United States General Accounting Office

GAO

Comptroller General's Task Force on AIDS in the Workplace

December 1987

Coping With AIDS in the GAO Workplace

The Task Force Report

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Abbreviations

AFMD	Accounting and Financial Management Division
AIDS	acquired immune deficiency syndrome
AFGE	American Federation of Government Employees
ARC	AIDS-related complex
AZT	azidothymidine
CCD	Counseling and Career Development Branch
CDC	Centers for Disease Control
CSRS	Civil Service Retirement System
DOD	Department of Defense
ELISA	enzyme-linked immunosorbent assay
FEGLI	Federal Employee Group Life Insurance
FEHBP	Federal Employee Health Benefits Plan
FERS	Federal Employee Retirement System
GAO	General Accounting Office
GS&C	General Services and Controller
HIV	human immunodeficiency virus
HRD	Human Resources Division
LWOP	leave without pay
NLRB	National Labor Relations Board
NSIAD	National Security and International Affairs Division
OGC	Office of the General Counsel
OOHD	Office of Organization and Human Development
OPM	Office of Personnel Management
RCED	Resources, Community, and Economic Development Division
WHO	World Health Organization

Abstract

In December 1986, the Comptroller General established a GAO Task Force to determine how the growing incidence of AIDS could be expected to affect GAO and to identify any policy clarifications or changes needed to respond appropriately to this problem. The Task Force was chaired by Eleanor Chelimsky, and its members included Felix Brandon, Richard Brown, John Cherbini, Judy England-Joseph, Ira Goldstein, Murray Grant, Mary Hamilton, James Hinchman, David Littleton, and Herbert McLure. They were assisted by staff from the Office of Organization and Human Development; the Program Evaluation and Methodology Division; the Offices of the General Counsel, General Services and Controller, and Personnel; and representatives of several GAO employee organizations.

The present document, which is the full report of the Task Force, sketches the methods the Task Force used to fulfill its mandate and proposes guidelines and an action plan to deal with AIDS in the GAO workplace. It also includes appendixes on particular aspects of AIDS, prepared for the Task Force by individual members and their staffs.

The Task Force found a clear consensus in the medical and scientific community that typical workplace interaction bears no risk of AIDS transmission. It therefore recommends that the following GAO guidelines concerning the rights and responsibilities of managers, of employees with AIDS, and of their coworkers be promulgated:

- GAO intends to maintain a safe and healthful work environment for all GAO staff.
- Freedom from AIDS is not a condition for hiring or continued employment.
- An employee's health condition is private and confidential. An employee with AIDS is under no obligation to disclose his/her condition to a supervisor or any other GAO staff.
- GAO will make every effort to offer reasonable accommodation for the employee with AIDS. These efforts will be consistent with accommodations offered to employees suffering from other life-threatening illnesses.

The action plan developed by the Task Force involves the following major components:

Education and Counseling	During its deliberations, the Task Force had begun an effort to educate GAO employees about AIDS by distributing the Surgeon General's report GAO-wide. It now further recommends that GAO initiate education sessions for all employees to discuss the GAO guidelines and their rationale. The Task Force had also published resource guides listing community facilities for AIDS counseling and testing for the use of GAO employees at headquarters and in the regional offices who might want to discuss their concerns with a qualified professional. The Task Force further recommends that GAO provide expert and confidential counseling, in-house, for employees with AIDS and their coworkers.
Managerial Guidelines	Guidelines have been prepared to help managers deal with AIDS in the workplace. They focus on the practical problems managers face, using a question-and-answer format. The Task Force recommends that the guidelines be made available to managers within each unit at their request.
Managerial Focal Points	The Task Force recommends the designation of an individual within each unit at the deputy director or assistant regional manager level to act as a focal point for AIDS, handling personnel issues and serving as a resource person and an intermediary.
Monitoring	Because of the rapidly expanding state of knowledge about AIDS, the Task Force recommends continued monitoring of scientific and legal developments related both to AIDS and to the successful implementation of its guidelines.

