Prisons in 28 CFR 0.96(q), 28 CFR, Chapter V is amended by adding a new Subpart E to Part 541.

Dated: October 2, 1987.

J. Michael Quinlan,

Director.

SUBCHAPTER C—INSTITUTIONAL MANAGEMENT

PART 541—INMATE DISCIPLINE AND SPECIAL HOUSING UNITS

I. The authority citation for Part 541 is revised to read as follows:

Authority: 5 U.S.C. 301; 18 U.S.C. 4001, 4042, 4081, 4082, 4161-4166, 5006-5024, 5039; 28 U.S.C. 509, 510; 28 CFR 0.95-0.99.

II. Part 541 is amended by adding a new Subpart E to read as follows:

Subpart E—Procedures for Handling of HIV Positive Inmates Who Pose Danger to Others

Sec.

541.60 Purpose and scope.
541.61 Standard for placement in controlled housing status.
541.62 Referral for placement.
541.63 Hearing procedure.
541.64 Decision of the Hearing Administrator.
541.65 Regional Director review and appeal.
541.66 Programs and services.
541.67 Review of controlled housing status.
541.68 Release from controlled housing status.

Subpart E—Procedures for Handling of HIV Positive Inmates Who Pose Danger to Others

§ 541.60 Purpose and scope.

In an effort to maintain a safe and orderly environment within its institutions, the Bureau of Prisons may place in controlled housing status an inmate who tests HIV positive when there is reliable evidence that the inmate may engage in conduct posing a health risk to another person.

§ 541.61 Standard for placement in controlled housing status.

An inmate may be placed in a controlled housing status when there is reliable evidence causing staff to believe that the inmate may engage in conduct posing a health risk to others. This evidence may be the inmate's behavior, or statements of the inmate, or other reliable evidence.

§ 541.62 Referral for placement.

(a) The Warden shall consider an inmate for controlled housing status when the inmate has been confirmed as testing HIV positive and when there is reliable evidence indicating that the inmate may engage in conduct posing a health risk to others. This evidence may come from the statements of the individual, repeated misconduct (including disciplinary actions), or other behavior suggesting that the inmate may engage in predatory or promiscuous sexual behavior, assaultive behavior where body fluids may be transmitted to another, or the sharing of needles.

(b) The Warden shall submit a recommendation for referral of an inmate for placement in a controlled housing status to the Regional Director in the region where the inmate is located.

(c) Based on the perceived health risk to others posed by the inmate's threatened or actual actions, the Warden may, with the telephonic approval of the Regional Director, temporarily (not to exceed 20 work days) place an inmate in a special housing status (e.g., administrative detention, or a secure hospital room), pending the inmate's appearance before the Hearing Administrator. Reasons for this placement, and the approval of the Regional Director, shall be documented in the inmate central file. The inmate should be seen daily by case management and medical staff while in this temporary status, and a psychological or psychiatric assessment report should be prepared during this temporary placement period.

§ 541.63 Hearing procedure.

(a) The Regional Director in the region where the inmate is located shall review the institution's recommendation for referral of an inmate for controlled housing status. If the Regional Director concurs with the recommendation, the Regional Director shall designate a person in the Regional Office or a person at department head level or above in the institution to conduct a hearing on the appropriateness of an inmate's placement in controlled housing status. This Hearing Administrator shall have correctional experience, no former personal involvement in the instant situation, and a knowledge of the type of behavior that poses a health risk to others, and of the options available for dealing with an inmate who poses such a health risk to others.

(b) The Hearing Administrator shall provide a hearing to an inmate recommended for controlled housing status. The hearing ordinarily shall take place at the institution housing the inmate.

(c) The hearing shall proceed as follows:

(1) Staff shall provide an inmate with an advance written notice of the hearing and a copy of this rule at least 24 hours prior to the hearing. The notice will advise the inmate of the specific act(s) or other evidence which forms the basis for a recommendation that the inmate be placed in a controlled housing status, unless such evidence would likely endanger staff or others. If an inmate is illiterate, staff shall explain the notice and this rule to the inmate and document that this explanation has occurred.

(2) The Hearing Administrator shall upon request of the inmate provide an inmate the service of a full-time staff member to represent the inmate. The Hearing Administrator shall document in the record of the hearing an inmate's request for, or refusal of staff representation. The inmate may select a staff representative from the local institution. If the selected staff member declines for good reason or is unavailable, the inmate has the option of selecting another representative or, in the case of an absent staff member, of waiting a reasonable period (determined by the Hearing Administrator) for the staff member's return, or of proceeding without a staff representative. When an inmate is illiterate, the Warden shall provide a staff representative. The staff representative shall be available to assist the inmate and, if the inmate desires, shall contact witnesses and present favorable evidence at the hearing. The Hearing Administrator shall afford the staff representative adequate time to speak with the inmate and to interview available witnesses.

(3) The inmate has the right to be present throughout the hearing, except where institutional security or good order is jeopardized. The Hearing Administrator may conduct a hearing in the absence of the inmate when the inmate refuses to appear. The Hearing Administrator shall document an inmate's refusal to appear, or other reason for non-appearance, in the record of the hearing.

(4) The inmate is entitled to present documentary evidence and to have witnesses appear, provided that calling witnesses would not jeopardize or threaten institutional security or individual safety, and further provided that the witnesses are available at the institution where the hearing is being conducted.

(i) The evidence to be presented must be material and relevant to the issue as to whether the inmate can and would pose a health risk to others, if allowed to remain in general prison population. This evidence may come from the statements of the individual, repeated misconduct (including disciplinary actions), or other behavior suggesting that the inmate may engage in predatory or promiscuous sexual behavior, assaultive behavior where body fluids may be transmitted to others, or the sharing of needles.

(ii) Repetitive witnesses need not be called. Staff who recommend placement in a controlled housing status are not required to appear, provided their recommendation is fully explained in the record.

(iii) When a witness is not available within the institution, or not permitted to appear, the inmate may submit a written statement by that witness. The Hearing Administrator shall, upon the inmate's request, postpone any decision following the hearing for a reasonable time to permit the obtaining and forwarding of written statements.

(iv) The Hearing Administrator shall document in the record of the hearing the reasons for declining to hear a witness or to receive documentary evidence.

§ 541.64 Decision of the Hearing Administrator.

(a) At the conclusion of the hearing and following review of all material related to the recommendation for placement of an inmate in a controlled housing status, the Hearing Administrator shall prepare a written decision as to whether this placement is warranted. The Hearing Administrator shall:

(1) Prepare a summary of the hearing and of all information presented upon which the decision is based; and

(2) Indicate the specific reasons for the decision, to include a description of the act, or series of acts, or other reliable evidence on which the decision is based, along with evidence of the inmate's HIV positive status.

(b) The Hearing Administrator shall advise the inmate in writing of the decision. The inmate shall receive the information described in paragraph (a) of this section unless it is determined that the release of this information could pose a threat to individual safety, or institutional security, in which case that limited information may be withheld. The Hearing Administrator shall advise the inmate that the decision will be submitted for review of the Regional Director in the region where the inmate is located. The Hearing Administrator shall advise the inmate that, if the inmate so desires, the inmate may submit an appeal of the Hearing Administrator's decision to the Regional Director. This appeal, with supporting documentation and reasons, must be filed within five working days of the inmate's receipt of the Hearing Administrator's decision.

(c) The Hearing Administrator may order the continuation of the inmate in special housing pending review by the Regional Director. The Hearing Administrator should state the reasons for this order in the record of the Hearing.

(d) The Hearing Administrator shall send the decision, whether for or against placement in a controlled housing status, and supporting documentation to the Regional Director. Ordinarily, this is done within 20 working days after conclusion of the hearing. Any reason for extension is to be documented.

§ 541.65 Regional Director review and appeal.

