State of Wisconsin
Department of Health and Social Services

Information and Guidelines

Preventing the Transmission of HTLV-III in the Prison Setting

Acquired Immunodeficiency Syndrome (AIDS)

Wisconsin Department of Health and Social Services

Guidelines for Preventing the Transmission of Human T-cell Lymphotropic Virus Type III in the Prison Setting

February 1986
Madison, Wisconsin

Acknowledgments

This document was prepared by the staff of the Wisconsin Division of Health (Bureau of Community Health and Prevention; Bureau of Correctional Health Services) and the Division of Corrections with input provided by the Wisconsin Public Health Task Force on AIDS and John Connell, Jail Administrator, Dane County Sheriff Department. Background information and suggestions were also provided by John Bennett, M.D., Assistant Director of the Center for Infectious Diseases, Centers for Disease Control.

Wisconsin Department of Health and Social Services

Linda Reivitz, Secretary, Department of Health and Social Services
Kathryn Morrison, Administrator, Division of Health
Walter Dickey, Administrator, Division of Corrections

Division of Health, Bureau of Community Health and Prevention

Ivan Imm, Director
Nancy Kaufman, R.N., Deputy Director
Jeffrey P. Davis, M.D., State Epidemiologist
James M. Vergeront, M.D., Medical Epidemiologist
Holly M. Dowling, Health Educator
Virginia E. Stauffacher, Word Processing Operator

Division of Health, Bureau of Correctional Health Services

Barbara Whitmore, Director
Linda Kleinsteiber, R.N., Nurse Supervisor
Dianne Meyer, M.D., Physician, Oakhill Correctional Institution

Division of Corrections

Gary McCaughtry, Deputy Superintendent, Oshkosh Correctional Institution
Jack Stoddard, Chief, Program Services, Bureau of Clinical Services
Jeff Endicott, Deputy Superintendent, Portage Correctional Institution
Kris Krenke, Treatment Director, Taycheedah Correctional Institution
Gordon Abrahamson, Superintendent, Dodge Correctional Institution
Kay Kendall, Unit Supervisor, Bureau of Community Corrections
John Ross, Director, Bureau of Juvenile Services
Larry Kane, Ph.D., Chief Psychologist, Oakhill Correctional Institution
Lee Pray, DOC Legal Counsel
Dave Kindschuh, Correctional Officer, Dodge Correctional Institution

Public Health Task Force on AIDS

David Kindig, M.D., Chairperson
Professor of Preventive Medicine, Director of Administrative Medicine and Health Services Administration Programs
University of Wisconsin-Madison

Ray Bachhuber, M.D.
St. Vincent Hospital, Bellin Memorial Hospital, Green Bay

Starkey Davis, M.D.
Professor and Chairman, Department of Pediatrics, Medical College of Wisconsin; Pediatrician in Chief, Milwaukee Children's Hospital, Milwaukee

Susan Dietz, R.N.
Director, Milwaukee AIDS Project

Norman Fost, M.D., Professor of Pediatrics and History of Medicine Director, Program in Medical Ethics, University of Wisconsin Clinical Sciences Center, Madison

Tim Franson, M.D.
Assistant Professor of Medicine, Medical College of Wisconsin
Hospital Epidemiologist, Veterans Administration Hospital, Milwaukee

Will Handy, MSSW
Moon Tree Collective, Madison

Jane DeGroot-Kosolcharoen, R.N.
Infection Control Nurse, Wm. S. Middleton Memorial Veterans Administration Hospital, Madison

Dennis Maki, M.D.
Professor of Medicine, Head, Section of Infectious Diseases
University of Wisconsin Clinical Sciences Center, Madison

Jay Menitove, M.D.
Medical Director, Blood Center of Southeastern Wisconsin, Milwaukee

Paul Meyer
Program Director, Dane County Unified Services Board, Madison

Doug Mormann
Director, La Crosse County Health Department, La Crosse

Margaret Schmelzer, R.N.
Director of Public Health Nursing, City of Madison Health Department, Madison

Richard Theado
Executive Director, The Planning Council for Mental Health and Social Services, Milwaukee

Tim Tillotson
Sexually Transmitted Disease Program Coordinator, University Health Service, Madison

Paul Turner, M.D.
Instructor of Medicine, Division of Infectious Diseases, Medical College of Wisconsin, Milwaukee

Technical Advisors

John Connell, Jail Administrator, Dane County Sheriff Department

Table of Contents

Wisconsin Department Of Health And Social Services
Guidelines For Preventing The Transmission Of Human T-Cell Lymphotropic Virus Type III In The Prison Setting

Purpose

The information and guidelines contained in this document have been developed for correctional staff to assist in the management of inmates infected with human T-cell lymphotropic virus type III (HTLV-III), the virus that causes acquired immunodeficiency syndrome (AIDS). The document is intended to provide overall guidance on preventing the transmission of HTLV-III within the correctional system, as well as protecting the confidentiality of infected inmates and reducing the anxiety and misunderstanding about the disease within the correctional system. In addition, the guidelines address general infection control precautions. Adherence to these policies will also reduce the risk of transmission of other viral and bacterial infections in the correctional setting.

Applicability

The guidelines provided in this document are applicable to all adult and juvenile correctional institutions in Wisconsin under the jurisdiction of the Division of Corrections and all institution staff (correctional and health service unit staff) should become thoroughly familiar with the guidelines. The guidelines address issues specific for the correctional institutions and may not be directly applicable to all situations encountered in community correction programs.

Background Information On HTLV-III Infections

Acquired immunodeficiency syndrome (AIDS) is a serious communicable disease caused by the human T-cell lymphotropic virus type III (HTLV-III), a virus that alters the body's immune system. As a result of the damage to their immune system caused by HTLV-III, persons with AIDS are susceptible to serious infections ("opportunistic infections") and specific cancers which would not normally be a threat to individuals whose immune systems are functioning normally. For the purposes of surveillance, the Centers for Disease Control (CDC) has defined a case of AIDS as an illness moderately indicative of a cellular immune deficiency in a person who has no known reason for having a deficient immune system (i.e., they do not have cancer or are not on immunosuppressive drugs). About 85 percent of the AIDS patients studied have had one or both of two diseases: Pneumocystis carinii pneumonia, a parasitic opportunistic infection of the lungs; and a type of cancer known as Kaposi's sarcoma which usually initially appears as a reddish or blue-violet spot on the surface of the skin or in the mouth.

Not all individuals infected with HTLV-III develop AIDS. In fact, most individuals (60 percent) infected with the virus have no symptoms and generally feel well. Approximately 25 percent of infected persons develop persistent symptoms which may include fatigue, fever, loss of appetite and weight, chronic or recurrent diarrhea, night sweats, non-productive cough,

shortness of breath, and swollen lymph nodes (lymph glands)--usually in the neck, armpits or groin. In addition, individuals infected with HTLV-III may have altered immune function that may be detected on blood tests (e.g., T-cell lymphocyte studies). Persons who develop two or more clinical signs or symptoms and two or more laboratory abnormalities related to an HTLV-III infection are classified as having AIDS-Related Complex or ARC. Thus, HTLV-III infections represent a spectrum of severity of illness; individuals may be totally symptom-free, have mild signs or symptoms, ARC, or the nearly always fatal AIDS. All of these individuals should be considered to be infected with HTLV-III and to be infectious. Progression to AIDS does not always occur. Initial studies have shown that 7-19 percent of persons with HTLV-III infections have developed AIDS; however, because the latent period (the time between exposure and development of disease) is long (6 months to 5 years and possibly longer) and our experience with this virus is short (the first U.S. cases were diagnosed in 1981), we cannot accurately project the long term consequences and complications of an infection with HTLV-III.

HTLV-III has been isolated from blood, semen, saliva, tears, urine and breast milk. However, only intimate exposure to blood and semen appear to be associated with transmission of the virus. Although HTLV-III is present in low concentrations in saliva and tears of some infected individuals, the evidence to date indicates that casual contact with these body fluids does not result in transmission of infection. AIDS, ARC and HTLV-III infections are transmitted primarily by sexual contact (homosexual or heterosexual) and by the sharing of blood contaminated needles. Transmission may occur less commonly through transfusions of blood or blood products and from mothers to their babies during pregnancy or during birth. Thus, persons at increased risk of acquiring an HTLV-III infection are:

- sexually active homosexual and bisexual men typically with multiple partners (73 percent of the cases of AIDS)
- present and past users of intravenous drugs (17 percent)
- persons with hemophilia (1 percent)
- persons who have transfusions with blood or blood products (2 percent)
- heterosexual contacts of someone with AIDS or at risk for HTLV-III infections (1 percent)

Six percent of AIDS cases could not be placed in one of the identified risk groups. These cases included recent Haitian immigrants and immigrants of other developing countries where AIDS is known to exist, persons who could not be or refused to be interviewed and men who gave histories of sexual contact with female prostitutes.