Copies of this report, the summary report of Results and Recommendations, and Managers' Guidelines for Dealing with Individual Cases of AIDS are available for sale from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Executive Summary

Some Basics on AIDS

The following pages summarize the background medical information that the Task Force reviewed in formulating its recommendations. A more detailed and authoritative source of AIDS information is the U.S. Surgeon General's report on AIDS,[1] copies of which have been distributed to all GAO employees.

What Is AIDS?

Acquired immune deficiency syndrome, or AIDS, is a fatal disease that cripples the body's immune system by destroying certain white blood cells (known as T-lymphocytes). This destruction is caused by a virus called human immunodeficiency virus (HIV). Because of the damage to the immune system, the AIDS patient becomes vulnerable to infections that healthy individuals can usually resist. The most common of these opportunistic infections are Kaposi's sarcoma (a type of cancer characterized by multiple purplish blotches on the skin) and a form of pneumonia known as pneumocystis carinii. The virus can cause brain damage as well.

Persons infected by the virus may have no symptoms at all and remain apparently healthy for years after infection. The incubation period of the disease has not been definitively determined, in part because scientists became aware of the disease only in the early 1980's. The virus can remain dormant for 5 years or more, and its incubation period may extend to 10 or more years.

How Is AIDS Diagnosed?

In the first few years after the disease was identified, a diagnosis was usually made on the basis of a depressed immune system and secondary infections characteristic of the disease. Once scientists had established HIV as the source of the disease, it became possible to identify persons infected with that virus—who had not developed AIDS—through blood tests for antibodies to the virus.

The prognosis for persons whose blood tests positive for HIV antibodies is unclear. Some may never have AIDS symptoms, others may present mild symptoms, and others will develop AIDS. Scientists are not certain how many of the HIV-infected persons will eventually develop AIDS. Common estimates now range from 30 to 50 percent, but some suggest that everyone infected with the virus will sooner or later succumb to AIDS.

[1] U.S. Department of Health and Human Services, Surgeon General's Report on Acquired Immune Deficiency Syndrome (Jan. 1987.)

Other uncertainties are associated with the blood tests. Because the body may take several months to produce sufficient HIV antibodies for the test to detect, a person only recently infected may test falsely negative. When a low-risk population is screened for AIDS, a large proportion can be incorrectly identified as positive. Therefore, positive results of an initial screening must be confirmed by additional tests.

How Is AIDS Transmitted?

AIDS is transmitted, as far as is known, either through sexual contact or through direct blood-to-blood transmission such as that which occurs in blood transfusions or in sharing needles by intravenous drug users. In many cases, AIDS is transmitted by a person who is infected with HIV but shows no active AIDS symptoms.

HIV is not robust. It does not live long in the open air, and it is not transmitted by casual contact with an AIDS carrier. AIDS is not communicated by shaking hands, hugging, crying, sneezing, coughing, insect bites, or by eating food prepared by an AIDS patient. Typical workplace interaction bears no risk of HIV transmission.

How Widespread Is AIDS?

As of August 1987, more than 41,000 AIDS cases had been identified in the United States and nearly 24,000 people had died of it. Common estimates of the number of HIV-infected Americans range from 1 million to 2 million.

Reported AIDS cases in the United States are concentrated most heavily among a few high-risk groups and in a small number of urban areas. About 90 percent of cases involve homosexual or bisexual males and/or intravenous drug abusers. Only 4 percent have thus far involved heterosexual transmission. Other groups with elevated risk of HIV infection are children born to infected mothers and those who received multiple blood transfusions before blood screening was routinely performed by blood donation centers (in general, before 1985). For this reason, hemophilia, a condition that may require frequent transfusions, is also considered a risk factor for AIDS.

At the time of this writing, 70 percent of all AIDS cases have been reported from only five states: New York, California, Florida, Texas, and New Jersey. The metropolitan areas of New York City, San Francisco, Los Angeles, Houston, and Washington, D.C., which account for slightly more than 10 percent of the country's population, contain more than half of the reported AIDS cases in the United States.