(a) The Regional Director shall review the decision and supporting documentation of the Hearing Administrator and, if submitted, the information contained in an inmate's appeal. The Regional Director shall accept or reject the Hearing Administrator's decision within 30 working days of its receipt, unless for good cause there is reason for delay, which shall be documented in the record. The authority of the Regional Director may not be delegated below the level of acting Regional Director.

(b) The Regional Director shall provide a copy of his decision to the Warden at the institution housing the inmate, to the inmate, and to the Hearing Administrator.

(c) An inmate may appeal a decision of the Regional Director, through the Administrative Remedy Procedure, directly to the Office of General Counsel, Bureau of Prisons, within 30 calendar days of the inmate's receipt of the Regional Director's decision.

§ 541.66 Programs and services.

To the extent consistent with available resources and the security needs of the institution, an inmate in controlled housing status is to be considered for activities and privileges afforded to the general population. This includes, but is not limited to, providing an inmate with the opportunity for participation in an education program, library services, counseling, and religious guidance, as well as access to case management, medical and mental health assistance, and legal services, including access to the institution's law libraries. An inmate in controlled housing status should be afforded at least five hours weekly recreation and exercise out of the cell. The recreation shall be by himself or under close supervision. Unless there are compelling reasons to the contrary, institutions shall provide commissary privileges and reasonable amounts of personal property. The Warden may restrict for reasons of security, fire safety, or housekeeping the amount of personal property that an inmate may retain while in controlled housing status. An inmate shall be permitted to have a radio, provided it is equipped with ear plugs. Visits shall be carefully monitored.

§ 541.67 Review of controlled housing status.

(a) Staff designated by the Warden shall evaluate regularly an inmate's adjustment while in controlled housing status. A medical staff member shall see the inmate daily, and regularly record medical and behavorial impressions. Once every 90 days, staff, comprised of a correctional and case management supervisor, and a member of the medical staff, shall meet with the inmate. The inmate is required to attend this meeting in order to be considered for release to the general population. Any refusal by the inmate to attend this meeting will be documented. Staff, at this meeting, shall make an assessment of the inmate's adjustment while in controlled housing and the likely health threat the inmate poses to others by his actions.

(b) The Warden shall serve as the review authority at the institutional level, and shall make a recommendation to the Regional Director when he believes the inmate should be considered for release from controlled housing.

(c) An inmate may appeal a Warden's decision not to recommend release from controlled housing to the Regional Director within five working days of receipt of that decision.

(d) Upon recommendation of the Warden, or upon appeal from the inmate, the Regional Director may decide whether or not to release the inmate to general population from controlled housing status.

(e) An inmate may appeal a decision of the Regional Director, through the Administrative Remedy Procedure, directly to the Office of General Counsel, Bureau of Prisons within 30 calendar days from the date of the Regional Director's decision.

§ 541.68 Release from controlled housing status.

(a) Only the Regional Director may release an inmate from controlled housing status. The following factors are considered in the evaluation of an inmate's readiness for return to the general population:

(1) Relationships with other inmates and staff members, which demonstrate that the inmate is able to function in a less restrictive environment without posing a health threat to others or to the orderly operation of the institution;

(2) Involvement in work and recreational activities and assignments or other programs; and

(3) Adherence to institution guidelines and Bureau of Prisons rules and policy.

(b) An inmate released from a controlled housing status may be returned to the general population of that institution, or to another federal or non-federal institution.

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CENTERS FOR DISEASE CONTROL

June 24 1988 Vol 37 No 24

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

377 Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings
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Perspectives in Disease Prevention and Health Promotion

Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings

Introduction

The purpose of this report is to clarify and supplement the CDC publication entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*).*

In 1983, CDC published a document entitled "Guideline for Isolation Precautions in Hospitals" (*2*) that contained a section entitled "Blood and Body Fluid Precautions." The recommendations in this section called for blood and body fluid precautions when a patient was known or suspected to be infected with bloodborne pathogens. In August 1987, CDC published a document entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*). In contrast to the 1983 document, the 1987 document recommended that blood and body fluid precautions be consistently used for all patients regardless of their bloodborne infection status. This extension of blood and body fluid precautions to all patients is referred to as "Universal Blood and Body Fluid Precautions" or "Universal Precautions." Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens.

*The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.

Copies of this report and of the *MMWR* supplement entitled *Recommendations for Prevention of HIV Transmission in Health-Care Settings* published in August 1987 are available through the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850.

Update HIV – Continued

Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposures of health-care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood (*3,4*).

Since the recommendations for universal precautions were published in August 1987, CDC and the Food and Drug Administration (FDA) have received requests for clarification of the following issues: 1) body fluids to which universal precautions apply, 2) use of protective barriers, 3) use of gloves for phlebotomy, 4) selection of gloves for use while observing universal precautions, and 5) need for making changes in waste management programs as a result of adopting universal precautions.

Body Fluids to Which Universal Precautions Apply

Universal precautions apply to blood and to other body fluids containing visible blood. Occupational transmission of HIV and HBV to health-care workers by blood is documented (*4,5*). **Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV, and other bloodborne pathogens must focus on preventing exposures to blood as well as on delivery of HBV immunization.**

Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV and HBV, they have not been implicated in occupational transmission from patient to health-care worker. This observation is not unexpected, since exposure to semen in the usual health-care setting is limited, and the routine practice of wearing gloves for performing vaginal examinations protects health-care workers from exposure to potentially infectious vaginal secretions.

Universal precautions also apply to tissues and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk of transmission of HIV and HBV from these fluids is unknown; epidemiologic studies in the health-care and community setting are currently inadequate to assess the potential risk to health-care workers from occupational exposures to them. However, HIV has been isolated from CSF, synovial, and amniotic fluid (*6–8*), and HBsAg has been detected in synovial fluid, amniotic fluid, and peritoneal fluid (*9–11*). One case of HIV transmission was reported after a percutaneous exposure to bloody pleural fluid obtained by needle aspiration (*12*). Whereas aseptic procedures used to obtain these fluids for diagnostic or therapeutic purposes protect health-care workers from skin exposures, they cannot prevent penetrating injuries due to contaminated needles or other sharp instruments.

Body Fluids to Which Universal Precautions Do Not Apply

Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. The risk of transmission of HIV and HBV from these fluids and materials is extremely low or nonexistent. HIV has been isolated and HBsAg has been demonstrated in some of these fluids; however, epidemiologic studies in the health-care and community setting have not implicated these fluids or materials in the transmission of HIV and HBV infections (*13,14*). Some of the above fluids and excretions represent a potential source for nosocomial and community-acquired infections with other pathogens, and recommendations for preventing the transmission of nonbloodborne pathogens have been published (*2*).

Update HIV - Continued

Precautions for Other Body Fluids in Special Settings

Human breast milk has been implicated in perinatal transmission of HIV, and HBsAg has been found in the milk of mothers infected with HBV (*10,13*). However, occupational exposure to human breast milk has not been implicated in the transmission of HIV nor HBV infection to health-care workers. Moreover, the health-care worker will not have the same type of intensive exposure to breast milk as the nursing neonate. Whereas universal precautions do not apply to human breast milk, gloves may be worn by health-care workers in situations where exposures to breast milk might be frequent, for example, in breast milk banking.

Saliva of some persons infected with HBV has been shown to contain HBV-DNA at concentrations 1/1,000 to 1/10,000 of that found in the infected person's serum (*15*). HBsAg-positive saliva has been shown to be infectious when injected into experimental animals and in human bite exposures (*16–18*). However, HBsAg-positive saliva has not been shown to be infectious when applied to oral mucous membranes in experimental primate studies (*18*) or through contamination of musical instruments or cardiopulmonary resuscitation dummies used by HBV carriers (*19,20*). Epidemiologic studies of nonsexual household contacts of HIV-infected patients, including several small series in which HIV transmission failed to occur after bites or after percutaneous inoculation or contamination of cuts and open wounds with saliva from HIV-infected patients, suggest that the potential for salivary transmission of HIV is remote (*5,13,14,21,22*). One case report from Germany has suggested the possibility of transmission of HIV in a household setting from an infected child to a sibling through a human bite (*23*). The bite did not break the skin or result in bleeding. Since the date of seroconversion to HIV was not known for either child in this case, evidence for the role of saliva in the transmission of virus is unclear (*23*). Another case report suggested the possibility of transmission of HIV from husband to wife by contact with saliva during kissing (*24*). However, follow-up studies did not confirm HIV infection in the wife (*21*).

