UW Medicine

SCHOOL OF MEDICINE

BLOOD-BORNE PATHOGENS POLICY

The Blood-Borne Pathogens SOM Committee:

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POLICY

1. The University of Washington School of Medicine (SOM) is dedicated to educating its students in the provision of health care of the highest quality, and it abides by a professionalism that recognizes the primacy of patient welfare and the need to avoid harm within the framework of quality medical education.

2. The SOM is firmly committed to educating all University of Washington medical students in universal precautions and in doing so before the start of their clerkship years. In addition, the School is committed to reemphasizing and reinforcing universal precautions training regularly over the course of the clerkship years.

3. Every student on any clerkship, regardless of their location in the WWAMI region, must strictly adhere to universal precautions, including appropriate hand washing, recommended protective barriers, and meticulous care in the use and disposal of needles and other sharp instruments.

4. The School follows the Public Health Service recommendation that any person (including medical students) who perform tasks involving contact with blood, blood-contaminated body fluids, other body fluids, or sharps should be vaccinated against hepatitis B and their response to vaccination documented.

5. The SOM considers it mandatory for students who know they are Hep B s Antigen and Hep B e Ag positive to report their status to the Associate Dean for Curriculum (Dr. Michael Ryan) and their College Head so that the student can be further counseled about infection control measures and take additional and needed precautions to maximize patient safety while pursuing their on-going medical school training.

6. The SOM strongly recommends that any student who has risks for a blood-borne pathogen be tested and KNOW their own status with respect to HIV, hepatitis B, and hepatitis C. In addition to following universal precautions, students with a known blood-borne pathogen are expected to:
   - Double glove during all procedures involving the possibility of blood-borne exposure
   - Refrain from all direct patient care and the handling of patient care equipment used in invasive procedures if the student has exudative lesions or weeping dermatitis
   - Refrain from direct participation in exposure-prone procedures, which at the minimum include the following:
     - Digital palpation of a needle tip in a body cavity
     - Simultaneous presence of the student's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site

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7. The reporting of the hepatitis C status and HIV-status of students to the School is voluntary. If a blood-borne exposure occurs, however, in which there is a reasonable chance that blood was transmitted from the student to the patient, then the School considers it mandatory for the student to immediately report their blood-borne pathogen status to their supervisory attending physician so that appropriate post-exposure prophylaxis may be undertaken on behalf of the patient. Similarly, should a blood-borne exposure occur from the patient to any student, it is considered mandatory for the student to immediately report the event to the supervisory attending so that appropriate evaluation and post-exposure prophylaxis may be undertaken on behalf of the student.

8. The SOM is committed to advising and providing continued career guidance to any and all students who know, or suspect they have, a blood-borne pathogen. Furthermore, the SOM will provide, when appropriate, reasonable accommodations in training for students with blood-borne pathogens to enable the student to complete their medical school training without penalty while at the same time optimizing patient safety.

9. The SOM believes it is important to annually review this policy, and change and update it as necessary, to reflect the current level of science and national guidelines with respect to blood-borne pathogens.

APPENDIX A: CONSIDERATIONS

CONSIDERATIONS by the Committee in formulating School of Medicine policy concerning medical student blood-borne pathogen status include the following:

10. Non-maleficence: health care providers have a duty to their patients to do no harm, which also includes not placing patients in harm's way in the name of professional training. The School of Medicine has a duty to our students to maximize their learning experience and beneficial social impacts, and to avoid unfairly compromising these outcomes based on hypothetical, fear-based reasoning that does not reflect current practice and science-based reality.

11. The School has an obligation to its students to explicitly adapt and teach universal precautions (and to periodically repeat that instruction throughout their clinical years).

12. As is true for patients, SOM students have a right to privacy, and the SOM has a duty to preserve, as much as possible without compromising patient safety, the students' confidentiality.

13. Additional professional and ethical issues involved in policy formulation include the following:
    - The students, as is true of all health care providers, have a professional duty to act in the **service** of their patients throughout their training
    - The students, as is true of all health care providers, have a professional and ethical obligation to be **honest** in their dealings with one another and with patients as is appropriate to the given situation and site of training.