Predictions of the form and magnitude that the AIDS epidemic will assume over the next several years are difficult to make precisely. Last year the U.S. Public Health Service projected that, by the end of 1991, the total number of AIDS cases in the United States would exceed 270,000, with more than 179,000 deaths. A key determinant of the size of the future epidemic in this country will be the rate of heterosexual transmission. Some scientists foresee an explosion of the epidemic into the general population once it is solidly established among heterosexuals. However, the reported rate of heterosexual transmission has failed to increase substantially over the past year and some doubt has been cast on the more dire predictions. Because the virus can lie dormant for so many years before AIDS symptoms appear, questions regarding the future size and shape of the epidemic cannot now be answered definitively. But most Americans are likely to come into contact with someone having AIDS sometime in the next few years. Many of these interactions will occur in the workplace and can be expected to involve federal agencies and organizations, including GAO, as frequently as their counterparts in the private sector.

Task Force Recommendations and Their Rationale

The Task Force report contains two general recommendations: first, that GAO guidelines concerning the rights and responsibilities of managers, of employees with AIDS, and of their fellow employees be promulgated and, second, that an action plan be implemented to inform GAO staff and ensure that these guidelines are followed consistently throughout the Office. The following pages provide specific details of these general recommendations and summarize the findings upon which they were based.

GAO Guidelines Concerning Employees With AIDS and Their Coworkers

The Task Force recommends that the following policy be adopted at GAO and that a copy of it be distributed to every employee:

On the basis of available medical and scientific information, the U.S. General Accounting Office recognizes that acquired immune deficiency syndrome (AIDS) is a life-threatening illness that is not transmissible under ordinary GAO work conditions. Therefore, GAO has determined that the following four principles will guide its personnel procedures:

- GAO intends to maintain a safe and healthful work environment for all GAO staff. Because all medical evidence indicates that AIDS is not transmitted in a typical office environment, staff will be expected to continue working relationships with any fellow employee who is recognized as having AIDS. To help allay any coworkers' fears of catching the disease,

and to prepare them to cope with its effects in the workplace, GAO will offer education and counseling to any coworkers concerned about the possibility of AIDS infection or other deleterious consequences of this situation.

- Freedom from AIDS is not a condition for hiring or continued employment. Neither a clinical diagnosis of AIDS nor the presence of the HIV antibody in the bloodstream constitutes sufficient reason to deny employment to an otherwise qualified applicant or to dismiss an employee so long as he/she can meet acceptable performance standards and medical evidence indicates that his/her condition is not a threat to others.
- An employee's health condition is private and confidential. An employee with AIDS is under no obligation to disclose his/her condition to a supervisor or to any other GAO staff. However, the employee is strongly encouraged to make the condition known as soon as possible to the proper management level in order to receive informed advice on tailoring the use of appropriate employee benefits to his/her situation. Any disclosure by an employee with AIDS will be maintained in strict confidence in accordance with the specific guidelines for managerial focal points (see pp. 13 and 14); the manager must take all reasonable precautions to protect this information from unauthorized disclosure.
- GAO will make every effort to offer reasonable accommodation for the employee with AIDS. These efforts will be consistent with accommodations offered to employees suffering from other serious illnesses. This accommodation may include, but will not be limited to, flexible or part-time work schedules, advance sick leave, light duty assignments, working at home, and voluntary reassignment.

The shape and scope of this policy reflect underlying principles of GAO's management philosophy. It is based on a review of federal personnel laws and regulations, along with the best available medical information on AIDS. (See appendixes I and II of the full Task Force report.)

Action Plan

To facilitate the consistent implementation of these guidelines, the Task Force recommends that several initiatives be implemented GAO-wide and that GAO's progress toward providing both humane treatment for the employee with AIDS and a safe, healthful, and productive work environment be continually monitored.

Education and Counseling Program

As a first step in ensuring that all employees have adequate information about GAO's AIDS policy, the Task Force recommends that a summary of

its results and recommendations be distributed throughout GAO and that several copies of its full report be distributed to, and made generally available within, each administrative unit. In addition, it recommends that continuing education efforts be made with the following objectives:

- People suffering from AIDS should understand what GAO's policy is toward them and should know how to get the support available to them.
- Managers and staff should also understand GAO's policy and how to protect all employees' rights, reassure employees who are not ill, and assist employees needing help.
- All GAO employees should have the opportunity to be well-informed about AIDS.