Casual contact with either individuals infected with HTLV-III or persons who are at increased risk for acquiring an HTLV-III infection does not place others at risk for getting the infection. Even in the households of over 18,000 AIDS patients, spread of HTLV-III infection to household contacts has not been detected when the contacts have not been sex partners or have not been infants of infected mothers. Seven studies of family members of patients with HTLV-III infection have failed to demonstrate HTLV-III transmission to adults who are not sexual contacts of the infected patients or to older children who are not likely to have been infected during pregnancy or delivery [1-7]. One recent exception to this is a report of a mother who appears to

have acquired her HTLV-III infection as a result of providing direct and extreme care to her child with transfusion associated AIDS [8]. Even non-sexual household contacts of persons with hemophilia who actively and regularly assist in blood product infusions have not developed evidence of HTLV-III infections [7].

Exposure to inmates that are bleeding or who have bitten a staff member should be considered more than casual contact. The highest risk for transmission of HTLV-III to a staff member would involve staff receiving a cut or stick exposure to a needle, knife, or other sharp instrument contaminated with blood from an infected person. However, even among the thousands of health care workers who have cared for the over 18,000 individuals with AIDS, no reported cases of AIDS have occurred that can be linked to a specific occupational exposure. National studies of 666 health care workers who have inadvertently been exposed to blood or body fluids of AIDS patients (e.g., by accidental needle sticks) have identified only two persons who potentially may have developed an HTLV-III infection through occupational exposure [9]. Both of these cases involved direct inoculation of infected blood via a needle stick injury. One case of apparent transmission of HTLV-III to a health care provider after a needle stick injury has also been reported in England [10]. These results suggest that the risk of transmitting infection from an infected person by needle stick injury is probably less than 1 percent, and reveal no evidence of any other mode of spread from cases to attendants despite their far more frequent contact with secretions and excretions of infected persons than would generally be expected for correctional staff. Finally, there has not been a single case in which a policeman, paramedic, security officer or prison guard has developed an HTLV-III infection as a result of assisting an AIDS patient or in providing cardiopulmonary resuscitation (CPR).

HTLV-III And Hepatitis B Infections In Correctional Facilities

The need for institutional control programs to prevent HTLV-III infections depends on two main factors:

1. The likely frequency of sharing of equipment of IV drug abuse and frequency of male homosexual activity among inmates.

2. The prevalence of HTLV-III infections among prisoners.

Transmission requires both the presence of the virus in the prison population and opportunities for spread. The risk of transmission of HTLV-III increases as the frequencies of both factors increase.

Nationally, AIDS cases have been reported from correctional facilities in 24 states [11]. Among the 766 cases reported by January 1986, the largest numbers were reported from New York State and New Jersey. These numbers are underestimates, since many inmate cases are not reported as being associated with a correctional facility. The duration of incarceration before onset of AIDS is not known for these cases. In a study reported in 1983 of seven AIDS cases among male inmates of a correctional facility in New York State [12], all cases occurred in persons who were IV drug abusers before incarceration and onsets of AIDS occurred 5-38 months after incarceration. These results suggest, but do not prove, that infections were acquired before incarceration, since these time periods are within the latent periods observed between single known exposures to HTLV-III and onset of AIDS.

Little is known about the prevalence of HTLV-III infections or their transmission in correctional facilities. However, since intravenous drug abuse is an important factor predisposing to both incarceration and HTLV-III infection, a higher proportion of prisoners will be infected with this virus than in the population at large. The reported prevalence of HTLV-III infections among unincarcerated heterosexual intravenous drug abusers in the U.S. has ranged from 2 percent to 59 percent [13, 14]. The prevalence of HTLV-III infections among IV drug abusers in Wisconsin is likely to be in the lower range.

A 1979 stratified random sample of 12,000 state prison inmates in the U.S. demonstrated that 30 percent of inmates had used heroin at sometime and 12 percent had used heroin in the month prior to the crime they had committed [15]. In Wisconsin, two studies estimated that 27 percent of inmates had used illicit IV drugs at sometime and 9 percent had used heroin in the six months prior to incarceration [16-18]. No definitive data on IV drug use within prisons is available; however, urine drug screenings conducted by the Wisconsin Division of Corrections suggest that IV drug use in the institutions occurs very rarely. The sharing of unsterilized needles used for tattooing may potentially result in the transmission of HTLV-III. Data on the practice of tattooing within the institutions is not available.

Though it is generally recognized that male homosexual activity may occur in association with incarceration, reliable estimates of the frequency of such activities are not available. Homosexual activity in the prisons may be engaged in through consent or coercion, with non-consenting sexual interactions resulting from sexual extortion (the inmate is pressured into paying his indebtedness to another inmate by relinquishing sex) or sexual assault (the inmate is overpowered or threatened with physical injury unless he submits sexually). The few studies that have been completed on homosexual activity in the prison conservatively estimate that 0.5 to 3 percent of inmates incarcerated are subjected to sexual assault; between 9 and 20 percent have been sexually victimized; and overall, 30 to 40 percent of inmates have had a homosexual experience while incarcerated [19-23]. The percentage of inmates having had a homosexual experience prior to incarceration is not markedly different from that of adult males in the general population. Data specific to the Wisconsin correctional system are not available.

The epidemiology of HTLV-III infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned about the risk of acquiring hepatitis B can be applied to understanding the risk of HTLV-III transmission in correctional facilities. Both viruses are transmitted through sexual contact, parenteral (needle stick or cut) exposure to contaminated blood or blood products, and perinatally from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III infection. Neither HBV nor HTLV-III has been shown to be transmitted by casual contact in the work place, contaminated food or water, or airborne or fecal-oral routes [24].

The prevalence of serologic evidence of HBV infections among male prisoners is high, ranging from 19 to 47 percent in recent studies [16, 25, 26]. The antibody profiles of nearly all of these men indicated that they were immune

to HBV, and the prevalence of carriers of the virus was only about 1 percent. A 1983 study of adult male prisoners entering the Wisconsin state prison system identified 1.1 percent of the study participants as carriers of HBV (HBsAg positive) and 19 percent as ever having been infected with HBV (any marker positive) [16]. Transmission of HBV within correctional facilities may be underestimated by the frequency of HBV infections, because inmates at highest risk of exposure to HBV are highly likely to be already immune when incarcerated [26]. Only one outbreak of hepatitis B has been reported from a prison setting [27]. That outbreak was related to plasmapheresis and drug abuse. Annual seroconversion rates to HBV among prisoners incarcerated for one year have ranged from 0.8 percent [26] to 1.32 percent [28]. All but one of the five seroconverters observed in these two studies admitted to intravenous drug abuse prior to incarceration.

Identification And Evaluation

The diagnosis of AIDS and ARC may be established based on a medical history, clinical evaluation and the results of laboratory studies. The development and implementation of protocols for the clinical management and assessment of symptomatic inmates is primarily the responsibility of the Bureau of Correctional Health Services; these protocols are not included in this document. Cases of AIDS and ARC only represent the most severe form of HTLV-III infections; approximately 60 percent of individuals infected with HTLV-III remain asymptomatic. Currently, the only method to identify individuals that have been infected with HTLV-III is through an HTLV-III antibody test. Antibody to HTLV-III in blood specimens may be detected by one of several federally licensed enzyme-linked immunoassay (ELISA) tests. The ELISA test will successfully identify 93-98 percent of individuals that have had an HTLV-III infection, thus false negative tests will occasionally occur. False positive tests may also occur, the magnitude of which depends upon the population group being tested. However, the accuracy of positive test results is greatly improved (false positives almost totally eliminated) by repeating an initially reactive ELISA test several times and by using a different antibody testing method (Western blot) to verify the ELISA test results.

It is important to understand that not all individuals with a positive HTLV-III antibody test result will develop AIDS or ARC. Current scientific data based on studies of individuals at high risk for HTLV-III infections suggest that 7-19 percent of individuals with a positive HTLV-III antibody will develop AIDS within 2 to 5 years; 25 percent will develop ARC or related conditions and approximately 60 percent will remain asymptomatic. However, the vast majority of individuals with a positive HTLV-III antibody test result remain infected with HTLV-III. The semen, blood, and possibly other body fluids of these individuals should be considered to be infective.