14. In the setting of infected patients, substantial blood-borne exposures, and the patient's ability to transmit *their* infection *to* a health care provider, the statistics are as follows (and risks vary greatly depending on the blood-borne pathogen, type and volume of exposure, and "infectivity" of the source patient):

    Hepatitis B
    - Source patient is HBsAg and HBeAg positive: risk of developing clinical hepatitis in the exposed health care worker is **22-31%**
    - Source patient is HBsAg positive but HBeAg negative: risk of developing clinical hepatitis in the exposed health care worker is **1-6%** (**Ann Intern Med** 1982; 97:367-369)
    - Protection afforded by HBIG initiated within one week following percutaneous exposure to HBsAg-positive blood is 75% (**MMWR** 2001;June 29 [vol 50/ No. RR-11])

    Hepatitis C
    - Hollow needle stick: average seroconversion rate is **1.8%**
    - Transmission is even "more rare" from mucous membrane exposure. (**Cleveland Clinic Journal of Medicine** 2003 70[5]: 457-465)

    HIV
    - Hollow needle stick: HIV transmission risk without post-exposure prophylaxis (PEP) is **0.3%** (**MMWR** 2000; 50[RR-11]:1)

- PEP decreases HIV transmission after percutaneous exposure by as much as 79%
  (**MMWR** 1995; 44[50]:929-933)
- Mucous membrane exposure: HIV transmission risk is **0.09%**
  (**Cleveland Clinic Journal of Medicine** 2003 70[5]: 457-465)
- To date, there have been **no** documented seroconversions in operating room personnel after a solid-bore needle injury in the OR
  (**ACS Surgery Principles & Practice** 2004 Chapter 21: 1412)

15. In the history of American Health care, transmission of the HIV-virus from a medical student to a patient has not, to date, been reported. The committee assumes, therefore, that such an occurrence, if it has indeed occurred, is exceedingly rare. [There have been such transmissions from patients to medical students, however, some of whom are now deceased].

16. Disabled employees, including those with HIV, and potentially (probably) those with chronic HCV and HBV, are protected by the Adults with Disabilities Act, which declares that it is unlawful to treat employees differently on the basis of their disability, provided that the disability does not preclude essential job functions. (The committee acknowledges, however, that medical students are not employees).

17. In 1991, the CDC published recommendations for preventing transmission of HIV and hepatitis B virus to patients during invasive "exposure-prone" procedures (**MMWR** 1991; 40[RR08]:1-9). Those recommendations have not been amended or changed since that time, [despite CDC Advisory Committee recommendations that they be modified]. Some professional organizations are also in disagreement with those 13 year old "recommendations." Currently (May 2004), the American College of Surgeons states the following:

    "The College has expressed concern that these actions were not based upon direct scientific data, were not cost-effective, and were intrusive to the extreme. We continue to feel that the recommendations of defining 'risk-prone procedures,' as was recommended by the CDC, cannot be determined in a scientific or rational way. We have felt, and continue to feel, that these recommendations were irrelevant and counterproductive. In formulating these guidelines, the CDC ignored the overwhelming testimony of the scientific community, and the fact that all currently available data indicate that transmission from surgeon to patient in a hospital setting continues to be a hypothetical event."
    (**American College of Surgeons** [revised May 2004]
    http://www.facs.org/fellows_info/statements/st-13.html)

    [Professional societies of orthopedic surgeons {who were targeted re: "exposure-prone" sharp bone fragments}, gynecologists {who perform vaginal hysterectomies blindly in tight spaces}, and of dentists {working in tight spaces with sharp instruments and cavity edges} have produced similar concerns, and all three groups have refused to define the key phrase in the CDC document "exposure-prone" procedures.]

18. Despite the inherent controversies outlined in item 8 above, however, the committee acknowledges that a student, unlike the patient's chosen licensed health care provider, is not usually essential to that given patient's care. So the committee deems it reasonable to hold the student with a known and potentially transmissible blood-borne pathogen to the conservative guidelines set forth by the CDC in 1991.