The Task Force recommends a program consisting of a 1- to 2-hour session moderated by a GAO manager at the deputy director or assistant regional manager level. During the session, a commercially produced videotape on AIDS in the workplace would be viewed and GAO's AIDS guidelines discussed. This discussion would include the following considerations:

- Managers are responsible for familiarity with current GAO policy and with the resources available within GAO for clarifying and interpreting it.
- Managers are obliged to protect the confidentiality of GAO staff's personal health information.
- Managers should provide reasonable accommodations for persons suffering from AIDS or other life-threatening illnesses.
- Managers should be familiar with information and counseling resources available within and outside GAO for employees with AIDS and for their concerned coworkers.
- All staff should recognize that AIDS presents no threat of infection in typical workplace interaction and that an employee with AIDS has a right to expect humane treatment from supervisors and coworkers.

The detailed curriculum and resource material for the education program would be developed, and managers would be trained, under the direction of the Office of Organization and Human Development (OOHD). After completion of the initial education program, the managers would continue to serve as focal points. (See below.) In addition, OOHD would provide any necessary training for its counseling staff to ensure their ability to offer appropriate and confidential services to employees with AIDS and their concerned coworkers.

The Task Force has already developed and published a series of resource guides to existing AIDS-related services. OOHD would maintain updated lists of these resources for the geographical areas in which GAO's headquarters and regional offices are located.

The recommendation for an education and counseling program resulted from a review of AIDS programs initiated in other organizations; from interviews with knowledgeable persons and institutions outside GAO; and from consistent suggestions by GAO management, staff, and employee organizations. All sources agreed on the need for ensuring a common understanding within GAO about the nature of AIDS, the implications of its presence in the workplace, and GAO's policies for dealing with it.

Managerial Guidelines

The Task Force also recommends that a set of specific management-oriented guidelines be made available to all managers to help them when they are confronted with a case of AIDS in the workplace. These guidelines are contained in appendix IX of the full report. They outline GAO policy on AIDS and address issues such as the confidential nature of an employee's health condition, the sources of assistance which a manager can recommend to an employee with AIDS, reasonable accommodation for an employee with AIDS, employee benefits, coworker concerns about AIDS transmission, and AIDS testing. The document also answers some common questions to which the supervisor may need to respond.

The idea of managerial guidelines emerged from the review undertaken by the Task Force of previous AIDS cases at GAO (see appendix III of the full report), and they were requested by some GAO employee organizations. Their content is based on the legal review performed by OGC and on the interviews performed by the Task Force with other organizations that had established AIDS policies. (See appendix VIII of the full report).

Managerial Focal Points

The Task Force recommends that each unit head (that is, assistant comptroller general, division director, regional manager, or office director) designate one staff member—at the deputy director or assistant regional manager level—to serve as a focal point for personnel issues related to AIDS. This individual would become knowledgeable about employee rights, benefit packages, and other personnel issues likely to be of concern to employees with AIDS, their supervisors, and coworkers. In addition to assuring education on AIDS for everyone in his/her unit, this person would also arrange for other meetings, as needed, in which

staff members could raise questions about AIDS and hear the views of GAO managers, Task Force members, and/or outside experts. This individual would also serve, with the consent of the employee who has AIDS, as the intermediary between the employee and GAO management in order to obtain any needed policy clarifications and to expedite special personnel arrangements, if necessary. The designated focal point would maintain all personal health information in strict confidence; that is, the information could be discussed only with staff in a direct supervisory chain above the employee and only as needed to maintain office productivity or to help the employee obtain necessary modifications to his/her working conditions.

The need for a specified focal point emerged from the Task Force review of how GAO had handled previous AIDS cases. (See appendix III of the full report.) In at least one case, the management of an AIDS situation would have been greatly facilitated by the existence of a focal point.