Universal precautions do not apply to saliva. General infection control practices already in existence — including the use of gloves for digital examination of mucous membranes and endotracheal suctioning, and handwashing after exposure to saliva — should further minimize the minute risk, if any, for salivary transmission of HIV and HBV (*1,25*). Gloves need not be worn when feeding patients and when wiping saliva from skin.

Special precautions, however, are recommended for dentistry (*1*). Occupationally acquired infection with HBV in dental workers has been documented (*4*), and two possible cases of occupationally acquired HIV infection involving dentists have been reported (*5,26*). During dental procedures, contamination of saliva with blood is predictable, trauma to health-care workers' hands is common, and blood spattering may occur. Infection control precautions for dentistry minimize the potential for nonintact skin and mucous membrane contact of dental health-care workers to blood-contaminated saliva of patients. In addition, the use of gloves for oral examinations and treatment in the dental setting may also protect the patient's oral mucous membranes from exposures to blood, which may occur from breaks in the skin of dental workers' hands.

Use of Protective Barriers

Protective barriers reduce the risk of exposure of the health-care worker's skin or mucous membranes to potentially infective materials. For universal precautions,

Update. HIV – Continued

protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gloves should reduce the incidence of contamination of hands, but they cannot prevent penetrating injuries due to needles or other sharp instruments. Masks and protective eyewear or face shields should reduce the incidence of contamination of mucous membranes of the mouth, nose, and eyes.

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using gloves to prevent gross microbial contamination of hands (*27*). Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised.

The risk of nosocomial transmission of HIV, HBV, and other bloodborne pathogens can be minimized if health-care workers use the following general guidelines:[†]

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.
2. Use protective barriers to prevent exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

Glove Use for Phlebotomy

Gloves should reduce the incidence of blood contamination of hands during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments. The likelihood of hand contamination with blood containing HIV, HBV, or other bloodborne pathogens during phlebotomy depends on several factors: 1) the skill and technique of the health-care worker, 2) the frequency with which the health-care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health-care worker who performs more procedures), 3) whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely), and 4) the prevalence of infection with bloodborne pathogens in the patient population. The likelihood of infection after skin exposure to blood containing HIV or HBV will depend on the concentration of virus (viral concentration is much higher for hepatitis B than for HIV), the duration of contact, the presence of skin lesions on the hands of the health-care worker, and – for HBV – the immune status of the health-care worker. Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is certainly much less than the 0.5% risk following percutaneous

[†]The August 1987 publication should be consulted for general information and specific recommendations not addressed in this update.

Update: HIV – Continued

needlestick exposures (*5*). In universal precautions, *all* blood is assumed to be potentially infective for bloodborne pathogens, but in certain settings (e.g., volunteer blood-donation centers) the prevalence of infection with some bloodborne pathogens (e.g., HIV, HBV) is known to be very low. Some institutions have relaxed recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of bloodborne pathogens is known to be very low.

Institutions that judge that routine gloving for *all* phlebotomies is not necessary should periodically reevaluate their policy. Gloves should always be available to health-care workers who wish to use them for phlebotomy. In addition, the following general guidelines apply:

1. Use gloves for performing phlebotomy when the health-care worker has cuts, scratches, or other breaks in his/her skin.
2. Use gloves in situations where the health-care worker judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative patient.
3. Use gloves for performing finger and/or heel sticks on infants and children.
4. Use gloves when persons are receiving training in phlebotomy.

Selection of Gloves

The Center for Devices and Radiological Health, FDA, has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or nonsterile examination gloves made of vinyl or latex. General purpose utility ("rubber") gloves are also used in the health-care setting, but they are not regulated by FDA since they are not promoted for medical use. There are no reported differences in barrier effectiveness between intact latex and intact vinyl used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed.

The following general guidelines are recommended:

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
3. Change gloves between patient contacts.
4. Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.
5. Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.

Waste Management

Universal precautions are not intended to change waste management programs previously recommended by CDC for health-care settings (*1*). Policies for defining, collecting, storing, decontaminating, and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information

Update: HIV ... (continued)

regarding waste management regulations in health care settings may be obtained from state or local health departments or agencies responsible for waste management.

Reported by: Center for Devices and Radiological Health, Food and Drug Administration; Hospital Infections Program, AIDS Program, and Hepatitis Br, Div of Viral Diseases, Center for Infectious Diseases, National Institute for Occupational Safety and Health, CDC.

Editorial Note: Implementation of universal precautions does not eliminate the need for other category- or disease-specific isolation precautions, such as enteric precautions for infectious diarrhea or isolation for pulmonary tuberculosis (*1,2*). In addition to universal precautions, detailed precautions have been developed for the following procedures and/or settings in which prolonged or intensive exposures to blood occur: invasive procedures, dentistry, autopsies or morticians' services, dialysis, and the clinical laboratory. These detailed precautions are found in the August 21, 1987, "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (*1*). In addition, specific precautions have been developed for research laboratories (*28*).

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Epidemiologic Notes and Reports

Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers

Acquired immunodeficiency syndrome (AIDS) among health-care workers in the United States results primarily from human immunodeficiency virus (HIV) infections that occur outside of the health-care setting. However, a small number of health-care workers have been infected with HIV through occupational exposures, and one such worker has developed AIDS after documented seroconversion. This report summarizes and updates both national surveillance data for AIDS among health-care workers and data from prospective studies on the risk of HIV transmission in the health-care setting.

Health-Care Workers with AIDS

The AIDS case report form used by CDC requests that state and local health departments collect information on employment since 1978 in a health-care or clinical laboratory setting. For surveillance purposes, any person who indicates such employment is classified as a health-care worker.

As of March 14, 1988, a total of 55,315 adults with AIDS had been reported to CDC. Occupational information was available for 47,532 of these persons, 2,586 (5.4%) of whom were classified as health-care workers. A similar proportion (5.7%) of the U.S. labor force was employed in health services (*1*).

Forty-six states, the District of Columbia, and Puerto Rico have reported health-care workers with AIDS. Like other AIDS patients, health-care workers with AIDS had a median age of 35 years. Males accounted for 91.6% of health-care workers with AIDS and 92.4% of other patients with AIDS. The majority of health-care workers with AIDS (62.8%) and of other AIDS patients (60.5%) were white.

Ninety-five percent of the health-care workers with AIDS were classified into known transmission categories (Table 1). Health-care workers with AIDS were significantly less likely than others with AIDS to be intravenous drug abusers and more likely to be homosexual or bisexual men. They were also less likely to have a known risk factor reported ($p < 0.001$).

AIDS and HIV – Continued

To determine the possible cause of HIV infection, state and local health departments investigate those AIDS patients reported as having no identified risk. As of March 14, 1988, investigations had been completed for 121 of the 215 health-care workers initially reported with undetermined risk. Risk factors were identified for 80 (66.1%) of these. Of the 135 health-care workers who remain in the undetermined-risk category, 41 (30.4%) could not be reclassified after follow-up; 20 (14.8%) had either died or refused to be interviewed; and 74 (54.8%) are still under investigation.