19. Most authorities suspect that blood-borne exposures are underreported [in both directions: from provider to patient and from patient to provider]. Still, the settings in which the majority of blood-borne exposures occur do not involve students, and they do not take place during the CDC's defined "high risk procedures." According to data gathered by the National HIV/AIDS Clinicians' Consultation Center of the University of California San Francisco:
    - Students represent **3%** of reported exposures (the highest exposed group are registered nurses [22%])
    - Most blood-borne exposures occur on inpatient units (23%) as compared to the operating room or labor and delivery (9% combined). http://www.nccc.ucsf.edu

20. Practice liability insurers currently make it difficult for candidates applying for hospital appointments to hide their chronic blood-borne disease status. The result is that persons who are trained and seeking to perform any significant invasive procedures are possibly/probably unlikely to find employment in their field within any setting requiring liability insurance.

21. While HIV, HCV, and HBV are of greatest immediate concern for such policies, other viral illnesses exist which appear to be blood-borne, and some of these are also chronic infections. Examples include: HHV-8 (the KS virus) and West Nile Virus. It seems likely that additional viruses and other agents transmissible through blood and other inter-human exposures will be identified with the passage of time and the advancement in science.

APPENDIX B: Definitions

Blood-borne Pathogen

Hepatitis B virus
Hepatitis C virus
Human immunodeficiency virus (HIV)

(The committee acknowledges that many other infectious agents are potentially transmitted by blood, including: hepatitis D virus, hepatitis G virus/GB virus C, HTLV I and II viruses, Human herpesvirus 8, Parvovirus, West Nile virus, malaria [Plasmodium sp], Treponema pallidum [syphilis], Trypanosoma cruzi [Chagas' disease], Leishmania sp [leishmaniasis], etc.)

Bodily Fluids that May Contain a Blood-borne Pathogen

Blood as well as cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids. Note that Universal Precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. Universal precautions also do not apply to saliva except when visibly contaminated with blood or in the dental setting where blood contamination of saliva is predictable.

Characteristics of Persons at Moderate/High Risk for HIV Infection

Injection drug use
Homosexual/bisexual men
Multiple blood transfusions 1978-*85*
History of exchanging sex for money/drugs
Multiple sexual partners
Sexual partner with any of the above

Exposure

1. A percutaneous injury: such as a needle-stick or cut with a sharp object that may be contaminated with blood or other potentially infectious bodily fluid.
2. Contact of a mucous membrane or non-intact skin with blood, tissue, or other body fluids that are potentially infectious.

Factors Influencing Risk of Infection

Pathogen involved
Type of exposure
Duration of exposure
Amount of blood involved in the exposure
Amount of virus in the "donor person's" blood at the time of exposure

Health Care Providers

Practitioners, medical students and trainees, and any other members of the UW workforce who come into direct contact with patients or the blood or other potentially infectious bodily fluids of patients.

Infection Control

Infection control policies include specific practices to reduce the transmission of blood borne pathogens. These policies and procedures are found in the relevant infection control manuals of each facility.

Post-Exposure Prophylaxis

Drug and/or immunization interventions administered to help prevent acquiring a blood-borne infection after an exposure (followed by immediate washing/wound care) has occurred.

Universal Precautions

http://www.cdc.gov/niosh/topics/bbp/universal.html

These are a set of precautions designed to prevent transmission of HIV, HBV, and other blood-borne pathogens when providing first aid or health care. They involve the use of appropriate hand washing combined with the use of protective barriers, such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the health care worker's skin or mucous membranes to potentially infective materials. Universal precautions also include the concept whereby health care providers take all necessary and appropriate precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices (including the proper disposal of used devices in appropriately labeled and secure containers for such disposal).

APPENDIX C:
Recommendations on Universal Precautions Training and Review

Universal precautions training is provided to medical students in the University of Washington School of Medicine as follows:

First year: Medical student orientation

Second year:

- Mandatory phlebotomy tutorial, which occurs as part of the Introduction to Clinical Medicine (ICM) II over the course of the second year
- Transition to the wards session in ICM II, end of spring quarter

Third year/Fourth year:

Universal precautions training will be focused primarily during the OB/GYN, Medicine, Surgery, and ER rotations. An additional review will occur during the Capstone course.