Employee Benefits

The Task Force reviewed existing employee benefits and personnel practices and found them generally adequate to meet the needs of an employee with AIDS. Most health insurance plans cover the majority of health expenses associated with AIDS, and present personnel policies are sufficiently flexible to offer reasonable accommodation to an employee with AIDS who wished to continue working. However, because the plans differ substantially in their coverage for out-of-hospital expenses, the Task Force recommends that Personnel make available a brief summary of these variations during the annual open season. In addition, its AIDS case study review suggested that unnecessary delays in processing requests for disability retirement could occur. The Task Force, therefore, recommends that Personnel act to expedite the approval of such requests by the Office of Personnel Management.

Public Health Considerations Concerning AIDS in the Workplace

The Task Force found no reason to recommend any changes in the established personnel policies and maintenance practices at GAO because of the likelihood of AIDS in the workplace. It based this conclusion on a review it conducted of public health rules that must be considered in developing workplace guidelines on AIDS. (See appendix I of the full report.)

The review indicated that the presence of AIDS in the typical workplace does not pose a public health hazard. The Public Health Service states that "there is no known risk of AIDS virus transmission" for "persons in

settings such as offices, schools, factories and construction sites."[2] Even in the case of food service workers, the Centers for Disease Control see no public health reason why workers infected with AIDS should be restricted from preparing or serving food and observe that following recommended standards of good personal hygiene and food sanitation suffices in this area. The Task Force concluded, therefore, that extra health measures specific to AIDS were not required in the GAO workplace.

The Task Force does not recommend employee blood tests for AIDS on the following grounds:

- AIDS poses no risk of transmission under ordinary office working conditions.
- Current tests do not screen for AIDS itself but rather for antibodies to HIV; whether and when someone testing positive for HIV will develop AIDS is unknown.
- Testing employees or applicants for employment could be viewed as discriminatory under current law.

Periodic Review of Policy Implementation

The Task Force recommends that

- scientific and legal developments related to AIDS continue to be monitored by GAO;
- the implementation of the GAO guidelines on AIDS be periodically reviewed in light of their objectives to provide humane treatment to employees with AIDS and a safe, healthful, and productive office environment for all staff;
- these tasks be monitored by a standing group of three members of the present Task Force (the Director of Personnel, the Chief Medical Advisor, and the General Counsel); and
- the Task Force reconvene annually to receive a report on these reviews and consider modifications to its policy recommendations. Additional meetings would be held if significant developments warranted policy consideration.

In formulating these recommendations, the Task Force has recognized that new developments in our understanding of AIDS occur almost daily. The recommendations are based on the best currently available medical,

[2]"Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," Morbidity and Mortality Weekly Report (Atlanta, Ga.: U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, Vol. 34, No. 45, Nov. 15, 1985), pp. 681-695.

scientific, and legal expertise. However, the law could change, there could be important new knowledge about AIDS, and the accelerating search for a cure for and a vaccine against this disease could well prove successful sooner than expected. The Task Force also recognizes that the United States can expect to know within the next few years whether the spread of AIDS in this country will be self-limiting or whether an explosion of the disease into the general population should be anticipated. This knowledge will help to determine the nature of the public policy response to the problem.

In conclusion, the Task Force expresses its conviction that the goals of its recommendations are achievable. It seems eminently possible, given the nature and means of transmission of AIDS, to maintain a safe, healthful, and productive work environment for all employees while simultaneously ensuring humane treatment to those employees suffering from the disease. In general, the Task Force's recommendations flow from the view, derived from its research, that the major source of AIDS problems in the workplace will not be the disease itself but fear and ignorance about it. The Task Force hopes that its recommended program will allow GAO to continue both to fulfill its obligations to its employees—all of them—and to maintain its commitment of service to the Congress.

Some Basics on AIDS

In December 1986, the Comptroller General established a GAO Task Force to determine how the growing incidence of acquired immune deficiency syndrome (AIDS) could affect GAO and to identify any policy clarifications or changes needed to respond appropriately to this problem. There were several reasons why it seemed important to take a close look at AIDS, as opposed to other life-threatening illnesses. First, AIDS has the unusual characteristic of being both infectious and incurable. It can go undetected for years, but it leaves each infected person permanently capable of infecting others. Second, it was defined and diagnosed only 6 years ago, but already the World Health Organization (WHO) and others have labeled it a pandemic with many millions of people said to have been exposed to the virus worldwide. AIDS has been compared with various great plagues of the past, and current predictions are that by 1991, in the United States alone, 54,000 people will be dying of AIDS each year. It seemed unlikely that a disease of this magnitude and character would fail to make its presence felt in the near future across the workplaces of this nation.