Testing of all inmates for antibody to HTLV-III upon admittance or during incarceration is not considered likely to be an effective means to prevent spread from prisoners to correctional staff, since the usual, nonsexual contacts between prisoners and correctional staff will not spread infection. However, counseling persons on ways to prevent transmission or acquisition of infection at the time of testing may be useful in preventing transmission of HTLV-III among prisoners by alteration of behavior. Ideally, all inmates belonging to risk groups for HTLV-III should be able to voluntarily, safely

and confidentially seek serologic testing and counseling, and subsequently behave responsibly in accord with the test results. In addition to potentially changing personal sexual behavior, the test results might influence important personal decisions in the life of an inmate, and could assist medical staff of the prison in medically managing the inmate. Knowledge of HTLV-III infection would assist in more rapid, accurate diagnosis and treatment of intercurrent illness, assist in determining the need for prophylaxis following exposure to certain infections such as tuberculosis, serve as a relative contraindication for use of immunosuppressive agents, and contraindicate the donation of blood or organs. Unfortunately these ideals cannot always be achieved in a prison environment. Serologic test information also has more general uses, such as permitting sexual contacts of infected persons to be identified, tested and counseled. Routine systematic testing of persons at the beginning of custody and perhaps periodically thereafter could be used for surveillance of trends in the incidence of HTLV-III infection and for evaluation of the effectiveness of educational and control programs within correctional facilities. Information from testing would also facilitate incident management, since the probable infection status of the person in custody could be established at the time of the incident. However, knowledge that a person in custody was previously uninfected would not obviate the need to ascertain infection status at the time of an incident, and a delay of several days in determining that the person to whom one was exposed was infected would not importantly influence the ability to document seroconversions in exposed persons. Finally, knowledge of infection status at the time of incarceration would permit the assignment of appropriate housing for infected persons likely to engage in behavior that might pose a risk of transmission to others.

There are potentially serious complications deriving from the serologic testing of prisoners, regardless of the purposes for which testing was performed. If individually identifiable results of such tests could not be kept confidential in correctional settings, and if the lives of infected prisoners would be endangered by violent acts of other prisoners, total separation of infected from uninfected prisoners would be needed. Theoretically, such total separation of prisoners from each other (totally separate cells, dining halls, and indoor and outdoor recreational facilities), though imposed for safety purposes, could nonetheless prevent transmission without requiring behavior changes of prisoners. If infected prisoners were not completely separated from uninfected prisoners, tests would need to be repeated periodically on those who were uninfected. Knowledge that a person in custody was infected might also lead some correctional staff to the unwarranted neglect of activities affecting the welfare of the person in custody, and, even if the correctional facility could segregate, it might be difficult to identify correctional staff who would be willing to work with infected prisoners.

Thus, if confidentiality of test results cannot be maintained in prison environments, routine testing on admission should only be performed if the safety of infected inmates can be guaranteed, which may require separate facilities for infected inmates. Even if routine serologic screening upon admission is not performed, the proportion of prisoners who are either aware of their HTLV-III infection status, or have medical records reflecting such a

status at the time they are incarcerated, is likely to increase greatly over the next several years as serologic testing becomes more widely used in public health prevention programs.

Support Services

Providing optimal care for persons diagnosed as having AIDS, ARC or an HTLV-III infection, or persons who are at risk for an HTLV-III infection, requires having appropriate referral and social/psychological support services available. Persons with these diagnoses are generally anxious and may have special psychological as well as medical needs. Being able to offer services directed at fulfilling these special needs is an important aspect in the comprehensive treatment and care of infected persons.

Members of groups at highest risk for HTLV-III/LAV infections are common in prison populations and, if tests are not performed while incarcerated, testing should be offered to high risk persons at the time of release into society. This would permit infected persons to be counseled regarding precautions and responsibilities to prevent spread to others, and uninfected risk group members to be counseled about how to remain uninfected. Such programs should be jointly developed by public health officials and correctional authorities.

Education Of Staff And Inmates

A comprehensive educational effort directed at the correctional staff and inmates is an important aspect of preventing transmission of infections and in reducing the anxiety and misunderstanding about the potential for transmission of infectious agents within the institution. Although educational initiatives need to address communicable diseases in general, specific emphasis should be directed at AIDS and HTLV-III infections. The goal of such an education plan is to combat fear that is based on misinformation or lack of information and to minimize the risk of transmission of HTLV-III by promoting good health practices, including routine use of infection control precautions and eliminating high risk behaviors. Thus, staff and inmates need to be provided with information regarding the signs and symptoms of HTLV-III infections, the methods of transmission of the virus and preventive measures. This information should be presented in terms that are easily understood by the general public and should include literature in foreign languages (e.g., Spanish).

Confidentiality

The diagnosis of AIDS or associated illnesses may evoke fear from others in contact with the infected individual and may evoke suspicion of lifestyles that may not be acceptable to some persons. If medical information regarding infected prisoners could not be kept confidential in the correctional setting, infected individuals may be at risk of physical harm from other prisoners. Thus, prison officials need to be sensitive to the importance for maintaining confidentiality and the right to privacy in these cases, including maintaining confidential records. The number of staff made aware of the inmate's condition should be kept at the minimum needed to assure proper treatment and care of the inmate, and proper protection of individuals the inmate may come into contact with.

Legal Issues

Policies regarding the management of inmates infected with HTLV-III must consider current Wisconsin statutes pertaining to the confidentiality of HTLV-III antibody test results (Wis. Stat. 146.025) and the Department of Health and Social Service's (DH&SS) responsibility for the administration of the prison system and its duty to provide health services to inmates (Wis. Stats. 46.03 (1) and 53.385). Within the prison context, there are three major issues of concern:

1. Providing blood tests for HTLV-III antibody.

2. Limiting access to medical records; specifically, access to HTLV-III antibody test results.

3. Housing inmates infected with HTLV-III.

A discussion of each issue follows:

Providing blood tests for HTLV-III antibody. Wisconsin statute 146.025 describes the conditions under which an individual may be tested for antibody to HTLV-III and to whom the test results may be disclosed. This statute would apply to any inmate in the correctional system and any proposed HTLV-III antibody testing protocol.

> Specifically, "no health care provider...may subject a person to a test for the presence of antibody to HTLV-III unless the subject of the test first provides informed consent for testing...The results of a test for the presence of antibody to HTLV-III may be disclosed only to the following persons or under the following circumstances [only those circumstances related to the prison setting are listed here]...
>
> 1. To the subject of the test.
>
> 2. To the test subject's health care provider, including those instances in which a health care provider provides emergency care to the subject.
>
> 3. To an agent or employee of the test subject's health care provider who provides patient care or handles or processes specimens of body fluids or tissues...
>
> 6. To the state epidemiologist...
>
> 8. To health care facility staff committees or accreditation or health care services review organizations for the purposes of conducting program monitoring and evaluation and health care services reviews.
>
> 9. Under a lawful order of a court of record."

The statute also requires the mandatory reporting of positive test results for antibody to HTLV-III to the state epidemiologist. Finally the statute provides for significant civil and criminal penalties for negligent or intentional violation of provisions of the statute. Any person violating the specified testing and disclosure provisions "is liable to the subject of the test for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation. Whoever intentionally discloses the results of a blood test in violation...[of the statute provisions] and thereby causes bodily harm or psychological harm to the test subject may be fined not more than $10,000 or imprisoned not more than 9 months or both."

The discussion above specifically relates to disclosure of HTLV-III antibody test results. Restrictions pertaining to the disclosure of the fact that an individual is diagnosed as having AIDS or ARC would be governed by statutes that generally protect the confidentiality of medical records (Wis. Stats. 146.81-146.82). Disclosure of medical information in general is discussed below.

Access to medical records and HTLV-III antibody test results. The basic statutes concerning disclosure of medical records are set forth in Wisconsin statutes 146.81-146.82 in which a "health care provider" is prohibited from making disclosures from health care records except under certain circumstances. Wisconsin statute 146.025 as noted above also prohibits the "health care provider" from disclosure of the HTLV-III antibody test results except under certain circumstances [Wis. Stat. 146.025 (5a)]. In both cases, the term "health care provider" is defined by reference to Wisconsin statute 146.81 which is phrased in terms of the applicable licensed medical professional, such as a physician or nurse. However, other statutes clearly assign responsibility for operation of the prisons to the Department of Health and Social Services as a whole. It is the responsibility of the Department of Health and Social Services as a whole for ensuring that inmates receive proper medical care [Wis. Stats. 46.03 (1), 46.03 (6), 46.115, 46.16 and 53.385], and those statutes must be honored. Additionally, the superintendents of the State's prisons also have a duty to provide a healthy and safe environment for all inmates [Wis. Stats. 53.04, 53.07 and 53.08, and HSS 306.03 and 306.04]. Moreover, the Department of Health and Social Services employs and supervises the superintendents and the medical staff. Thus, the Department must be considered as the legal "health care provider" in a prison context and can determine which of its health or corrections staff will have access to medical records. In order for the superintendents and other corrections staff to fulfill the prison system's statutory obligations, there must be sufficient access to medical information which is necessary to protect the health and safety of staff and inmates. This does not mean that all correctional staff should have access to all types of medical information. Rather, these statutes as interpreted above indicate that there is no legal obstacle for correctional staff, who have a legitimate need to know, from having access to inmate HTLV-III antibody test information or to inmate medical information covered by Wisconsin statute 146.82, if the Department approves that access. Recommendations on who needs to have access to HTLV-III antibody results in the correctional setting are included in the section on "Confidentiality.

