



Dennis Allin, M.D., Chair
Steven Sutton, Executive Director

**Board of
Emergency Medical Services**

Sam Brownback, Governor

Testimony

Date: March 12, 2013

To: The Honorable Senator Mary Pilcher-Cook
Chair, Senate Committee on Public Health and Welfare

From: Steven Sutton, Executive Director

RE: HB 2183, Communicable Disease Testing and Disclosure of Information

Madam Chair and Members of the Senate Committee on Public Health and Welfare, thank you for the opportunity to provide testimony on behalf of the Kansas Board of Emergency Medical Services for HB 2183. My name is Steven Sutton, and I am the Executive Director for the Kansas Board of Emergency Medical Services (KBEMS).

On behalf of KBEMS I am here to provide testimony supportive of HB 2183, dealing with Communicable Disease Testing and Disclosure of Information. This bill incorporates new language in several statutes and will include language in yet to be developed regulations which define, clarify, and identity updates to information and processes that address the management and follow-up of exposure to communicable diseases by individuals who provide medical or nursing services, clinical or forensic laboratory services, emergency medical services and firefighting, law enforcement and correctional services, or who provide any other service or individuals who receive any such services or are in any other employment where the individual may encounter occupational exposure to blood and other potentially infectious materials. This bill identifies mechanisms to ensure that those providers found to be affected are made aware of that exposure and a treatment regime implemented. If not known and not treated, there is the potential for continued exposure to fellow workers, family members and other patients treated after the exposure. This bill is particularly important to those volunteers especially in fire and emergency medical services providing community service with little or no remuneration or insurance. We ask for your unanimous support of the bill to protect those that serve you, your family and the citizens of Kansas.

Thank you for allowing me to provide testimony on HB 2183. I am more than happy to answer any questions you may have of me.

Occupational risk exposure reports among first responders in Oklahoma, January 1989-December 1990.

(PMID:1839555)

[Gildon B, Harkess J](#)

Oklahoma State Department of Health, STD/HIV Division, Oklahoma City 73117-1299.

[The Journal of the Oklahoma State Medical Association](#) [1991, 84(12):604-606]

In response to the risk of occupationally acquired infection with hepatitis B and human immunodeficiency virus, the State of Oklahoma enacted legislation which provided for a system of notification of emergency medical personnel who sustain risk exposures to blood or other potentially infectious body fluids. The system is based on the immediate report of the exposure to the STD/HIV Division of the Oklahoma State Department of Health. Between January 1, 1989, and December 31, 1990, emergency response facilities reported 115 exposures to blood or other body fluids. There was a mean delay of 12 days between exposure and report to the STD/HIV Division. Only 10 (9%) of the exposed workers had been previously vaccinated against hepatitis B, and universal precautions were in use only 40% of the time. Forty-eight reports (41.7%) indicated exposures that did not pose a risk of disease transmission. These data indicate that emergency response facilities are in need of further education directed at the risk and prevention of transmission of bloodborne pathogens.

[J Emerg Med.](#) 1993 Jan-Feb;11(1):9-16.

Occupational infectious disease exposures in EMS personnel.

[Reed E](#), [Daya MR](#), [Jui J](#), [Grellman K](#), [Gerber L](#), [Loveless MO](#).

Source

Portland Bureau of Fire, Rescue and Emergency Services, OR 97204-3590.

Abstract

Reports of occupationally transmitted hepatitis B virus (HBV) and human immunodeficiency virus (HIV) prompted the Portland Bureau of Fire Rescue and Emergency Services (PFB) to institute a comprehensive program for handling and tracking on-the-job infectious disease exposures. Data were collected for a 2-year period beginning January 1, 1988, and ending December 31, 1989, utilizing verbal and written exposure reports, prehospital care reports, and PFB statistical information. Two hundred and fifty-six (256) exposures were categorized. The overall incidence of reported exposure was 4.4/1,000 emergency medical service (EMS) calls. Of these exposures, 14 (5.5%) were needle sticks, 15 (5.9%) were eye splashes, 8 (3.1%) were mucous membrane exposures, 38 (14.8%) were exposure to nonintact skin, 120 (46.9%) were exposures to intact skin, and 61 (23.8%) involved respiratory exposure only. The incidence of exposure of nonintact skin or mucous membranes to blood or body fluids and needle sticks was 1.3/1,000 EMS calls. Forty-eight individuals (64% of those incurring needle sticks, or exposure of non-intact skin or mucous membranes to blood or body fluids) were treated and followed for signs of infection. Of this group, 11 individuals (26%) previously vaccinated against hepatitis B demonstrated inadequate HBsAb titers at the time of exposure. Requests for HIV and HBV information on source patients were made for needle sticks or exposure of nonintact skin or mucous membranes to blood or high-risk body fluids. **Information on the source patient's HIV status was obtained for 57% of these requests.**(ABSTRACT TRUNCATED AT 250 WORDS)

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8445190

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Occupational Blood Contact Among Prehospital Providers

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Abstract

Study objective: To assess the nature and frequency of blood contact (BC) among emergency medical service (EMS) workers.

Design: During an 8-month period, we interviewed EMS workers returning from emergency transport calls on a sample of shifts. We simultaneously conducted an HIV seroprevalence survey among EMS-transported patients at receiving hospitals served by these workers. **Setting:** Three US cities with high AIDS incidence. **Participants:** EMS workers. **Results:** During 165 shifts, 2,472 patients were attended. Sixty-two BCs (1 needlestick and 61 skin contacts) were reported. Individual EMS workers had a mean of 1.25 BCs, including .02 percutaneous exposures, per 100 patients attended. The estimated annual frequency of BC for an EMS worker at the study sites was 12.3, including .2 percutaneous exposures. For 93.5% of the BCs, the HIV serostatus of the source patients was unknown to the EMS worker. HIV seroprevalences among EMS-transported patients at the three receiving hospital emergency departments were 8.3, 7.7, and 4.1 per 100 patients; the highest rates were among male patients 15 to 44 years old who presented with pneumonia. **Conclusion:** EMS personnel regularly experience BCs, most of which are skin contacts. Because the HIV serostatus of the patient is usually unknown, EMS workers should practice universal precautions. Postexposure management should include a mechanism for voluntary HIV counseling and testing of the patient after transport and transmittal of the results to the EMS.

[Marcus R, Srivastava PU, Bell DM, McKibben PS, Culver DH, Mendelson MH, Zalenski RJ, Kelen GD: Occupational blood contact among prehospital providers. *Ann Emerg Med* June 1995;25:776-779.]

Review of Accidents/Injuries Among Emergency Medical Services Workers in Baltimore, Maryland

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Abstract

Objectives: To characterize the types of occupational exposures and injuries reported by emergency medical service (EMS) workers.

Methods: A blinded review of accidents/exposures among EMS workers employed by a Baltimore County fire department was conducted. Medical records for 1992 were reviewed.

Results: Two hundred and twenty-six reports were filed by EMS workers (n = 197) employed by a large, urban fire department in 1992. The most commonly reported injuries were sprains (23%), strains (20%), and exposure to blood and body fluids (15%). The body site most commonly injured was the back (20%) followed by the respiratory system (10%). Most incidents were treated at the employee health clinic, and 13% of the incidents resulted in a hospital visit. Fifteen percent of the injuries resulted in more than seven lost work days. Most incidents were caused by stretcher mishaps, especially during transport of heavy patients. Walkway impediments (e.g., icy steps, wet leaves, broken and uneven pathways) also played an important role in creating slipping and tripping hazards.

Conclusion: These results suggest a variety of prevention strategies aimed at reducing accidents and exposures among EMS workers.