Other clerkships:

Each facility has procedures and practices to work with individuals whose special needs may require modified barrier protection. Each facility will ensure that all practitioners, medical students and trainees, and other members of the UW workforce who have direct contact with patients, receive appropriate education and training regarding communicable diseases, infection control policies, and the means of preventing the transmission of blood borne infections.

Additional student self-study is encouraged via the following internet sites:

1. Universal precautions for prevention of transmission of HIV and other blood borne infections

   http://www.cdc.gov/niosh/topics/bbp/universal.html

2. Emergency needlestick information

   http://www.cdc.gov/niosh/topics/bbp/emergnedl.html

3. Blood borne infectious diseases, then access the following general resource: ***Exposure to Blood: What Healthcare Personnel Need to Know***

   http://www.cdc.gov/ncidod/dhqp/pdf/bbp/Exp_to_Blood.pdf

(revised 3/24/05 – Required Clerkship Committee)

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APPENDIX D:
QUESTIONS & ANSWERS CONCERNING BLOOD-BORNE PATHOGENS, WITH SPECIAL EMPHASIS ON MEDICAL STUDENTS

As a medical student, must I be tested for blood-borne diseases?

- The University of Washington SOM does not require medical students/trainees to undergo routine serologic testing for HIV or HCV. But students who have risks for a blood-borne pathogen (see Appendix B: Definitions) are strongly encouraged to know their HIV and HCV status in the interest of their own health and to afford them the best opportunity of honoring their professional and ethical duty to protect their patients.
- On the other hand, immunizations and routine testing for TB are required for all medical students. Hepatitis B immunization, and documentation of the response, is part of the immunization requirements. Because of this, a student's hepatitis B status will become known to the student.
- Failure to comply with required immunizations and TB testing will result in an inability to participate in courses and clerkships.

Where can I get tested for a blood-borne pathogen?

Students can request testing at Hall Health (phone: 206-685-1011) or from another health care provider of their choice. Testing is also available from the Department of Public Health (phone: 206-205-7837). To the extent allowed by law, this information will remain a confidential part of the student's medical record.

Are blood-borne pathogens public health reportable conditions?

Yes. In Washington State, acute and chronic hepatitis B, acute and chronic hepatitis C, and both HIV and AIDS are mandatory reportable conditions to the local Department of Public Health. As for all reportable diseases in Washington State, both HIV and AIDS are reported by name and other identifiers. For asymptomatic HIV infection, however, the name of the HIV-infected person is converted to a non-name code within 90 days after the receipt of a completed case report.

What should I do if I know that I carry a blood-borne pathogen?

- Students who are HIV-positive or HCV-positive are not required to report their positive status, but they are strongly encouraged to do so to the Associate Dean for Curriculum (Dr. Michael Ryan; phone: 206-543-5560) and/or their College Head. This is to optimize the career planning and training of the student while simultaneously maximizing patient safety.
- Students who know they are both hepatitis B Ag and hepatitis B e Ag positive are reminded of the real and serious risk this may pose to unimmunized patients during those rotations that may involve invasive prone procedures. The SOM considers it a professional duty of the student to inform the Associate Dean for Curriculum of this particular blood-borne pathogen situation so that the student's

training can proceed while simultaneously allowing the School to maximize patient safety.

- The SOM strongly recommends adherence to the 1991 CDC recommendations for preventing transmission of HIV and Hep B virus to patients during exposure prone procedures: **http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm**.
  Under these recommendations, in addition to following universal precautions, infected students should:
  - Double glove during all procedures involving the possibility of blood-borne exposure
  - Refrain from all direct patient care and the handling of patient care equipment used in invasive procedures if the student has exudative lesions or weeping dermatitis
  - Refrain from direct participation in exposure-prone procedures, which at the minimum include the following:
    - Digital palpation of a needle tip in a body cavity
    - Simultaneous presence of the student's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site
- Students who know they carry a blood-borne pathogen may wish to discuss the implications of their infection further with a SOM faculty (see Appendix F: Resources).
- Regardless of infection status, all practitioners, students, and trainees who perform or participate in invasive procedures shall follow best practices for protecting patients and are strongly encouraged to wear two layers of protective gloves during such procedures.