Finally, it should be noted that the Employee's Right to Know Law [Wis. Stats. 101.58-101.599] does not require disclosure of HTLV-III test results in the correctional setting. This law only applies to an infectious agent that is "introduced" by an employer to be "used, studied or produced" in the work place. An inmate infected with HTLV-III would not qualify under this statutory description.

Legal issues regarding the housing of inmates infected with HTLV-III. Inmate housing decisions are for the most part, based on security and medical (recommendations of the health services unit staff) concerns with the superintendent of the institution ultimately having the legal authority for the placement of inmates. In general, legal authorities, when considering issues of inmate housing (e.g., constitutional concerns regarding prisoner liberty which might be violated as a result of segregation based on medical grounds) have established that the court is not a proper body to measure the propriety of medical standards and precautions. Accordingly, the courts will generally defer to the judgement of medical authorities where such authorities' determinations appear to be reasonable in light of the present available medical information. Therefore, as long as prison authorities' decisions to house inmates infected with HTLV-III are based on clinically substantiated indications and health concerns, and where present available information provides no contraindications, courts are likely to support the prison authorities' decisions on housing.

Specific Guidelines For The Identification And Evaluation Of HTLV-III Infections

1. All newly-admitted inmates will routinely be screened to identify individuals with symptomatic or clinically apparent HTLV-III infections. This screening procedure will include:

   a. History--A standardized questionnaire will be utilized to identify specific symptoms and risk activities associated with HTLV-III infections. The questionnaire will be included in the Bureau of Correctional Health Services protocol and will be administered by the Bureau's health care staff. An assessment of risk activities will include any information available from pre-sentence reports or other routine entrance interviews conducted by correctional staff.

   b. Physical examination--The routine entrance physical examination will include a careful evaluation of the skin, mouth and pharynx, lymph nodes and rectum for pathology and infectious processes related to HTLV-III infections. A standardized physical examination form will be included in the Bureau of Correctional Health Services protocol.

   c. Laboratory--As part of a routine entrance evaluation all inmates will have performed a complete blood cell count (CBC) with a differential, a serologic test for syphilis, a urinalysis and a Mantoux tuberculin skin test (PPD).

2. Inmates already within the system who have symptomatic HTLV-III infections will most likely come to the attention of the health service unit staff through either staff or inmate initiated clinic visits. Any inmate complaining of a symptom suggestive of an HTLV-III infection should be evaluated by the health service unit staff through careful history taking (including standardized HTLV-III related questionnaire), physical examination and medically appropriate laboratory tests and diagnostic procedures.

3. HTLV-III antibody testing.

   a. Inmates will not be routinely tested for antibody to HTLV-III upon entrance into the correctional system or during their incarceration.

   b. Inmates who have a history of high risk activities for acquiring an HTLV-III infection, or who have a physical examination or laboratory studies suggestive of a HTLV-III infection should be counseled by the Bureau of Correctional Health Services staff regarding the need for further medical evaluation and should be informed of the availability of the HTLV-III antibody test.

   c. Inmates who independently request an HTLV-III antibody test should be medically evaluated and counseled by the health service unit staff prior to the HTLV-III antibody test being performed. No more than two inmate requested and not medically indicated (as determined by the health services unit) HTLV-III antibody tests will be provided to an inmate per year.

d. The HTLV-III antibody test will be performed after an inmate has been medically evaluated, has signed an informed consent form and has received counseling from the health service unit staff regarding the test. Inmates who have had a test performed will receive additional counseling by the health service unit staff upon receiving the test results. Any necessary referral services will be coordinated through the health service unit staff.

Specific Guidelines Regarding Confidentiality

1. Information regarding who has been tested and/or who is being evaluated for an HTLV-III infection will be limited to the medical record and the medical staff.

2. Individually identifiable information regarding inmates diagnosed with an HTLV-III infection (AIDS, ARC or persons with a validated positive HTLV-III antibody test) will be limited:

   a. On a routine basis to the Superintendent of the appropriate institution and his/her legal designees ("chain of command"), the institution program review committee, the institution health unit staff, the Director of the Bureau of Correctional Health Services and designated bureau staff and the State Epidemiologist and his/her designated staff.

   b. In special circumstances as deemed necessary by the institution superintendent (e.g., an infected inmate involved in a sexual assault, an employee with a significant exposure to the body fluids of an infected inmate, a security disruption related to an infected inmate), to the Director of the Bureau of Correctional Health Services, the Secretary of the Department of Health and Social Services, the Administrators of the Divisions of Health and Corrections and their respective designated staff.

3. Exemptions to the above disclosure guidelines include circumstances where:

   a. The inmate has provided a written informed consent for disclosure to other specified persons or disclosures specifically permitted under Wisconsin statute 146.025.

   b. It has been determined by the Superintendent of the institution in consultation with the health services unit staff that for non-medical reasons the inmate requires special handling (as discussed in the section on "Specific Infection Control Guidelines," point 3). In those situations, only staff who have a need to know will be informed of the need for special handling precautions. In most cases, this information should be restricted to the specifics of handling precautions and does not require the disclosure of the specific diagnosis.

   c. In the event that an inmate in the state correctional system is transferred to a county jail, the medical status of the individual should be communicated by the Health Services Unit to the medical care provider responsible for medical care in the jail.

4. It is the responsibility of the institution superintendent to inform staff of the consequences of violations of confidentiality.

General Infection Control Guidelines

1. With the assistance of the health service unit staff, each superintendent will review aspects of institution operations including security, housing, laundry, work areas, food services, visiting, barber services, recreation, transportation, and maintenance, to assess areas where improvements can be made to reduce the risk of transmission of infectious diseases. Particular attention should be given to circumstances where the potential exists for someone to come in contact with the body fluids of another. To facilitate this process, the Division of Corrections and Bureau of Correctional Health Services should establish a committee to review infection control policies utilized in the institutions.

2. Institutions should evaluate and improve, if indicated, programs to control illegal drug use, non-authorized tattooing and illicit sexual activity.

3. Institution procedures and operations will discourage the sharing of unsterilized objects such as razors (electric or straight edge) and toothbrushes which could be contaminated with the body fluids of others.

4. Cleaning supplies including brushes, baskets, bleach, rubber gloves, and plastic bags should be available in housing and program areas. Inmates should be supplied with cleaning supplies and encouraged to routinely clean their cell or room.

5. First aid information and supplies, including CPR masks, should be available in housing and program areas.

6. All correctional staff should routinely wear gloves for direct contact with mucous membranes or non-intact skin of all inmates.

7. Standard procedures should be developed for inmates and staff to use when cleaning up after any accident or injury, and for cleaning areas or handling objects potentially contaminated with body fluids. These procedures would include:

   - Wearing of gloves, especially when individuals have open lesions on their hands.

   - Cleaning up of blood and body fluid spills on environmental surfaces soon after the spill with a disposable towel and a freshly prepared household bleach in water solution (1 part household bleach to 9 parts water) or another disinfectant.

   - Placing blood (or body fluid) soaked items that are disposable in a sturdy plastic bag, and sealing and marking the bag with "blood and body fluid precautions." Persons disposing of the plastic bag should wear gloves.

- Persons cleaning up spills or handling contaminated items should wash their hands after such activities, even if they had been wearing gloves.

- Clothes and linens contaminated with body fluids should be placed in a water soluble bag and then in a plastic bag and laundered separately. Persons handling contaminated clothing should wear gloves.

- Persons whose clothes have been contaminated with body fluids of another person should be provided with a change of clothes and an opportunity to wash as soon as possible.

- Any person that has had a significant exposure (splashing of a body fluid into the eye, mouth or an open lesion; puncture with an item contaminated with a body fluid; or a bite) should consult with the health service unit staff regarding the exposure and potential follow-up recommendations.

Specific Infection Control Guidelines For HTLV-III Infections

1. Inmates under medical evaluation for a suspected HTLV-III infection or having been diagnosed with an HTLV-III infection will not be managed differently than other inmates unless medically indicated on the basis of signs, symptoms or co-existing infections.

   - Housing--Inmates with HTLV-III infections should be housed with the general population, although they will not be placed in multi-person cells or rooms.

   - Activities--Inmates with HTLV-III infections will be allowed standard access to recreational activities, work assignments, visitation privileges, showers and bathroom facilities, food services and other program activities.

   - Laundry--The laundry of inmates with HTLV-III infections will be handled using the general guidelines listed above and washed with that of the general population unless grossly soiled with bodily fluids.

   - Transportation--When transporting inmates with HTLV-III infections, standard security precautions shall be utilized. No special infection control precautions need to be instituted.

   - Security--Routine security procedures should be utilized when handling infected inmates or responding to security situations. No special infection control precautions need to be instituted.

   - Classification and transfer--Routine classification and transfer policies will be observed for infected inmates.

2. When an inmate with an HTLV-III infection requires special handling or infection control precautions based on his/her health status (e.g., symptoms, co-existing infections, or immune suppression) the health service unit staff will recommend special handling orders based on standard medical practice. These recommendations should be made to the superintendent.