Overall, 5.3% of health-care workers with AIDS had an undetermined risk. When examined by year of report to CDC, the proportion of such health-care workers appears to have increased from 1.5% in 1982 to 6.2% in 1987. However, 71 of the 135 health-care workers for whom risk is still undetermined have been reported since March 1987, and 80.0% of these 71 cases are still under investigation. The proportion of other AIDS patients with an undetermined risk has also increased over time. However, previous experience suggests that other risk factors for HIV infection will be identified for many of these persons when investigations have been completed (*2*). Ten percent of all reported AIDS patients with undetermined risk are health-care workers; this proportion has not changed over time.

A health-care worker reported to have developed AIDS after a well-documented occupational exposure to blood and HIV seroconversion is included among the 80 health-care workers who were reclassified after follow-up. The worker was accidentally self-injected with several milliliters of blood from a hospitalized patient with AIDS while filling a vacuum collection tube. Investigation revealed no other risk factors for this health-care worker.

Forty-one health-care workers could not be reclassified after investigation; 68.3% were men. In contrast, 23.0% of individuals employed in hospitals and health services in the United States are men (*1*). These 41 health-care workers comprised eight physicians, four of whom were surgeons; one dentist; five nurses; eleven nursing assistants or orderlies; seven housekeeping or maintenance workers; four clinical laboratory technicians; one respiratory therapist; one paramedic; one mortician; and two others who had no contact with patients or clinical specimens. A comparison of

TABLE 1. Comparison of health-care workers with AIDS and other AIDS patients reported to CDC, by transmission category – through March 14, 1988

Transmission Category	Health-Care Workers with AIDS		Other AIDS Patients	
	No.	(%)	No.	(%)
Homosexual or Bisexual Male	1,916	(74.1)*	28,820	(64.1)
Heterosexual Intravenous Drug Abuser	161	(6.2)*	8,263	(18.4)
Homosexual or Bisexual Male and Intravenous Drug Abuser	187	(7.2)	3,267	(7.3)
Hemophilia/Coagulation Disorder	20	(0.8)	451	(1.0)
Heterosexual	119	(4.6)	1,772	(3.9)
Blood/Blood Component Recipient	47	(1.8)	1,105	(2.5)
Other†	1	(<1.0)	0	(0.0)
Undetermined§	135	(5.3)*	1,268	(2.8)
Total	**2,586**	**(100.0)**	**44,946**	**(100.0)**

*$p<0.001$, chi square analysis.

†Represents health-care worker who seroconverted to HIV and developed AIDS after documented needlestick exposure to blood.

§Includes patients who are under investigation, who died or refused interview, or for whom no risk was identified after follow-up.

AIDS and HIV – Continued

the occupations of these 41 health-care workers with those of health-care workers for whom risk factors and job information were available showed that maintenance workers were the only occupational group significantly more likely to have an undetermined risk (7 [17.1%] of 41 health-care workers with undetermined risk, compared with 160 (7.1%] of 2,263 health-care workers with identified risk, p = 0.02).

Seventeen of the 41 investigated health-care workers with undetermined risk (including two of the seven maintenance workers) reported needlestick and/or mucous-membrane exposures to the blood or body fluids of patients during the 10 years preceding their diagnosis of AIDS. However, none of the patients was known to be infected with HIV at the time of exposure, and none of the health-care workers was evaluated at the time of exposure to document seroconversion to HIV antibody. None of the remaining 24 health-care workers reported needlestick or other nonparenteral exposures to blood or body fluids.

Other Health-Care and Laboratory Workers with HIV Infection

As of December 31, 1987, 1,176 health-care workers had been enrolled and tested for HIV antibody in ongoing CDC surveillance of health-care workers exposed to blood or other body fluids from HIV-infected patients. Of the 1,070 workers tested ≥90 days after exposure, 870 (81.3%) had parenteral exposures to blood; 104 (9.7%) had exposures of mucous membrane or nonintact skin to blood; and 96 (9.0%) had exposures to other body fluids (Table 2).

Four (0.5%) of the 870 workers with parenteral exposures to blood were seropositive for HIV antibody (upper bound of the 95% confidence interval [CI] = 1.1%). However, one of these four was not tested until 10 months after exposure (*3,4*). In addition, this worker had an HIV-seropositive sexual partner, and heterosexual acquisition of infection could not be excluded. Of the 489 health-care workers who sustained parenteral exposures to blood and for whom both acute- and convalescent-phase serum samples had been obtained, three, or 0.6%, seroconverted to HIV within 6 months of exposure (upper bound of the 95% CI = 1.6%) (*4-6*). Investigation revealed no nonoccupational risk factors for these three workers.

Two other ongoing prospective studies assess the risk of nosocomial acquisition of HIV infection among health-care workers in the United States (*7,8*). As of April 30, 1987, the National Institutes of Health had tested 103 health-care workers with documented needlestick injuries and 691 health-care workers with more than 2,000 cutaneous or mucous-membrane exposures to blood or other body fluids of

TABLE 2. HIV infection among health-care workers, by type of exposure and body fluid – CDC Prospective Study, August 15, 1983–December 31, 1987

Type of Exposure	No. of Health-Care Workers with Exposure to				No. of Infections
	Blood	Saliva	Urine	Other/Unknown	
Parenteral (needlestick or cut with sharp object)	870	7	3	21	4*
Contamination of mucous-membrane, open wound, or nonintact skin	104	42	12	11	0

*All four health-care workers had parenteral exposure to HIV-infected blood; risk is 4/870, or 0.5% (upper bound of 95% confidence interval = 1.1%).

AIDS and HIV – Continued

HIV-infected patients; none had seroconverted (*7*). As of March 15, 1988, a similar study at the University of California of 235 health-care workers with 644 documented needlestick injuries or mucous-membrane exposures had identified one seroconversion following a needlestick (*9*; University of California, San Francisco, unpublished data). Prospective studies in the United Kingdom and Canada show no evidence of HIV transmission among 220 health-care workers with parenteral, mucous-membrane, or cutaneous exposures (*10,11*).

In addition to the health-care workers enrolled in these longitudinal surveillance studies and the case reported here, six persons from the United States and four persons from other countries who denied other risk factors for HIV infection have reportedly seroconverted to HIV after parenteral, nonintact skin, or mucous-membrane exposures to HIV-infected blood or concentrated virus in a health-care or laboratory setting (Table 3) (*12-20*). Six additional health-care workers with no other identified risk factors reportedly acquired HIV infection, but the date of seroconversion is unknown (*3,15,21-23*).

Reported by: AIDS Program, Hospital Infections Program, Center for Infectious Diseases, CDC.

Editorial Note: These data are consistent with previous observations that the occupational risk of acquiring HIV in health-care settings is low and is most often associated with percutaneous inoculation of blood from a patient with HIV infection. Prospective surveillance studies, which provide data on the magnitude of the risk of HIV infection, indicate that the risk of seroconversion following needlestick exposures to blood from HIV-infected patients is less than 1.0%. The level of risk associated with the exposure of nonintact skin or mucous membranes is likely far less than that associated with needlestick exposures. Individual published case reports must be interpreted with caution because they provide no data on the frequency of occupational exposures to HIV or the proportion of exposures resulting in seroconversion.

The reasons that a higher proportion of health-care workers with AIDS have no identified risk than do other persons with AIDS are unknown. They could include a tendency of health-care workers not to report behavioral risk factors for HIV infection, the occupational risk of HIV infection as a result of blood exposure, or both. The first hypothesis is suggested by the overrepresentation of men among these health-care workers, a finding that is similar to the overrepresentation of men among AIDS patients infected with HIV through sexual activity or intravenous drug abuse. The second hypothesis is suggested by the documentation of HIV transmission in the health-care setting. Similar hypotheses may be raised for the apparent excess of maintenance personnel among health-care workers with no identified risk for AIDS. Occupationally acquired HIV infection in such workers would be difficult to determine unless the source patient or clinical specimen was known to be HIV-positive, the occupational exposure had been well documented, and the HIV seroconversion of the health-care worker had been detected.