Can I pass clerkships if my blood-borne pathogen status is positive?

Yes! The SOM is committed to providing reasonable accommodations for the ongoing medical training of students regardless of their blood-borne pathogen status.

APPENDIX E: Procedure Following an Occupational Exposure to Blood/Body Fluid

Did YOU just receive a blood / body fluid exposure via a needlestick or a spillage on mucous membrane or non-intact skin? Then PROCEED as follows:

1. **PLEASE, DON'T PANIC**
   The vast majority of body substance exposures do not result in harm to the exposed health care worker, but one event is an important reminder to be more alert, aware, and careful while a sharp is being used and subsequently disposed of. Learn all that you can from this experience, and vow to not have another event happen. Time matters though, so please proceed swiftly as follows.

2. **REMOVE** all soiled clothing.

3. **WASH**
   - Wounds and skin with soap and water.
   - Flush mucous membranes copiously with water.

4. **WRITE** down the source patient's name, hospital number, date of birth, and location in the hospital or clinic.

5. **NOTIFY** your supervising staff member that you need to report to Campus or Employee Health.

6. **REPORT TO "CAMPUS" or "EMPLOYEE" HEALTH** (after hours report to your facility's **EMERGENCY DEPARTMENT**)
   - At this time, your risks of acquiring a blood-borne pathogen vary with the variables of the exposure. Consider the type and volume of fluid and type of exposure; also consider the characteristics of the source patient with respect to infectivity (see Table on next page).
   - **It is not appropriate for you to consent the source patient and draw their blood yourself.** Different facilities may follow a different protocol, but there is a designated person at each hospital (via employee health typically) who will go to the source patient, consent them via appropriate protocol, and test their venous blood.
   - **Needed Studies on Source Patient:**
     - ***Hepatitis B surface antigen*** (HBsAg)
     - ***Hepatitis C antibody*** (anti-HCV), and
     - ***HIV antibody*** (with consent).
       Note: in a high risk source patient whose HIV status is unknown, or if PEP medications will be taken by the student, some facilities (including HMC & UWMC—via Children's Hospital virology laboratory) have a rapid HIV test protocol – and the rapid test should be ordered.
     - ***Special Studies:*** in high risk source patients believed or known to be HIV +, and/or known to be anti-HCV +, viral "load" studies (i.e., quantitative viral RNA) should also be sent for each respective virus.

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- **Needed Studies on Exposed Student:**
  - ***Hepatitis B surface antibody*** (HBsAb)—this should be checked if you have not completed a Hepatitis B immunization series or if your level of protective antibody from such a series is unknown. If the patient is HBsAg positive, and if your anti-Hep B antibody level is < 10 mIU/mL, you will need an injection of hepatitis B immune globulin within 96 hr of the exposure (dose of HBIG: 0.06 mL/kg IM).
  - ***Hepatitis C antibody*** (anti-HCV), and
  - ***HIV antibody*** (with consent).
  - ***Additional Studies:*** if you elect to take post-exposure prophylaxis (PEP), additional baseline blood tests will be necessary (such as a CBC, renal function, hepatic function, and pregnancy test).

7. HELP!

If you have questions about your exposure, or believe you are a candidate for the antiretroviral PEP protocol and want further assistance, contact someone at one of the following numbers:

- If away from Seattle, call MEDCON (1-800-326-5300) and ask to be connected to the UWMC Campus Health Service or Emergency Department (ED) -- numbers below.
- In Seattle, call UWMC Campus Health Services (206-598-4848; 7:30 a.m.–4:00 p.m., M-F),
  or the UWMC ED (206-598-4000; 24 hours/day).

  Identify yourself as a UW medical student with a possible HIV / blood-borne pathogen exposure and ask for the attending physician or charge nurse to assist you.