3. Persons who work and reside in institutions have a right to be protected from acquiring an HTLV-III infection in the institution. This includes protecting them from infected individuals that exhibit behaviors such as sexual assault or physical assault that might lead to the exchange of bodily fluids. Persons responsible for the administration of these institutions should take appropriate measures to protect residents and staff from situations which pose such risks. Appropriate protective measures may include segregation or more intensive supervision of the aggressive (dangerous) infected individual and special handling of the bodily fluids.

   The only exceptions to guidelines #1 and #2 listed above relate to circumstances where the infected inmate poses a significant risk of transmitting HTLV-III to other inmates and staff because of non-medical characteristics or behaviors, as identified in the correctional system. In these situations the program review committee can dictate special handling orders after consulting with the health service unit staff. This decision should be based on an evaluation of the inmate's behavior pattern and the risks the infected inmate poses of exposing other persons to his body fluids. Special handling orders may consist of limitations and restrictions on housing, program activities or work assignments and should be consistent with the policies and procedures for inmate security classification and program assignments outlined in Wisconsin Administrative Code HSS 302.

4. The superintendent, the health service unit supervisor or physician, and the program review committee should review available information on an infected inmate's health status and behavior record at the time the inmate enters the institution and periodically during the course of the stay. Any recommendations regarding precautions to be taken in addition to standard infection control and security procedures should be carefully documented by this group. Documentation regarding the management and treatment of all HTLV-III infected inmates (excluding identifying information) should be submitted monthly by this group to the Administrator of the Division of Corrections and the Director of the Bureau of Correctional Health Services.

5. The above measures should reduce risks of transmission of infection, but accidents resulting in exposure will still occur and some persons in custody may exhibit violent, aberrant or uncontrolled behavior, including rape, resulting in exposure of others to their blood or other body fluids. Serological testing plays a useful role in the management of such incidents.

   If a parenteral (e.g., cut or needle stick) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids of another person occurs, the health service unit should be consulted concerning the likelihood of HTLV-III infection in the source person. If the health service unit judges that infection may exist and the exposure was significant, then the source person in custody should be strongly encouraged to voluntarily consent to serological testing for evidence of HTLV-III infection. <u>This would be done with the informed consent of the source person</u>. If the source person has AIDS, other evidence of HTLV-III

infection, or a positive test for HTLV-III, the exposed person should be evaluated clinically and serologically for clinical evidence of HTLV-III infection as soon as possible after the exposure, and, if seronegative, at a minimum be retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6 and 12 months) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks when most infected persons are expected to seroconvert, exposed persons should receive counseling about the risk of infection and follow U.S. Public Health Service recommendations for preventing transmission of AIDS [29, 30]. If the source person is seronegative, remains seronegative in follow-up testing, and has no other evidence of HTLV-III infection, no further follow-up of the exposed person is necessary.

Specific Guidelines For Providing Support Services

1. The health services unit staff is responsible for providing the inmate with counseling prior to testing for HTLV-III antibody, for informing the inmate of the test result and for counseling the inmate regarding the meaning of the test result and prevention implications.

2. Consultation with a psychologist or psychiatrist should be offered to every inmate with an HTLV-III infection and the psychologist/psychiatrist in coordination with the health services unit staff should make an assessment of the need for medical or social/psychological referral services. Such an assessment should be made initially and repeated as needed.

3. Prior to release from prison or release on furloughs, infected inmates should receive counseling regarding recommended precautions and prevention procedures to be utilized when they return to society. Community medical and psychological service referrals should also be made for inmates that desire such follow-up upon their release. Inmates in groups at highest risk for HTLV-III infections who were not tested during their incarceration should be offered HTLV-III antibody testing prior to their time of release into society. Testing at the time of release is a joint concern of the Divisions of Health and Corrections, and should be pursued collaboratively.

Specific Guidelines For The Education Of Staff And Inmates

1. The Divisions of Corrections and Health will be jointly responsible for developing an educational program for the correctional system directed at both staff and inmates. This educational program should include information on communicable diseases and infection control precautions in general, as well as specific emphasis on HTLV-III infections. The Divisions will also be responsible for the development of appropriate educational materials for use by the institutions.

   Educational materials and opportunities should be provided as part of an orientation package for staff beginning employment or an inmate entering the system. Inmates and employees should also be provided with periodic information updates as well as continued access to written materials or other information sources.

2. Each institution, in cooperation with the appropriate Division training director and health service unit staff will develop and implement an education program that specifically addresses the needs and concerns of their staff and inmates regarding infection control precautions and HTLV-III infections.

3. The Bureau of Correctional Health Services is responsible for providing its staff with an education program specifically addressing infection control precautions and HTLV-III infections. Bureau staff at the institutions should assist the superintendent in implementing educational programs.

4. It is important that several persons at each institution develop an expertise regarding HTLV-III infections so that they may be available to staff and inmates for responding to questions. These persons should include at least one member of the health services unit and one correctional staff member that is not in the health service unit.

References

1. Jason JM, Mc Dougal JS, Dixon G, Lawrence DN, Kennedy MS, Hilgartner M, Evatt BL. HTLV-III antibody and immune status of household contacts and sexual partners of persons with hemophilia. JAMA 1986; 255:212-5.

2. Kaplan JE, Oleske JM, Getchell JP, et al. Evidence against transmission of human T-cell lymphotropic virus/lymphadenopathy-associated virus (HTLV-III/LAV) in families of children with AIDS. Pediatr Infect Dis 1985; 4:468-71.

3. Redfield RR, Markham PD, Salahuddin SZ, et al. Frequent transmission of HTLV-III among spouses of patients with AIDS-related complex and AIDS. JAMA 1985; 253:1571-3.

4. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-3 serology, T cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, GA, April 1985.

5. Fischl MA, Dickinson G, Scott G, Klimas N, Fletcher M, Parks W. Evaluation of household contacts of adult patients with the acquired immunodeficiency syndrome. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, GA, April 1985.

6. Friedland GH, Saltzman BR, Rogers MF, et al. Lack of transmission of HTLV-III/LAV infection to household contacts of patients with AIDS or AIDS-related complex with oral candidiasis. N Engl J Med 1986; 314:344-9.

7. Lawrence DN, Jason JM, Boushasin JD, et al. HTLV-III/LAV antibody status of spouses and household contacts assisting in home infusion of hemophilia patients. Blood 1985; 66:703-5.

8. CDC. Apparent transmission of human T-cell lymphotropic virus type III/ lymphadenopathy-associated virus from a child to a mother providing health care. MMWR 1986; 35:76-9.

9. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel--United States. MMWR 1985; 34:575-8.

10. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. Lancet 1984; ii:1376-7.

11. CDC. Acquired immunodeficiency syndrome in correctional facilities: A report of the National Institute of Justice and the American Correctional Association. MMWR 1986; 35:195-9.

12. Wormser GP, Krupp LB, Hanrahan JP, et al. Acquired immunodeficiency syndrome in male prisoners. Annals Int Med 1988; 98:297-03.

13. Spira TJ, Des Jarlais DC, Bokos D, et al. HTLV-III/LAV Antibodies in intravenous drug abusers: comparison of low and high risk areas for AIDS. Presented at the International Conference on Acquired Immunodeficiency Syndrome, April 17, 1985, Atlanta, GA.

14. Weiss SH, Ginzburg HM, Goedert JJ, et al. Risk for HTLV-III exposure and AIDS among parenteral drug abusers in New Jersey. Presented at the International Conference on Acquired Immunodeficiency Syndrome, April 17, 1985, Atlanta, GA.

15. U.S. Department of Justice. Prisoners and drugs. Bureau of Justice Statistics Bulletin. March 1983.

16. Anda RF, Perlman SB, D'Alessio, et al. Hepatitis B in Wisconsin Male Prisoners: Considerations for Serologic Screening and Vaccination. Am J Pub Health 1985; 75:1182-5.

17. Wisconsin Division of Corrections. 1983 study of drug use among inmates prior to incarceration.

18. Wisconsin Division of Corrections. 1976 study of drug use among inmates prior to incarceration.

19. Davis AJ. Sexual assaults in the Philadelphia prison system and sheriff's vans. Transaction. December 1968:8-16.

20. Scacco A. Rape in prison. Springfield, IL. C. C. Thomas, 1975.

21. Moss CS, Hosford RE, Anderson W. Sexual assault in a prison. Psych Reports (Missoula, MT) 1979; 44:823-8.

22. Lockwood D. Prison sexual violence. New York Elsevier 1980.

23. Nacci PL, Kane TR. Sex and sexual aggression in federal prisons. Bureau of Prison Policy Progress Reports 1982; 1(1).