The increasing number of persons being treated for HIV-associated illnesses makes it likely that more health-care workers will encounter patients infected with HIV. The risk of transmission of HIV can be minimized if health-care workers use care while performing all invasive procedures, adhere rigorously to previously published recommendations, and use universal precautions when caring for all patients (*5*). In addition, employers should instruct health-care workers on the need for routine use of universal precautions, provide equipment and clothing necessary to minimize the risk of infection, and monitor workers' adherence to these precautions (*5,24*).

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TABLE 3. HIV-infected health-care workers with no reported nonoccupational risk factors and for whom case histories have been published in the scientific literature

Cases with Documented Seroconversion					
Case	**Occupation**	**Country**	**Type of Exposure**	**Source**	**Reference**
1*	NS†	United States	Needlestick	AIDS patient	This report
2	NS	United States	Needlestick	AIDS patient	(4,6)
3	NS	United States	Needlestick	AIDS patient	(5)
4	NS	United States	2 Needlesticks	AIDS patient, HIV-infected patient	(5)
5	NS	United States	Needlestick	AIDS patient	(9)
6	Nurse	England	Needlestick	AIDS patient	(12)
7	Nurse	France	Needlestick	HIV-infected patient	(13)
8	Nurse	Martinique	Needlestick	AIDS patient	(14)
9	Research lab worker	United States	Cut with sharp object	Concentrated virus	(15,16)
10	Home health-care provider	United States	Cutaneous§	AIDS patient	(17)
11	NS	United States	Nonintact skin	AIDS patient	(18)
12	Phlebotomist	United States	Mucous-membrane	HIV-infected patient	(18)
13	Technologist	United States	Nonintact skin	HIV-infected patient	(18)
14	NS	United States	Needlestick	AIDS patient	(19)
15	Nurse	Italy	Mucous-membrane	HIV-infected patient	(20)

Cases without Documented Seroconversion					
Case	**Occupation**	**Country**	**Type of Exposure**	**Source**	**Reference**
1	NS	United States	Puncture wound	AIDS patient	(3,4)
2	NS	United States	2 Needlesticks	2 AIDS patients	(3)
3	Research lab worker	United States	Nonintact skin	Concentrated virus	(15,16)
4	Home health-care provider	England	Nonintact skin	AIDS patient	(21)
5	Dentist	United States	Multiple needlesticks	Unknown	(22)
6*	Technician	Mexico	Multiple needle-sticks and mucous-membrane	Unknown	(23)
7	Lab worker	United States	Needlestick, puncture wound	Unknown	(3)

*Health-care worker diagnosed with AIDS.
†NS = not specified.
§Mother who provided nursing care for her child with HIV infection; extensive contact with the child's blood and body secretions and excretions occurred; the mother did not wear gloves and often did not wash her hands immediately after exposure.

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MINNESOTA OSHA
AIDS Issues
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The purpose of Minnesota's Occupational Safety and Health (OSHA) program is to ensure that workplaces are safe and healthful for working people. The OSHA program, which is in the Department of Labor and Industry, enforces the Federal OSHA regulations, some "localizing" state OSHA standards, and the state Employee Right-to-Know Act. The program covers private and public employers and is partially funded with federal funds. Thirty-two safety investigators and fourteen industrial hygienists conduct about 6,000 unannounced inspections each year. Inspection sites are based on employee complaints, locations where accidents occur, and statistical information obtained from the workers' compensation injury records. Following an inspection, citations describing the unsafe or unhealthful conditions are issued to the employer and penalties may be associated with the more significant violations. Followup investigations are conducted to assure that compliance with the citations has been accomplished.

The OSHA program includes a provision that no employee is ever expected to work under significantly unsafe or unhealthful work conditions. If the employee has a reasonable belief that work conditions are "imminently dangerous", they can refuse to work, notify the employer, and have the dangerous conditions corrected. If there is a dispute between the employer and employee, Minnesota OSHA will conduct a discrimination investigation and resolve the conflict. There is also a "General Duty Clause" which OSHA uses to cite obvious and serious violations of good safety or health practices where there is not a specific standard.

In 1983 the Minnesota Employee Right-to-Know Act was passed and blended directly into the Minnesota OSHA program. The main thrust of this Act is to increase knowledge of how to work safely with chemicals. The Act also includes worker exposure to infectious agents in hospitals and clinics. AIDS is one of those infectious agents that is specifically addressed. Minnesota OSHA has conducted investigations in hospitals and clinics and has issued citations requiring that employees be furnished written information and training on how to deal with AIDS in the workplace. We believe the Right-to-Know legislation will be changed in 1988 to include infectious agents coverage in workplaces other than hospitals and clinics.

Federal OSHA does not have jurisdiction in Minnesota other than to monitor the Minnesota OSHA program. Just recently, they mailed about 450,000 packets of information to health care facilities throughout the United States. That packet included the Centers for Disease Control guidelines and suggested methods of dealing with blood-borne diseases in health care facilities. This information is similar to the background information we, in Minnesota OSHA, use.

Minnesota OSHA has some specific standards that can be applied in some workplaces and has established a Division Operating Policy for dealing with AIDS exposure in several other work settings.

1. Frequently, there is a question in employee's minds about working with another employee who has AIDS. We do not believe this to be a problem, nor do we require employers to provide that information to their employees, since AIDS is not transmitted through casual contact which is the only "routine exposure" which should occur.

2. Employees in hospitals and clinics are specifically covered by the Right-to-Know Act and we will require hospitals and clinics to have an effective infection control program. We will use the guidelines handed out by the Centers for Disease Control.

3. Employees in nursing care centers who care for AIDS patients must have the same protection as employees in hospitals and clinics. The Right-to-Know Act does not specifically cover nursing care centers but we can and will use the Minnesota OSHA General Duty Clause to require the same training and protection for these employees.

4. Emergency response team personnel (police, firefighters, medical responders, etc.) must also be provided with training and personal protective equipment so they are protected from this infectious agent. Again, we will use the General Duty Clause since there is not a specific standard.

5. Another group of employees who have potential AIDS exposure problems are correctional officers. These employees must also be provided with information and training and must be furnished with necessary personal protective equipment. The General Duty Clause will apply.

completed, the name of the reporter shall be confidential but shall be accessible to the individual subject of the record upon court order.

Notwithstanding sections 138.163 and 138.17, records maintained by local welfare agencies, the police department or county sheriff under this section shall be destroyed as described in clauses (a) to (d):

(a) If upon assessment or investigation a report is found to be false, notice of intent to destroy records of the report shall be mailed to the individual subject of the report. At the subject's request the records shall be maintained as private data. If no request from the subject is received within 30 days of mailing the notice of intent to destroy, the records shall be destroyed.

(b) All records relating to reports which, upon assessment or investigation, are found to be substantiated shall be destroyed seven years after the date of the final entry in the case record.

(c) All records of reports which, upon initial assessment or investigation, cannot be substantiated or disproved to the satisfaction of the local welfare agency, local police department or county sheriff may be kept for a period of one year. If the local welfare agency, local police department or county sheriff is unable to substantiate the report within that period, each agency unable to substantiate the report shall destroy its records relating to the report in the manner provided by clause (a).

(d) Any notification of intent to interview which was received by a school under subdivision 10, paragraph (c), shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

Subd. 11a. **Disclosure of information not required in certain cases.** When interviewing a minor under subdivision 10, an individual does not include the parent or guardian of the minor for purposes of section 13.04, subdivision 2, when the parent or guardian is the alleged perpetrator of the abuse or neglect.

Subd. 12. **Duties of facility operators.** Any operator, employee, or volunteer worker at any facility who intentionally neglects, physically abuses, or sexually abuses any child in the care of that facility may be charged with a violation of section 609.255, 609.377, or 609.378. Any operator of a facility who knowingly permits conditions to exist which result in neglect, physical abuse, or sexual abuse of a child in the care of that facility may be charged with a violation of section 609.23 or 609.378.