- If questions/concerns are not fully answered by the above sources, call: Dr. Doug Paauw (Pager: 206-991-0909); or Dr. Amy Baernstein (Pager: 206-663-1909).
- If testing, prophylaxis, or counseling is deemed necessary and the training site outside the Seattle area cannot absorb these costs, bills for initial testing and preventive drugs may be forwarded to:

  Stephen E. Boerstler, Assistant to the Director
  Health Sciences Administration
  Box 356355
  Seattle, WA 98785-6355
  (206) 543-7926 FAX: (206) 543-3473

8. POST-EXPOSURE PROPHYLAXIS (PEP) for HIV

- If you are going to take PEP, start it as soon as possible after exposure (within 1-2 hours). (You can stop the medicines once the source patient's HIV test is negative). If the source patient is HIV +, then PEP is continued for 4 weeks.
- **Follow-up Information**: while on PEP, you will need a repeat CBC, chemistry panel, and liver function tests checked again at 2 weeks. In addition, you will need repeat HIV testing at 6 weeks, 3 months, and 6 months (minimally).

- Consider PEP as outlined in the following **TABLE**:

TYPE OF EXPOSURE	SOURCE PATIENT CHARACTERISTICS	
	HIV+ or High Risk	**? HIV or Low Risk**
MORE SEVERE PARENTERAL • **Transfusion of blood** • **Large (> 1 mL) injection of blood** • **Large-bore hollow needle, deep puncture, visible blood on device, needle used in patient's artery or vein** • **Parenteral exposure to lab material w/ high viral titer**	**RECOMMEND** Triple Drug PEP Regimen	**OFFER** Double Drug PEP Regimen
LESS SEVERE PARENTERAL • **Solid needle** • **Superficial injury** **(This Table Continues on the next page!)**	**RECOMMEND** Double Drug PEP Regimen (**RECOMMEND** Triple Drug PEP Regimen if source symptomatic HIV, AIDS, known high viral load, or acute seroconversion)	**NONE** generally warranted or **OFFER** Double Drug PEP Regimen
MUCOUS MEMBRANE—LARGE VOLUME • **Major mucous membrane splash with infectious material**	**RECOMMEND** Double Drug PEP Regimen (**RECOMMEND** Triple Drug PEP Regimen if source symptomatic HIV, AIDS, known high viral load, or acute seroconversion)	**NONE** generally warranted or **OFFER** Double Drug PEP Regimen
MUCOUS MEMBRANE—SMALL VOLUME • **Only a few drops of infectious material**	**RECOMMEND** Double Drug PEP Regimen	**NONE** generally warranted or **OFFER** Double Drug PEP Regimen
DOUBTFUL PARENTERAL • **Injuries that do <u>not</u> involve blood or other infectious body fluids**	**NO**	**NO**
NON-PARENTERAL • **Intact skin visibly contaminated with blood/body fluid**	**NO**	**NO**

ADDITIONAL INFORMATION:

- **BODY FLUIDS DEEMED POTENTIALLY INFECTIOUS FOR HIV:**
  Blood products, bloody fluids, semen, CSF, amniotic fluid, menstrual discharge, vaginal secretions; pleural, peritoneal or pericardial fluid; inflammatory exudate, and other body fluid/tissue contaminated w/blood.

- **PEP Regimens:**

  There are three different **two-drug PEP** regimens:

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Usually, the following regimen is used: **Zidovudine** (300 mg PO bid) + **Lamivudine** (150 mg PO bid); these two medications come in a combined formulation named **Combivir** (1 tablet PO bid);

Other two drug PEP options include:

Lamivudine (150 mg PO bid) + **Stavudine** (40 mg PO bid; if weight < 60 kg; use 30 mg PO bid); or

Didanosine (400 mg PO q D; if < 60 kg; use 125 mg PO bid) + **Stavudine** (40 mg PO bid; if < 60 kg use 30 mg PO bid)

For more severe parenteral exposures, a **third drug** should be **added** to one of the two drug regimens above. (For a list of advantages and disadvantages of each of these, consult the following web resource):
http://www.cdc.gov/mmwr/PDF/rr/rr5409.pdf

Choices for the added third drug include:

Usually, **Nelfinavir** (1250 mg PO bid with meals or snacks); but other options include:

Indinavir (800 mg PO on empty stomach q 8 hr), or

Efavirenz (600 mg PO at bedtime), or

Abacavir (300 mg PO bid).