24. CDC. ACIP recommendations for protection against viral hepatitis. MMWR 1985; 34:313-24, 329-35.

25. Decker MD, Vaughn WK, Brodie JS, et al. Seroepidemiology of hepatitis B in Tennessee prisoners. J Infect Dis 1984; 150:450-9.

26. Hull HF, Lyons LH, Mann JM, et al. Incidence of hepatitis B in the penitentiary of New Mexico. Am J Pub Health 1985; 75:1213-4.

27. Koplan JP, Walker JA, Bryan JA. Prevalence of hepatitis B surface antigen and antibody at a state prison in Kansas. J Infect Dis 1978; 137:505.

28. Decker MD, Vaughn WK, Brodie JS, et al. The incidence of hepatitis B in Tennessee prisoners. J Infect Dis 1985; 152:213-7.

29. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983; 32:101-3.

30. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985; 34:1-5.

Appendix A

The Case Definition of AIDS Used by CDC for National Reporting (CDC Reportable AIDS) August 1, 1985

For the limited purposes of national reporting of some of the severe late manifestations of infection with human T-cell lymphotropic virus type III/ lymphadenopathy-associated virus (HTLV-III/LAV) in the United States, CDC defines a case of "acquired immunodeficiency syndrome" (AIDS) as an illness characterized by:

I. One or more of the opportunistic diseases listed below (diagnosed by methods considered reliable) that are at least moderately indicative of underlying cellular immunodeficiency, and

II. Absence of all known underlying causes of cellular immunodeficiency (other than HTLV-III/LAV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

Despite having the above, patients are excluded as AIDS cases if they have negative result(s) on testing for serum antibody to HTLV-III/LAV*, do not have a positive culture for HTLV-III/LAV, and have both a normal or high number of T-helper (OKT4 or LEU3) lymphocytes and a normal or high ratio of T-helper to T-suppressor (OKT8 or LEU2) lymphocytes. In the absence of test results, patients satisfying all other criteria in this definition are included as cases.

This general case definition may be made more explicit by specifying:

I. The particular diseases considered at least moderately indicative of cellular immunodeficiency, which are used as indicators of AIDS, and

II. The known causes of cellular immunodeficiency, or other causes of reduced resistance reported to be associated with particular diseases, which would disqualify a patient as an AIDS case.

This specification is as follows:

I. <u>Diseases at least moderately indicative of underlying cellular immunodeficiency</u>:

In the following list of diseases, the required diagnostic methods with positive results are shown in parentheses. "Microscopy" may include cytology.

---

* A single negative test for HTLV-III/LAV may be applied here if it is an antibody test by ELISA, immunofluorescent, or Western blot methods, because such tests are very sensitive. Viral cultures are less sensitive but more specific, and so may be relied on if positive but not if negative. If multiple antibody tests have inconsistent results, the result applied to the case definition should be that of the majority. A positive culture, however, would overrule negative antibody tests.

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over 1 month (on histology or stool microscopy).

2. *Pneumocystis carinii* pneumonia (on histology, or microscopy of a "touch" preparation, bronchial washings, or sputum).

3. Strongyloidosis, causing pneumonia, central nervous system infection, or infection disseminated beyond the gastrointestinal tract (on histology).

4. Toxoplasmosis, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or microscopy of a "touch" preparation).

B. Fungal Infections:

1. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic or autopsy findings of white plaques on an erythematous mucosal base, but not by culture alone).

2. Cryptococcosis, causing central nervous system or other infection disseminated beyond lungs and lymph nodes (on culture, antigen detection, histology, or India ink preparation of CSF).

C. Bacterial Infections:

1. *Mycobacterium avium* or *intracellulare* (*Mycobacterium avium* complex), or *Mycobacterium kansasii*, causing infection disseminated beyond lungs and lymph nodes (on culture).

D. Viral Infections:

1. Cytomegalovirus, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or cytology, but not by culture or serum antibody titer).

2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract (beyond mouth, throat, or rectum), or disseminated infection (but not encephalitis alone) (on culture, histology, or cytology).

3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus) (on histology).

E. Cancer:

1. Kaposi's sarcoma (on histology).

2. Lymphoma limited to the brain (on histology).

F. Other Opportunistic Infections With Positive Test For HTLV-III/LAV*:

In the absence of the above opportunistic diseases, any of the following diseases is considered indicative of AIDS if the patient had a positive test for HTLV-III/LAV*:

1. Disseminated histoplasmosis (on culture, histology, or cytology).

2. Bronchial or pulmonary candidiasis (on microscopy or visualization grossly of characteristic white plaques on the bronchial mucosa, but not by culture alone).

3. Isosporiasis, causing chronic diarrhea (over 1 month) (on histology or stool microscopy).

G. Chronic Lymphoid Interstitial Pneumonitis:

In the absence of the above opportunistic diseases, a histologically confirmed diagnosis of chronic (persisting over 2 months) lymphoid interstitial pneumonitis in a child (under 13 years of age) is indicative of AIDS unless test(s) for HTLV-III/LAV are negative.* The histologic examination of lung tissue must show diffuse interstitial and peribronchiolar infiltration by lymphocytes, plasma cells with Russell bodies, plasmacytoid lymphocytes and immunoblasts. Histologic and culture evaluation must not identify a pathogenic organism as the cause of this pneumonia.

H. Non-Hodgkin's Lymphoma With Positive Test For HTLV-III/LAV*:

If the patient had a positive test for HTLV-III/LAV*, then the following histologic types of lymphoma are indicative of AIDs, regardless of anatomic site:

1. Small noncleaved lymphoma (Burkitt's tumor or Burkitt-like lymphoma), but not small cleaved lymphoma.

2. Immunoblastic sarcoma (or immunoblastic lymphoma) of B-cell or unknown immunologic phenotype (not of T-cell type). Other terms which may be equivalent include: diffuse undifferentiated non-Hodgkin's lymphoma, large cell lymphoma (cleaved or noncleaved), diffuse histiocytic lymphoma, reticulum cell sarcoma, and high-grade lymphoma.

Lymphomas should not be accepted as indicative of AIDS if they are described in any of the following ways: low grade, of T-cell type (immunologic phenotype), small cleaved lymphoma, lymphocyte lymphoma (regardless of whether well or poorly differentiated), lymphoblastic lymphoma, plasmacytoid lymphocytic lymphoma, lymphocytic leukemia (acute or chronic), or Hodgkin's disease (or Hodgkin's lymphoma).

---

* A positive test for HTLV-III/LAV may consist of a reactive test for antibody to HTLV-III/LAV or a positive culture (isolation of HTLV-III/LAV from a culture of the patient's peripheral blood lymphocytes). If multiple antibody tests have inconsistent results, the result applied to the case definition should be that of the majority done by the ELISA, immunofluorescent, or Western blot methods. A positive culture, however, would overrule negative antibody tests.

II. Known Causes of Reduced Resistance:

Known causes of reduced resistance to diseases indicative of immunodeficiency are listed in the left column, while the diseases that may be attributable to these causes (rather than to the immunodeficiency caused by HTLV-III/LAV infection) are listed on the right:

Known Causes of Reduced Resistance	Diseases Possibly Attributable to the Known Causes of Reduced Resistance
1. Systemic corticosteroid therapy	Any infection diagnosed during or within 1 month after discontinuation of the corticosteroid therapy, unless symptoms specific for an infected anatomic site (e.g., dyspnea for pneumonia, headache for encephalitis, diarrhea for colitis) began before the corticosteroid therapy or any cancer diagnosed during or within 1 month after discontinuation of more than 4 months of long term corticosteroid therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long term corticosteroid therapy
2. Other immunosuppressive or cytotoxic therapy	Any infection diagnosed during or within 1 year after discontination of the immunosuppressive therapy, unless symptoms specific for an infected anatomic site (as described above) began before the therapy or any cancer diagnosed during or within 1 year after discontinuation of more than 4 months of long term immunosuppressive therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long term therapy
3. Cancer of lymphoreticular or histiocytic tissue such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, or multiple myeloma	Any infection or cancer, if diagnosed after or within 3 months before the diagnosis of the cancer of lymphoreticular or histiocytic tissue

Known Causes of Reduced Resistance	Diseases Possibly Attributable to the Known Causes of Reduced Resistance
4. Age 60 years or older at diagnosis	Kaposi's sarcoma, but not if the patient has a positive test for HTLV-III/LAV
5. Age under 28 days (neonatal) at diagnosis	Toxoplasmosis or herpes simplex virus infection, as described above
6. Age under 6 months at diagnosis	Cytomegalovirus infection, as described above
7. An immunodeficiency atypical of AIDS, such as one involving hypogammaglobulinemia or angioimmunoblastic lymphadenopathy; or an immunodeficiency of which the cause appears to be a genetic or developmental defect, rather than HTLV-III/LAV infection	Any infection or cancer diagnosed during such immunodeficiency
8. Exogenous malnutrition (starvation due to food deprivation, not malnutrition due to malabsorption or illness)	Any infection or cancer diagnosed during or within 1 month after discontinuation of starvation

Document # 0312S

Appendix B

Definition of AIDS Related Complex (ARC)

At least two of the following clinical signs/symptoms lasting three of more months PLUS two or more of the following laboratory abnormalities, occurring in a patient in a cohort at increased risk for developing AIDS and having no underlying infectious cause for the symptoms.