Subd. 13. **Application of data practices act.** The classification of reports and records created or maintained for the purposes of this section shall be determined as provided by this section, notwithstanding any other classifications established by chapter 13.

History: *1975 c 221 s 1; 1977 c 130 s 9; 1977 c 212 s 2,3; 1978 c 755 s 1-9; 1979 c 143 s 1; 1979 c 255 s 7; 1980 c 509 s 50,181; 1981 c 240 s 2; 1981 c 273 s 12; 1981 c 311 s 39; 1Sp1981 c 4 art 1 s 15; 1982 c 393 s 1,2; 1982 c 545 s 24; 1982 c 636 s 1-4; 1983 c 217 s 8; 1983 c 229 s 1,2; 1983 c 345 s 13-19; 1984 c 484 s 3; 1984 c 573 s 10; 1984 c 577 s 1-6; 1984 c 588 s 12; 1984 c 654 art 5 s 58; 1984 c 655 art 2 s 14 subd 1; 1985 c 266 s 5-15; 1985 c 283 s 2-4; 1985 c 286 s 19,20; 1985 c 293 s 3-5; 1986 c 351 s 19,20; 1986 c 380 s 3; 1986 c 444; 1986 c 469 s 2; 1Sp1986 c 3 art 1 s 77*

626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.

Subdivision 1. **Public policy.** The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to abuse or neglect; to provide safe institutional or residential services or living environments for vulnerable adults who have been abused or neglected; and to assist persons charged with the care of vulnerable adults to provide safe environments.

In addition, it is the policy of this state to require the reporting of suspected abuse or neglect of vulnerable adults, to provide for the voluntary reporting of abuse or

neglect of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific context indicates otherwise.

(a) "Facility" means a hospital or other entity required to be licensed pursuant to sections 144.50 to 144.58; a nursing home required to be licensed to serve adults pursuant to section 144A.02; an agency, day care facility, or residential facility required to be licensed to serve adults pursuant to sections 245.781 to 245.812; or a home care provider licensed under section 144A.46.

(b) "Vulnerable adult" means any person 18 years of age or older:

(1) who is a resident or inpatient of a facility;

(2) who receives services at or from a facility required to be licensed to serve adults pursuant to sections 245.781 to 245.812, except a person receiving outpatient services for treatment of chemical dependency or mental illness;

(3) who receives services from a home care provider licensed under section 144A.46; or

(4) who, regardless of residence or type of service received, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

(c) "Caretaker" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

(d) "Abuse" means:

(1) any act which constitutes a violation under sections 609.221 to 609.223, 609.23 to 609.235, 609.322, 609.342, 609.343, 609.344, or 609.345;

(2) nontherapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress;

(3) any sexual contact between a facility staff person and a resident or client of that facility;

(4) the illegal use of a vulnerable adult's person or property for another person's profit or advantage, or the breach of a fiduciary relationship through the use of a person or a person's property for any purpose not in the proper and lawful execution of a trust, including but not limited to situations where a person obtains money, property, or services from a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(5) any aversive and deprivation procedures that have not been authorized under section 245.825.

(e) "Neglect" means:

(1) failure by a caretaker to supply a vulnerable adult with necessary food, clothing, shelter, health care or supervision;

(2) the absence or likelihood of absence of necessary food, clothing, shelter, health care, or supervision for a vulnerable adult; or

(3) the absence or likelihood of absence of necessary financial management to protect a vulnerable adult against abuse as defined in paragraph (d), clause (4). Nothing in this section shall be construed to require a health care facility to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

(f) "Report" means any report received by a local welfare agency, police department, county sheriff, or licensing agency pursuant to this section.

(g) "Licensing agency" means:

(1) the commissioner of health, for facilities as defined in clause (a) which are required to be licensed or certified by the department of health;

(2) the commissioner of human services, for facilities required by sections 245.781 to 245.813 to be licensed;

(3) any licensing board which regulates persons pursuant to section 214.01, subdivision 2; and

(4) any agency responsible for credentialing human services occupations.

Subd. 3. **Persons mandated to report.** A professional or the professional's delegate who is engaged in the care of vulnerable adults, education, social services, law enforcement, or any of the regulated occupations referenced in subdivision 2, clause (g)(3) and (4), or an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation, or an employee of or person providing services in a facility who has knowledge of the abuse or neglect of a vulnerable adult, has reasonable cause to believe that a vulnerable adult is being or has been abused or neglected, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained by the history of injuries provided by the caretaker or caretakers of the vulnerable adult shall immediately report the information to the local police department, county sheriff, local welfare agency, or appropriate licensing or certifying agency. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency. The local welfare agency, upon receiving a report, shall immediately notify the local police department or the county sheriff and the appropriate licensing agency or agencies.

A person not required to report under the provisions of this subdivision may voluntarily report as described above. Medical examiners or coroners shall notify the police department or county sheriff and the local welfare department in instances in which they believe that a vulnerable adult has died as a result of abuse or neglect.

Nothing in this subdivision shall be construed to require the reporting or transmittal of information regarding an incident of abuse or neglect or suspected abuse or neglect if the incident has been reported or transmitted to the appropriate person or entity.

Subd. 3a. **Report not required.** (a) Where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected abuse or neglect under Laws 1983, chapter 273, section 3, that person need not make a required report unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected abuse or neglect from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected abuse or neglect shall promptly seek consent to make a report.

(b) Except as defined in subdivision 2, paragraph (d), clause (1), verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior of these persons does not constitute "abuse" for the purposes of subdivision 3 unless it causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior in a manner that facilitates periodic review by licensing agencies and county and local welfare agencies.

(c) Nothing in this section shall be construed to require a report of abuse, as defined in subdivision 2, paragraph (d), clause (4), solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Subd. 4. **Report.** A person required to report under subdivision 3 shall make an oral report immediately by telephone or otherwise. A person required to report under subdivision 3 shall also make a report as soon as possible in writing to the appropriate police department, the county sheriff, local welfare agency, or appropriate licensing agency. The written report shall be of sufficient content to identify the vulnerable adult, the caretaker, the nature and extent of the suspected abuse or neglect, any evidence of previous abuse or neglect, name and address of the reporter, and any other information

that the reporter believes might be helpful in investigating the suspected abuse or neglect. Written reports received by a police department or a county sheriff shall be forwarded immediately to the local welfare agency. The police department or the county sheriff may keep copies of reports received by them. Copies of written reports received by a local welfare department shall be forwarded immediately to the local police department or the county sheriff and the appropriate licensing agency or agencies.

Subd. 5. **Immunity from liability.** (a) A person making a voluntary or mandated report under subdivision 3 or participating in an investigation under this section is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith.

(b) A person employed by a local welfare agency or a state licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with subdivision 10, 11, or 12 or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

Subd. 6. **Falsified reports.** A person who intentionally makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Subd. 7. **Failure to report.** (a) A person required to report by this section who intentionally fails to report is guilty of a misdemeanor.

(b) A person required by this section to report who negligently or intentionally fails to report is liable for damages caused by the failure.

Subd. 8. **Evidence not privileged.** No evidence regarding the abuse or neglect of the vulnerable adult shall be excluded in any proceeding arising out of the alleged abuse or neglect on the grounds of lack of competency under section 595.02.

Subd. 9. **Mandatory reporting to a medical examiner or coroner.** A person required to report under the provisions of subdivision 3 who has reasonable cause to believe that a vulnerable adult has died as a direct or indirect result of abuse or neglect shall report that information to the appropriate medical examiner or coroner in addition to the local welfare agency, police department, or county sheriff or appropriate licensing agency or agencies. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, the local welfare agency, and, if applicable, each licensing agency. A person or agency that receives a report under this subdivision concerning a vulnerable adult who was receiving residential treatment for mental illness, mental retardation, chemical dependency, or emotional disturbance from a mental health or mental retardation agency or facility as defined in section 245.91, shall also report the information and findings to the ombudsman for mental health and mental retardation.

