Miller, Diane M. (CDC/NIOSH/EID)

From:	Alan Tice [alantice@idlinks.com]
Sent:	Monday, February 07, 2011 2:00 AM
To:	NIOSH Docket Office (CDC)
Cc:	Alan Tice; Monica Quen
Subject:	Regarding Docket #219 Public Comments
Attachments:	Ryan White response.doc; ATT437164.htm

This is regarding Docket #219 - public comments regarding new Ryan White Act

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February 6, 2011

Comments regarding Ryan White Act

Docket #219 Public Comments –
Infectious Diseases, 42 U.S.C.300ff-131

• E-mail:
Docket #219 Public Comments
NIOSH Docket Officer,
"Infectious Diseases"
"42 U.S.C.300ff–131"
message.
nioshdocket@cdc.gov.

• Mail:
Docket #219 Public Comments
NIOSH Docket Office
Robert A. Taft Laboratories, MS–C34
4676 Columbia Parkway
Cincinnati, OH 45226.

Thank you for your interest in exposures of emergency response employees (EREs). It is very needed.

I am an Internist and Infectious Diseases Specialist physician. I am also the Designated Officer for Infectious Diseases exposures for the Police, Fire, Ambulance, and water safety services for the City and County of Honolulu.

In my role, I provide prompt advice and potentially intervention when there

is a work-related exposure to an infection. I am available 24 hours 7 days a week with a cell phone and a request to be called within 15 minutes after a possible significant exposure, the victim is stabilized, and there is time to respond. I also provide lectures and help with the education of EREs. My services and the information I gather are held in strict confidence with the EREs. I simply contract for these services with the different departments and am not employed otherwise by the City or County.

I would like to comment about the CDC proposal as an extension to the Ryan White Act to infections beyond HIV.

The infections noted all seem appropriate although they do not clearly mention bioterrorist agents.

There should be a lot more about the parameters of the exposures – to the extent they are known. Concerns of exposures within 6 feet with airborne transmission are appropriate but the space in which they occur is as well. Note might be made about closed and/or small spaces – such as a small bedroom or the back of an ambulance. This would contrast with an exposure in outside air. The duration of exposure is also important to mention although parameters and degree of risk are not clear

The "medical facility" management and expectations guidelines are not adequate and will not work well. "Medical facilities" cannot usually provide the rapid responses (within a few hours for HIV) and the expert advice needed for prompt evaluation and interventions in what may be an emergency for the ERE. I have often found even the emergency department physicians lack knowledge of many of the infections noted in your draft and are not familiar with appropriate interventions and the criteria for them. They are also usually very busy and do not have time to research them in a timely manner. For example, I have had a number of EREs who have had HIV medications ordered for a possible exposure without the risks and potential complications being discussed and the criteria for beginning therapy.

There is also a problem with the "medical facility" taking responsibility for notifying exposed EREs of lab results a day or two later (such as with meningococcus or blood borne pathogens). When a patient is admitted,

the emergency department usually does not follow them and the hospital doctor does not know of the exposure. The employer of the ERE may also not be notified, especially if the exposure occurs outside normal office hours. Even if the employer is notified, there is the problem of patient confidentiality.

Follow-up is also a problem in regard to getting baseline blood work then serologies for HIV, hepatitis C or hepatitis B up to 6 months later. Skin tests for tuberculosis may also be difficult to arrange and track results. The employers are often not able to provide appropriate medical and counseling services and should not do so – as per the provision for confidentiality in the Ryan White Act. The alternative of the EREs usual personal physician providing a timely response, appropriate decisions, intervention, and follow-up is small.

I believe you have the opportunity to provide far better safety measures for ERE exposures with the provisions of the Ryan White Act through developing the concept of the Designated Officer for Infectious Diseases – which is part of OSHA as well as federal regulations. This could be done in concert with or independently of the "medical facility"

An outline of the responsibilities of the Designated Officer would be helpful

Please contact me if you have any questions or comments that I can help with

Thank you

Alan Tice, MD