Clinical

1. Fever: > 100° F, intermittent or continuous, for at least 3 months, in the absence of other identifiable cause.

2. Weight Loss: 10 percent normal body weight or ≥ 15 pounds.

3. Lymphadenopathy: persistent over at least 3 months, involving ≥ 2 extrainguinal node-bearing areas.

4. Diarrhea: intermittent or continous, ≥ 3 months, in the absence of other identifiable cause.

5. Fatigue: to the point of decreased physical or mental function.

6. Night Sweats: intermittent or continuous, ≥ 3 months, in the absence of other identifiable cause.

Laboratory

1. Depressed helper T-cells (≥ 2 standard deviations below the mean).

2. Depressed helper/supressor ratio (≥ 2 standard deviations below the mean).

3. At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.

4. Elevated serum globulins.

5. Depressed blastogenesis (Pokeweed, phytohemagglutinin [PHA] mitogens).

6. Abnormal intradermal tests for delayed cutaneous hypersensitivity (using Multi-Test or equivalent).

Appendix C

Disinfectants

Various classes of disinfectants are listed below. Hypochlorite solution (bleach) is preferred for objects that may be put in the mouth.

1. Ethyl or isopropyl alcohol (70 percent).

2. Phenolic germicidal detergent in a 1 percent aqueous solution (Lysol*).

3. Sodium hypochlorite with at least 100 ppm available chlorine (1/2 cup household bleach in 1 gallon water, needs to be freshly prepared each time it is used).

4. Hydrogen peroxide (3 percent solution).

5. Quaternary ammonium germicidal detergent in 2 percent aqueous solution (Tri-quat*, Mytar*, or Sage*).

6. Iodophor germicidal detergent with 500 ppm available iodine (Wescodyne*).

7. Heat (130° F for 10 minutes).

---

* Brand names are used only as examples of each type of germicidal solution and should not be considered an endorsement of a specified product.

STATE OF WISCONSIN

1985 Assembly Bill 487

Date of enactment: November 14, 1985
Date of publication*: November 22, 1985

1985 Wisconsin Act 73

AN ACT *to amend* 20.435 (1) (a); *to repeal and recreate* 103.15, 146.025 and 631.90; and *to create* 146.023 and 619.12 (1) (e) of the statutes, *relating to* restricting the use of a test for an antibody to the virus that causes acquired immunodeficiency syndrome, requiring certain blood testing, providing penalties and making an appropriation.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.435 (1) (a) of the statutes is amended to read:

20.435 (1) (a) *General program operations.* The amounts included in the schedule for general program operations; including health services regulation, administration and field services. Of the amounts appropriated under this paragraph, unless the department has expended all federal moneys available for provision of these services:

1. In state fiscal year 1985-86 $75,000 may not be expended and in state fiscal year 1986-87 $150,000 may not be expended for the provision of in-person counseling services and laboratory testing services for the presence of an antibody to HTLV-III at alternate testing sites.

2. In state fiscal year 1985-86 $41,400 may not be expended and in state fiscal year 1986-87 $83,000 may not be expended to fund department administrative costs and a total of 1.5 full-time equivalent general purpose revenue positions to assist in responding to the epidemic of acquired immunodeficiency syndrome and HTLV-III infections.

SECTION 2. 103.15 of the statutes, as created by 1985 Wisconsin Act 29, is repealed and recreated to read:

103.15 Restrictions on use of a test for an antibody to HTLV-III. (1) In this section:

(a) "HTLV-III" means the human T-cell lymphotropic virus-type III that causes acquired immunodeficiency syndrome.

(b) "HTLV-III infection" means the pathological state produced by a human body in response to the presence of HTLV-III.

(c) "State epidemiologist" means the individual designated by the secretary of health and social services as the individual in charge of communicable disease control for this state.

(2) Notwithstanding ss. 227.01 (9) and 227.011 (1) unless the state epidemiologist determines and the secretary of health and social services declares under s. 140.05 (1) that individuals who have HTLV-III infections may, through employment, provide a significant risk of transmitting HTLV-III to other individuals, no employer or agent of an employer may directly or indirectly:

(a) Solicit or require as a condition of employment of any employe or prospective employe a test for the presence of an antibody to HTLV-III.

(b) Affect the terms, conditions or privileges of employment or terminate the employment of any employe who obtains a test for the presence of an antibody to HTLV-III.

(3) Any agreement by an employer or agent of the employer and an employe or prospective employe offering employment or any pay or benefit to an employe or prospective employe in return for taking a test for the presence of an antibody to HTLV-III is prohibited, except as provided under sub. (2) (intro.).

SECTION 2m. 146.023 of the statutes is created to read:

146.023 Blood tests for antibody to virus that causes acquired immunodeficiency syndrome. (1) Except as provided under sub. (3), any blood bank, blood center or plasma center in this state that purchases or receives voluntarily donated whole blood, blood

* Section 991.11, WISCONSIN STATUTES 1983-84: **Effective date of acts.** "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

plasma, a blood product or a blood derivative shall, prior to its distribution or use, subject that blood, plasma, product or derivative to a test approved by the federal food and drug administration and the department for the presence of an antibody to the human T-cell lymphotropic virus-type III that causes acquired immunodeficiency syndrome.

(2) If performance of a validated test as defined under s. 146.025 (1) (g) yields a result positive for the presence of an antibody to the human T-cell lymphotropic virus-type III, the whole blood, blood plasma, blood product or blood derivative so tested with this result may not be distributed or used except for purposes of research.

(3) If a medical emergency, including a threat to the preservation of life of a potential donee, exists under which whole blood, blood plasma, a blood product or a blood derivative that has been subjected to testing under sub. (1) is unavailable, the requirement of sub. (1) shall not apply.

(4) Subsections (1) and (2) do not apply to the extent that federal law or regulations require that a blood bank, blood center or plasma center test whole blood, blood plasma, a blood product or a blood derivative.

SECTION 3. 146.025 of the statutes, as created by 1985 Wisconsin Act 29, is repealed and recreated to read:

146.025 Restrictions on use of a test for an antibody to HTLV-III. (1) DEFINITIONS. In this section:

(a) "Health care provider" has the meaning given under s. 146.81 (1).

(b) "HTLV-III" means the human T-cell lymphotropic virus-type III that causes acquired immunodeficiency syndrome.

(c) "HTLV-III infection" means the pathological state produced by a human body in response to the presence of HTLV-III.

(d) "Informed consent for testing or disclosure" means consent in writing on an informed consent for testing or disclosure form by a person to the administration of a test to him or her for the presence of an antibody to HTLV-III or to the disclosure to another specified person of the results of a test administered to the person consenting.

(e) "Informed consent for testing or disclosure form" means a printed document on which a person may signify his or her informed consent for testing for the presence of an antibody to HTLV-III or authorize the disclosure of any test results obtained.

(f) "State epidemiologist" means the individual designated by the secretary of health and social services as the individual in charge of communicable disease control for this state.

(g) "Validated test result" means a result of a test for the presence of an antibody to HTLV-III that meets the validation requirements determined to be necessary by the state epidemiologist.

(2) INFORMED CONSENT FOR TESTING OR DISCLOSURE. (a) No health care provider, blood bank, blood center or plasma center may subject a person to a test for the presence of an antibody to HTLV-III unless the subject of the test first provides informed consent for testing or disclosure as specified under par. (b), except that consent to testing is not required for any of the following:

1. A health care provider who procures, processes, distributes or uses a human body part donated for a purpose specified under s. 155.06 (3) may, without obtaining consent to the testing, test for the presence of an antibody to HTLV-III in order to assure medical acceptability of the gift for the purpose intended.

2. The department, a laboratory certified under s. 143.15 (4) or a health care provider, blood bank, blood center or plasma center may, for the purpose of research and without first obtaining written consent to the testing, subject any body fluids or tissues to a test for the presence of an antibody to HTLV-III if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher.

(b) The health care provider, blood bank, blood center or plasma center that subjects a person to a test for the presence of an antibody to HTLV-III under par. (a) shall provide the potential test subject with an informed consent form for testing or disclosure that shall contain the following information and shall obtain the potential test subject's signature on the form:

1. The name of the potential test subject who is giving consent and whose test results may be disclosed.

2. A statement of explanation to the potential test subject that the test results may be disclosed as specified under sub. (5) (a) and either a listing that duplicates the persons or circumstances specified under sub. (5) (a) 2 to 10 or a statement that the listing is available upon request.