Subd. 10. **Duties of local welfare agency upon receipt of a report.** (a) The local welfare agency shall immediately investigate and offer emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Local welfare agencies may enter facilities and inspect and copy records as part of investigations. In cases of suspected sexual abuse, the local welfare agency shall immediately arrange for and make available to the victim appropriate medical examination and treatment. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. When necessary in order to protect the vulnerable adult from further harm, the local welfare agency shall seek authority to remove the vulnerable adult from the situation in which the neglect or abuse occurred. The local welfare agency shall also investigate to determine whether the conditions which resulted in the reported abuse or neglect place other vulnerable adults in jeopardy of being abused or neglected and offer protective social services that are called for by its determination. In performing any of these duties, the local welfare agency shall maintain appropriate records.

(b) If the report indicates, or if the local welfare agency finds that the suspected abuse or neglect occurred at a facility, or while the vulnerable adult was or should have been under the care of or receiving services from a facility, or that the suspected abuse or neglect involved a person licensed by a licensing agency to provide care or services,

the local welfare agency shall immediately notify each appropriate licensing agency, and provide each licensing agency with a copy of the report and of its investigative findings.

(c) When necessary in order to protect a vulnerable adult from serious harm, the local agency shall immediately intervene on behalf of that adult to help the family, victim, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 525.539 to 525.6198, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of an abusive or neglectful guardian or conservator and appointment of a suitable person as guardian or conservator, pursuant to sections 525.539 to 525.6198; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 525.703 and chapter 563.

In proceedings under sections 525.539 to 525.6198, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or nonprofit organization to provide ongoing guardianship services. If the county presents evidence to the probate court that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or conservatee even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Subd. 10a. **Notification of neglect or abuse in a facility.** (a) When a report is received that alleges neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under section 144A.02 or sections 245.781 to 245.812, the local welfare agency investigating the report shall notify the guardian or conservator of the person of a vulnerable adult under guardianship or conservatorship of the person who is alleged to have been abused or neglected. The local welfare agency shall notify the person, if any, designated to be notified in case of an emergency by a vulnerable adult not under guardianship or conservatorship of the person who is alleged to have been abused or neglected, unless consent is denied by the vulnerable adult. The notice shall contain the following information: the name of the facility; the fact that a report of alleged abuse or neglect of a vulnerable adult in the facility has been received; the nature of the alleged abuse or neglect; that the agency is conducting an investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) In a case of alleged neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under sections 245.781 to 245.812, the local welfare agency may also provide the information in paragraph (a) to the guardian or conservator of the person of any other vulnerable adult in the facility who is under guardianship or conservatorship of the person, to any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, and to the person, if any, designated to be notified in case of an emergency by any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, unless consent is denied by the vulnerable adult, if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, or sexual abuse has occurred.

(c) When the investigation required under subdivision 10 is completed, the local welfare agency shall provide a written memorandum containing the following information to every guardian or conservator of the person or other person notified by the agency of the investigation under paragraph (a) or (b): the name of the facility investigated; the nature of the alleged neglect, physical abuse, or sexual abuse; the investigator's name; a summary of the investigative findings; a statement of whether the report was found to be substantiated, inconclusive, or false; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the alleged victim and shall not contain the name or, to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation.

(d) In a case of neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under sections 245.781 to 245.812, the local welfare agency may also provide the written memorandum to the guardian or conservator of the person of any other vulnerable adult in the facility who is under guardianship or conservatorship of the person, to any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, and to the person, if any, designated to be notified in case of an emergency by any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, unless consent is denied by the vulnerable adult, if the report is substantiated or if the investigation is inconclusive and the report is a second or subsequent report of neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of the facility.

(e) In determining whether to exercise the discretionary authority granted under paragraphs (b) and (d), the local welfare agency shall consider the seriousness and extent of the alleged neglect, physical abuse, or sexual abuse and the impact of notification on the residents of the facility. The facility shall be notified whenever this discretion is exercised.

(f) Where federal law specifically prohibits the disclosure of patient identifying information, the local welfare agency shall not provide any notice under paragraph (a) or (b) or any memorandum under paragraph (c) or (d) unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Subd. 11. **Duties of licensing agencies upon receipt of report.** Whenever a licensing agency receives a report, or otherwise has information indicating that a vulnerable adult may have been abused or neglected at a facility it has licensed, or that a person it has licensed or credentialed to provide care or services may be involved in the abuse or neglect of a vulnerable adult, or that such a facility or person has failed to comply with the requirements of this section, it shall immediately investigate. Subject to the provisions of chapter 13, the licensing agency shall have the right to enter facilities and inspect and copy records as part of investigations. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. The licensing agency shall issue orders and take actions with respect to the license of the facility or person that are designed to prevent further abuse or neglect of vulnerable adults.

Subd. 11a. **Duties of prosecuting authorities.** Upon receipt of a report from a social service or licensing agency, the prosecuting authority shall immediately investigate, prosecute when warranted, and transmit its findings and disposition to the referring agency.

Subd. 12. **Records.** (a) Each licensing agency shall maintain summary records of reports of alleged abuse or neglect and alleged violations of the requirements of this section with respect to facilities or persons licensed or credentialed by that agency. As part of these records, the agency shall prepare an investigation memorandum. Notwithstanding section 13.46, subdivision 3, the investigation memorandum shall be accessible to the public pursuant to section 13.03 and a copy shall be provided to any public agency which referred the matter to the licensing agency for investigation. It shall contain a complete review of the agency's investigation, including but not limited to: the name of any facility investigated; a statement of the nature of the alleged abuse

or neglect or other violation of the requirements of this section; pertinent information obtained from medical or other records reviewed; the investigator's name; a summary of the investigation's findings; a statement of whether the report was found to be substantiated, inconclusive, or false; and a statement of any action taken by the agency. The investigation memorandum shall be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the name or, to the extent possible, the identity of the alleged perpetrator or of those interviewed during the investigation. During the licensing agency's investigation, all data collected pursuant to this section shall be classified as investigative data pursuant to section 13.39. After the licensing agency's investigation is complete, the data on individuals collected and maintained shall be private data on individuals. All data collected pursuant to this section shall be made available to prosecuting authorities and law enforcement officials, local welfare agencies, and licensing agencies investigating the alleged abuse or neglect. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the rules of criminal procedure.

(b) Notwithstanding the provisions of section 138.163:

(1) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be false may be destroyed two years after the finding was made;

(2) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be inconclusive may be destroyed four years after the finding was made;

(3) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be substantiated may be destroyed seven years after the finding was made.

Subd. 12a. **[Repealed, 1983 c 273 s 8]**

Subd. 13. **Coordination.** (a) Any police department or county sheriff, upon receiving a report shall notify the local welfare agency pursuant to subdivision 3. A local welfare agency or licensing agency which receives a report pursuant to that subdivision shall immediately notify the appropriate law enforcement, local welfare, and licensing agencies.

(b) Investigating agencies, including the police department, county sheriff, local welfare agency, or appropriate licensing agency shall cooperate in coordinating their investigatory activities. Each licensing agency which regulates facilities shall develop and disseminate procedures to coordinate its activities with (i) investigations by police and county sheriffs, and (ii) provision of protective services by local welfare agencies.

Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility shall develop an individual abuse prevention plan for each vulnerable adult residing there. Facilities designated in subdivision 2, clause (b)(2) or clause (b)(3) shall develop plans for any vulnerable adults receiving services from them. The plan shall contain an individualized assessment of the person's susceptibility to abuse, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

Subd. 15. **Internal reporting of abuse and neglect.** Each facility shall establish and enforce an ongoing written procedure in compliance with the licensing agencies' rules for insuring that all cases of suspected abuse or neglect are reported promptly to a person required by this section to report abuse and neglect and are promptly investigated.