The present report is the product of the Task Force's deliberations. It sketches the methods the Task Force used to fulfill its mandate and proposes guidelines and a plan to deal with AIDS in the GAO workplace.

As background, it is important to review at least briefly what is known about AIDS at this writing (September 1987), that is, what its nature is, how it is transmitted, how it can be prevented, and how widespread it is and may become over the next few years. This information formed the basis for the work of the Task Force and for its recommendations. A more extensive and authoritative treatment of these subjects can be found in the Surgeon General's report on AIDS,[1] copies of which have been distributed to all GAO employees. The GAO Office of Library Services has also recently published an annotated bibliography on AIDS.

What Is AIDS?

AIDS is a fatal disease that cripples the body's immune system by destroying certain white blood cells (known as T-lymphocytes). This destruction is caused by infection with a virus called human immunodeficiency virus (HIV). Because of the damage caused by HIV to the immune system, the AIDS patient becomes vulnerable to infections that healthy individuals can usually resist. The most common of these opportunistic infections are Kaposi's sarcoma (a type of cancer characterized

[1] U. S. Department of Health and Human Services, Surgeon General's Report on Acquired Immune Deficiency Syndrome (Jan. 1987).

by multiple purplish blotches on the skin), and a form of pneumonia known as pneumocystis carinii. The virus can cause brain damage as well.

HIV is also associated with other symptoms, including loss of appetite, fever, night sweats, diarrhea, recurrent infections, and swollen lymph nodes. This set of symptoms, when coupled with positive tests for antibodies to HIV, is referred to as AIDS-related complex, or ARC. Researchers are not yet certain as to whether ARC is caused by a virus identical to the one which causes AIDS or by one similar to, but distinct from, the AIDS virus.

Persons infected with HIV may have no symptoms at all and remain apparently healthy for years after infection. The incubation period of the disease has not been definitively determined, in part because scientists became aware of the disease only in the early 1980's. The virus can remain dormant for 5 years or more, and its incubation period may extend to 10 or more years.

Since scientists cannot differentiate the virus carried by asymptomatic carriers from that infecting ARC or AIDS patients, the prognosis for persons who test positive for HIV is unclear. Some may never have AIDS symptoms, others may present ARC symptoms, and others will develop AIDS. Scientific estimates of what percent of HIV-infected persons will eventually develop AIDS vary widely, and they have become increasingly pessimistic with time. While scientists originally estimated that only a small fraction would develop AIDS, present estimates have commonly risen to 30 to 50 percent; some scientists predict that everyone infected with the virus will sooner or later develop AIDS.

There is no known cure for AIDS, and most scientists are unwilling to predict when one will become available. Therapy for AIDS patients is now restricted to treating their opportunistic infections. The recently approved clinical trials of the new drug azidothymidine (AZT) offer hope of prolonging the life of some AIDS patients until a cure can be found. The development of an AIDS vaccine is not foreseen for at least 5 to 10 years.

On the other hand, history instructs that AIDS could be self-limiting. Some diseases of the past have ravaged whole continents over a finite period after which they disappeared (for example, the bubonic plague of 1347-50 and the influenza epidemic of 1917-19). However, during a typical influenza epidemic, people who have recovered from the disease

become temporarily immune to the particular type of virus that has caused the epidemic. And as larger and larger sections of the population become immune, the epidemic stops spreading and dies out. With AIDS, however, it is unclear that immunity to the disease can be acquired.

How Is AIDS Transmitted?

AIDS is transmitted, according to most scientists, either through sexual contact or through direct introduction of the virus into the bloodstream, such as might occur when intravenous drug users share needles or in blood transfusions. Since the advent in 1985 of AIDS screening for donated blood, the risk of contracting AIDS from medically supervised transfusions has been virtually eliminated. AIDS has also been transmitted from mother to child, either during birth or from contaminated breast milk.