3. Spaces specifically designated for the following purposes:

a. The signature of the potential test subject providing informed consent for the testing and the date on which the consent is signed.

b. The name of a person to whom the potential test subject authorizes that disclosure of test results be made, if any, the date on which the consent to disclosure is signed, and the time period during which the consent to disclosure is effective.

(3) WRITTEN CONSENT TO DISCLOSURE. A person who receives a test for the presence of an antibody to HTLV-III under sub. (2) (b) may authorize in writing a health care provider, blood bank, blood center or plasma center to disclose his or her test results to anyone at any time subsequent to providing informed consent for disclosure under sub. (2) (b) and a record of this consent shall be maintained by the health care

provider, blood bank, blood center or plasma center so authorized.

(4) RECORD MAINTENANCE. A health care provider, blood bank, blood center or plasma center that obtains from a person a specimen of body fluids or tissues for the purpose of testing for the presence of an antibody to HTLV-III shall:

(a) Obtain from the subject informed consent for testing or disclosure, as provided under sub. (2).

(b) Maintain a record of the consent received under par. (a).

(c) Maintain a record of the test results obtained.

(5) CONFIDENTIALITY OF TEST. (a) The results of a test for the presence of an antibody to HTLV-III may be disclosed only to the following persons or under the following circumstances, except that the person who receives a test may under sub. (2) (b) or (3) authorize disclosure to anyone:

1. To the subject of the test.

2. To the test subject's health care provider, including those instances in which a health care provider provides emergency care to the subject.

3. To an agent or employe of the test subject's health care provider under subd. 2 who provides patient care or handles or processes specimens of body fluids or tissues.

4. To a blood bank, blood center or plasma center that subjects a person to a test under sub. (2) (a), for any of the following purposes:

a. Determining the medical acceptability of blood or plasma secured from the test subject.

b. Notifying the test subject of the test results.

c. Investigating HTLV-III infections in blood or plasma.

5. To a health care provider who procures, processes, distributes or uses a human body part donated for a purpose specified under s. 155.06 (3), for the purpose of assuring medical acceptability of the gift for the purpose intended.

6. To the state epidemiologist or his or her designee, for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease.

7. To a funeral director, as defined under s. 445.01 (5) or to other persons who prepare the body of a decedent for burial or other disposition.

8. To health care facility staff committees or accreditation or health care services review organizations for the purposes of conducting program monitoring and evaluation and health care services reviews.

9. Under a lawful order of a court of record.

10. To a person who conducts research, for the purpose of research, if the researcher:

a. Is affiliated with the test subject's health care provider under subd. 3.

b. Has obtained permission to perform the research from an institutional review board.

c. Provides written assurance to the person disclosing the test results that use of the information requested is only for the purpose under which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final research product will not reveal information that may identify the test subject unless the researcher has first received informed consent for disclosure from the test subject.

(b) A private pay patient may deny access to disclosure of his or her test results granted under par. (a) 10 if he or she annually submits to the maintenance of his or her test results under sub. (4) (c) a signed, written request that denial be made.

(6) EXPANDED DISCLOSURE OF TEST RESULTS PROHIBITED. No person to whom the results of a test for the presence of an antibody to HTLV-III have been disclosed under sub. (5) (a) may disclose the test results except as authorized under sub. (5) (a).

(7) REPORTING OF POSITIVE TEST RESULTS. (a) Notwithstanding ss. 227.01 (9) and 227.011 (1), for the purposes of this subsection, the state epidemiologist shall determine, based on the preponderance of available scientific evidence, the procedures necessary in this state to obtain a validated test result for the presence of an antibody to HTLV-III and the secretary of health and social services shall so declare under s. 140.05 (1). The state epidemiologist shall revise this determination if, in his or her opinion, changed available scientific evidence warrants a revision, and the secretary of health and social services shall declare the revision under s. 140.05 (1).

(b) If a positive, validated test result for the presence of an antibody to HTLV-III is obtained from a test subject, the health care provider, blood bank, blood center or plasma center that maintains a record of the test results under sub. (4) (c) shall report to the state epidemiologist the following information:

1. The name and address of the health care provider, blood bank, blood center or plasma center reporting.

2. The name and address of the subject's health care provider, if known.

3. The name, address, telephone number, age or date of birth, race and ethnicity, sex and county of residence of the test subject, if known.

4. The date on which the test was performed.

5. The test result.

6. Any other medical or epidemiological information required by the state epidemiologist for the purpose of exercising surveillance, control and prevention of HTLV-III infections.

(c) A report made under par. (b) may not include any of the following:

1. Information with respect to the sexual orientation of the test subject.

2. The identity of persons with whom the test subject may have had sexual contact.

(d) This subsection does not apply to the reporting of information under s. 143.04 with respect to persons for whom a diagnosis of acquired immunodeficiency syndrome has been made.

(8) CIVIL LIABILITY. (a) Any person violating sub. (2), (5) (a), (6) or (7) (c) is liable to the subject of the test for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

(b) The plaintiff in an action under par. (a) has the burden of proving by a preponderance of the evidence that a violation occurred under sub. (2), (5) (a), (6) or (7) (c). A conviction under sub. (2), (5) (a), (6) or (7) (c) is not a condition precedent to bringing an action under par. (a).

(9) CRIMINAL PENALTY. Whoever intentionally discloses the results of a blood test in violation of sub. (5) (a) and thereby causes bodily harm or psychological harm to the subject of the test may be fined not more than $10,000 or imprisoned not more than 9 months or both.

SECTION 4. 619.12 (1) (e) of the statutes is created to read:

619.12 (1) (e) A notice of rejection or cancellation of coverage from one insurer and evidence of a positive test for the presence of an antibody to the human T-cell lymphotropic virus-type III that causes acquired immunodeficiency syndrome.

SECTION 5. 631.90 of the statutes, as created by 1985 Wisconsin Act 29, is repealed and recreated to read:

631.90 Restrictions on use of a test for an antibody to HTLV-III. (1) In this section, "HTLV-III" means the human T-cell lymphotropic virus-type III that causes acquired immunodeficiency syndrome.

(2) With regard to policies issued or renewed on and after July 20, 1985, an insurer may not do any of the following:

(a) Require or request directly or indirectly any individual to reveal whether the individual has obtained a test for the presence of an antibody to HTLV-III or what the results of this test, if obtained by the individual, were.

(b) Condition the provision of insurance coverage on whether an individual has obtained a test for the presence of an antibody to HTLV-III or what the results of this test, if obtained by the individual, were.

(c) Consider in the determination of rates or any other aspect of insurance coverage provided to an individual whether an individual has obtained a test for the presence of an antibody to HTLV-III or what the results of this test, if obtained by the individual, were.

(3) (a) Subsection (2) does not apply with regard to any test or series of tests for use in the underwriting of individual life, accident and health insurance policies that the person designated by the secretary of health and social services as the state epidemiologist finds medically significant and sufficiently reliable for the presence of an antibody to HTLV-III and that the commissioner finds and designates by rule as sufficiently reliable for use in the underwriting of individual life, accident and health insurance policies.

(b) Paragraph (a) does not authorize the use of any test or series of tests for the presence of an antibody to HTLV-III to discriminate in violation of s. 628.34 (3).

SECTION 6. **Appropriation changes; health and social services.** (1) The appropriation to the department of health and social services under section 20.435 (1) (a) of the statutes, as affected by the acts of 1985, is increased by $75,000 for fiscal year 1985-86 and by $150,000 for fiscal year 1986-87 to fund provision of in-service counseling services and laboratory testing services for the presence of an antibody to HTLV-III at alternate testing sites designated by the department.

(2) The appropriation to the department of health and social services under section 20.435 (1) (a) of the statutes, as affected by the acts of 1985, is increased by $41,400 for fiscal year 1985-86 and by $83,000 for fiscal year 1986-87 to fund department administrative costs and a total of 1.5 FTE GPR positions to assist in responding to the epidemic of acquired immunodeficiency syndrome and HTLV-III infections. The department shall reallocate a total of 1.5 FTE existing positions to assist in responding to the epidemic.

SECTION 7. **Program responsibility changes.** In the sections of the statutes listed in Column A, the program responsibilities references shown in Column B are deleted and the program responsibilities references shown in Column C are inserted:

A	B	C
Statute Sections	References Deleted	References Inserted
15.191 (intro.)	none	103.15 (2), 631.90 (3)(a)

SECTION 8. **Cross-reference changes.** In the sections of the statutes listed in Column A, the cross-references shown in Column B are changed to the cross-references shown in Column C:

A	B	C
Statute Sections	Old Cross-References	New Cross-References
103.20, as affected by 1985 Wis. Act 29	103.15	103.15 (2) or (3)

SECTION 9. **Initial applicability.** The treatment of section 631.90 (3) of the statutes by this act first applies to policies issued or renewed on the effective date of this SECTION.

SECTION 10. **Effective dates.** (1) Except as provided in subsection (2), this act takes effect on the day following publication.

(2) The treatment of section 146.023 of the statutes takes effect on January 1, 1986.