Subd. 16. **Enforcement.** (a) A facility that has not complied with this section

within 60 days of the effective date of passage of emergency rules is ineligible for renewal of its license. A person required by subdivision 3 to report and who is licensed or credentialed to practice an occupation by a licensing agency who willfully fails to comply with this section shall be disciplined after a hearing by the appropriate licensing agency.

(b) Licensing agencies shall as soon as possible promulgate rules necessary to implement the requirements of subdivisions 11, 12, 13, 14, 15, and 16, clause (a). Agencies may promulgate emergency rules pursuant to sections 14.29 to 14.36.

(c) The commissioner of human services shall promulgate rules as necessary to implement the requirements of subdivision 10.

Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person who reports in good faith suspected abuse or neglect pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.

(b) Any facility or person which retaliates against any person because of a report of suspected abuse or neglect is liable to that person for actual damages and, in addition, a penalty up to $1,000.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) Discharge or transfer from the facility;

(2) Discharge from or termination of employment;

(3) Demotion or reduction in remuneration for services;

(4) Restriction or prohibition of access to the facility or its residents; or

(5) Any restriction of rights set forth in section 144.651.

Subd. 18. **Outreach.** The commissioner of human services shall establish an aggressive program to educate those required to report, as well as the general public, about the requirements of this section using a variety of media.

Subd. 19. **Penalty.** Any caretaker, as defined in subdivision 2, or operator or employee thereof, or volunteer worker thereat, who intentionally abuses or neglects a vulnerable adult, or being a caretaker, knowingly permits conditions to exist which result in the abuse or neglect of a vulnerable adult, is guilty of a gross misdemeanor.

History: *1980 c 542 s 1; 1981 c 311 s 39; 1982 c 393 s 3,4; 1982 c 424 s 130; 1982 c 545 s 24; 1982 c 636 s 5,6; 1983 c 273 s 1-7; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 150 s 1-6; 1985 c 293 s 6,7; 1Sp1985 c 14 art 9 s 75; 1986 c 444*

626.558 MULTIDISCIPLINARY CHILD PROTECTION TEAM.

Subdivision 1. Establishment of the team. A county may establish a multidisciplinary child protection team comprised of the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees and representatives of health, education, mental health or other appropriate agencies and parent groups.

Subd. 2. **Duties of team.** A multidisciplinary child protection team shall be a consultant to the local welfare agency to better enable the agency to carry out its child protection functions pursuant to section 626.556 and the community social services act.

Subd. 2a. **Juvenile prostitutes outreach program.** A multidisciplinary child protection team may assist the local welfare agency, local law enforcement agency, or an appropriate private organization in developing a program of outreach services for juveniles who are engaging in prostitution. For the purposes of this subdivision, at least one representative of a youth intervention program or, where this type of program is unavailable, one representative of a nonprofit agency serving youth in crisis, shall be

PROPOSAL FOR IMPLEMENTATION OF AIDS EDUCATION FOR MINNESOTA STATE EMPLOYEES

I. PROGRAM INTRODUCTION.

A. Objectives.

1. Protect the health of state employees.
2. Maintain high worker productivity.
3. Promote a positive community image as a concerned employer.
4. Find the appropriate balance of legal, personal and professional rights and duties of the organization.
5. Control costs of medical benefits and legal issues.

B. Rationale.

1. State should serve as a model to other employers.
2. In Minnesota, the average cost per patient is $40,000-$60,000.
3. No effective AIDS vaccine in sight.
4. Prevention: Educating employees on how to avoid catching or spreading the disease.
5. To date, over 400 deaths reported in Minnesota.

II. PROGRAM DESCRIPTION AND CONTENT.

A. State Employees (32,000).

1. AIDS 101 course - 1 hour training session.
2. Copy of State policy.
3. Resource information.

B. Supervisors (3,000).

1. AIDS 101 course -- 3 hour course.
2. State policy.
3. Resource information.
4. Legal issues.
5. Procedures for policy implementation.

C. Managers (1,200).

1. AIDS 101 course -- 3 hour course.
2. State policy.

3. Resource information.

4. Legal issues.

5. Procedures for policy implementation.

6. Evaluation of program.

D. Summary of Program Description.

	AIDS 101	State Policy	Resource Information	Legal Issues	Procedures for Policy Implementation	Evaluation of Program
Employees	X	X	X			
Supervisors	X	X	X	X	X	
Managers	X	X	X	X	X	X

III. PROGRAM DEVELOPMENT.

A. Funding for Program.

B. Promotional Materials.

C. Educational Materials.

D. Evaluation Materials.

E. Management Materials.

F. Train-the-Trainers Program.

IV. PROGRAM COSTS.

A. Brochure including State Policy.

1. Copy and lay-out by DOER Training Division.

2. Brochure printing ($.12-.15 each).

3. Total cost $5,550.

B. Modular Package for Employee Training.

1. Internally prepared/externally presented.

2. Purchase updated videos (5 copies X $300 = $1,500).

3. Train-the-Trainers session developed by Training Division.

4. Written materials - $1,000.

C. Supervisor and Manager Training.

1. Add to training curriculum.

2. Half-day session.

3. Developed by professional from DOER Training Division.

4. Revolving fund used to recover costs.

5. Written materials = $1,000.

V. PROGRAM RESOURCE OPTIONS.

A. Legislature.

B. Large State Departments (Mn/DOT, Revenue, etc.).

C. Pharmaceutical Companies.

D. State Agencies/Departments.

1. DOER.

2. Department of Health.

3. Training Division.

4. Employee Assistance Program.

5. Safety and Workers' Compensation.

6. Health Promotion Coordinators.

7. Human Rights.

E. AIDS Task Force.

F. Health Insurance Carriers.

G. Labor Unions.

VI. PILOT SITES FOR AIDS EDUCATION.

A. Select Two Agencies.

1. Size.

2. Location.

3. Need.

B. Pilot Train-the-Trainer.

C. Implementation.

D. Evaluation of Pilot Training.

VII. STATEWIDE IMPLEMENTATION.

A. Phase 1 -- Managers and Supervisors.

1. Starting date.

2. Number of sessions.

3. Length of sessions.

4. Methodology.

B. Phase 2 -- State Employees.

VIII. ISSUES TO BE RESOLVED.

A. How do we fund AIDS training for the State of Minnesota? Should we be eligible for state funds granted to other employers?

B. Should we require mandatory training for managers (1,200), supervisors (3,000), and employees (32,000)?

C. Do we want to hold agencies accountable for delivery of AIDS training?

D. Should each agency be responsible for implementation of a model training plan developed by DOER?

IX. SUGGESTIONS FOR PROGRAM DEVELOPMENT.

A. Re-issue AIDS Policy.

B. Clarify Questions and Answers for Each Group.

C. Distribute Materials Statewide.

D. Purchase Updated Videos.

E. Develop Train-the-Trainers Course for Larger State Agencies:

1. Corrections.

2. Mn/DOT.

3. DHS.

4. DNR.

5. Public Safety.

6. Revenue.

F. DOER to Train Small Agencies Directly.

G. Evaluate a CEU Approach for Managers and Supervisors as a Training Option.

1. Self-study or "correspondence" course.

2. Satisfactory written exam to indicate knowledge of policy and implementation procedures.

H. Possible Methodology.

1. Video.

2. Presentation.

3. Pamphlet (purchase or develop).

4. Other written materials.

5. Communication campaign (paycheck stuffers, posters).

6. Novel items with AIDS Hotline phone number.

7. Correspondence courses.

8. Cassette tapes.

I. Add AIDS Education into Mandatory Supervisors and Managers Training.