No other mode of HIV transmission has been discovered after 6 years of careful tracking. Nevertheless, it cannot be categorically stated that other modes of transmission are theoretically impossible. Indeed, a theoretical risk can always be argued; however, there is no documentation or empirical evidence to back it up.

In many cases, AIDS is communicated by a person who is infected with HIV but shows no active AIDS symptoms. In this country, the identifiable groups with the highest likelihood of HIV infection at present are intravenous drug abusers and male homosexuals. However, as we shall discuss below, there is some evidence that heterosexual transmission of AIDS is becoming more common in the United States, as it already has in other parts of the world.

Other groups with elevated risk of HIV infection are children born to infected mothers and those who have received multiple blood transfusions in the period before blood screening was routinely performed by blood donation centers (in general, before 1985). For this reason hemophilia, a condition that may require frequent transfusions, is also considered a risk factor for AIDS.

HIV is not a robust virus, it does not live long in the open air, it is easily killed with common household cleansing agents, and it is not transmitted by casual contact with an AIDS carrier. AIDS is not communicated by shaking hands, hugging, crying, sneezing, coughing, eating food prepared by an AIDS victim, or insect bites. Typical workplace interaction bears no risk of HIV transmission. Even in home environments, there have been no occurrences of HIV transmission despite daily close contact

between AIDS patients and their families. With regard to transmission in hospitals and health care facilities, incidence has been extremely low. The few cases reported of HIV transmission in these settings have apparently resulted from accidental needlestick injury, or from large-scale skin or mucous membrane exposure to infected blood. Most of these cases might have been prevented had the precautions issued by the Centers for Disease Control (CDC) to prevent HIV transmission been followed. (See appendix IV.)

How Can AIDS Be Prevented?

The two most important steps for an individual to take in stopping the spread of AIDS are learning the facts about the disease and avoiding those behaviors through which it is transmitted. Users of intravenous drugs—whether licit or illicit—can negate the danger by using only sterile needles. Sexual partners of possible AIDS carriers can be completely safe from contracting the disease only through abstinence. Condoms, when used properly, have been demonstrated to decrease the risk of HIV transmission, and their use has been strongly recommended by the Surgeon General. The critical point here is that through an educated understanding of risk and an appropriate approach to self-protection, AIDS can, in fact, be prevented.

What Tests Are Available for AIDS?

Blood tests used to identify individuals who have been infected with HIV do not detect the virus itself but antibodies produced by the body's immune system. A confirmed positive test does not imply that an individual has AIDS or ARC; instead it indicates only that the immune system has produced antibodies to fight the AIDS virus. The test results have been used to confirm a diagnosis of AIDS or ARC; to avoid the inclusion of HIV-infected blood in blood banks; and to screen applicants for certain categories of employment, such as the military and the foreign service. Blood tests have also been proposed for other groups, such as immigrants, persons seeking marriage licenses, and hospital patients.

There are two common blood tests for HIV antibodies: the ELISA (enzyme-linked immunosorbent assay) and the Western Blot. Since the ELISA test is less expensive and easier to perform, it is usually used as a first screen for HIV. If the ELISA identifies an individual as "seropositive" (that is, the blood tests HIV antibody positive), a second ELISA is usually performed. If the second test is also positive, a Western Blot test is usually performed to confirm the results. However, antibodies may not develop for several months or longer after an individual has been

infected. Therefore, a negative result may not indicate freedom from the AIDS virus and, of course, says nothing about future infection.

High false positive rates (i.e., the percent of persons who test positive but who are not infected) have produced controversy concerning the advisability of screening low-risk segments of the population for HIV infection. It has been pointed out that a single ELISA test performed on the general, low-risk population would result in excessive false positive rates, that is, a single ELISA test could yield many more false positives than true positives. On the other hand, use of a second ELISA test and a confirmatory Western Blot test appears to yield more reliable results. (See appendix I.)