Besides the above, additional Regimens are also possible in consultation with an HIV-infection specialist (e.g., Dr. Bob Coombs, Office: 206-341-5201).

- **Additional Resources:**

24-hour Clinician Post-Exposure Hotline: 1-888-448-4911 (Univ. Calif. San Francisco)

http://aidsinfo.nih.gov/guidelines/
(At the above web site, look in the left hand column entitled “Clinical Guidelines Portal” and click on the entry “Health-Care Worker Exposure Guidelines”)

http://www.hopkins-aids.edu/

APPENDIX F:
RESOURCES CONCERNING BLOOD-BORNE PATHOGENS

WEB-BASED INFORMATION

- 1991 CDC recommendations for preventing transmission of HIV and Hep B virus to patients during exposure prone procedures:

  http://www.cdc.gov/mmwr

- 2001 CDC blood-borne exposure guidelines:

  http://aidsinfo.nih.gov/guidelines

- Emergency Needlestick Information

  http://www.cdc.gov/niosh/topics/bbp/emergnedl.html

- Universal precautions for prevention of transmission of HIV and other blood borne infections

  http://www.cdc.gov/niosh/topics/bbp/universal.html

- Blood borne infectious diseases, then access the following general resource: ***Exposure to Blood: What Healthcare Personnel Need to Know***

  http://www.cdc.gov/ncidod/dhqp/pdf/bbp/Exp_to_Blood.pdf

SCHOOL OF MEDICINE

- Advice Concerning Blood-Borne Exposures

  Dr. Doug Paauw
  C-511 Health Sciences Building, Box 356420
  Phone: 206-543-3604; Pager: 206-991-0909
  dpaauw@u.washington.edu

  Dr. Amy Baernstein
  Emergency Department, Harborview Medical Center
  Phone: 206-731-3263; Pager: 206-663-1909
  abaer@u.washington.edu

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- Advice and Information Related to Health Science Vaccine Requirements & Issues Related to Being a Hepatitis B and/or C Carrier

  Dr. N. Jean Haulman
  Associate Medical Director for Public Health & Immunization Services
  Hall Health Primary Care Center (206-685-1011)
  nhaulman@u.washington.edu

- Associate Dean for Curriculum
  Dr. Michael J. Ryan
  A-300 Health Science Building, Box 356340
  Phone: 206-543-5560
  mjryan@uw.edu

- College Heads
  Dr. Erika Goldstein – Director of the Colleges and Head, Rainier College
  Pager: 206-663-7240
  erika@u.washington.edu

  Dr. Hugh Foy – Head, Wind River College
  Pager: 206-405-5328
  hughfoy@u.washington.edu

  Dr. Raye Maestas – Head, Denali College
  Pager: 206-997-4609
  maestas@u.washington.edu

  Dr. Rick Arnold – Head, Snake River College
  Pager: 206-995-9049
  rwarnold@u.washington.edu

  Dr. Mark Whipple – Head, Big Sky College
  Pager: 206-997-9068
  mwhipple@u.washington.edu

  Dr. David Losh – Head, Columbia College
  Pager: 206-626-1888
  dlosh@u.washington.edu

- Employee Health, Harborview Medical Center (HMC)
  Phone: 206-731-3081

- Emergency Department, HMC
  Phone: 206-731-3074

- Campus Health, University of Washington Medical Center (UWMC)
  Phone: 206-598-4848

- Emergency Department, UWMC
  Phone: 206-598-4000

- Hall Health, University of Washington Campus
  Phone: 206-685-1011

- Liability Claims Manager, Office of Risk Management
  Ms. Kelly Williams, JD
  22 Gerberding Hall, Box 351276
  Phone: 206-685-1011
  kwilliam@u.washington.edu

PUBLIC HEALTH DEPARTMENT

- Dr. Robert Wood
  Director, HIV/AIDS Program
  Advisor the Gay & Lesbian Medical Association
  Phone: 206-296-4805
  Dr.BobWood@comcast.net

- Dr. Jeff Duchin
  Chief, Communicable Disease Control, Epidemiology & Immunization Section
  Public Health – Seattle & King County
  Phone: 206-296-4774
  jeff.duchin@kingcounty.gov