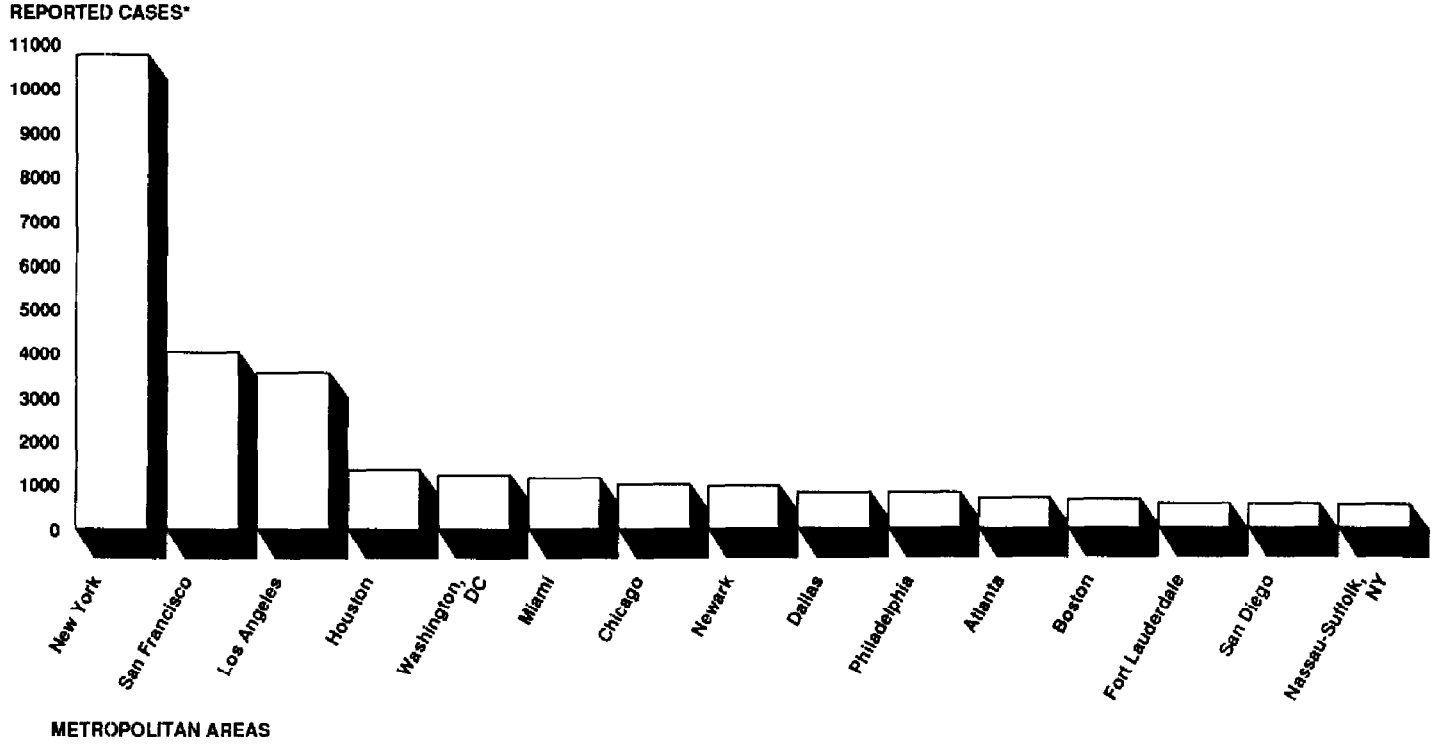
How Widespread Is AIDS?

Estimates of AIDS prevalence are far from precise, in part because of suspected underreporting due to the stigma associated with AIDS. As of August 31, 1987, more than 41,000 cases had been identified in the United States alone, and nearly 24,000 people had died of AIDS. To get some sense of the spread of the disease, these numbers should be compared with the 1,500 cases reported in the entire world in June 1983. Common estimates of the number of HIV-infected Americans currently range from 1 million to 2 million.

Reported AIDS cases in the United States are concentrated most heavily among a few high-risk groups and in a small number of urban areas. Ninety percent of cases involve homosexual or bisexual males and/or intravenous drug abusers. Only 4 percent have thus far involved heterosexual transmission. At the time of this writing, 70 percent of all AIDS cases have been reported from only five states: New York, California, Florida, Texas, and New Jersey. The metropolitan areas of New York City, San Francisco, Los Angeles, Houston, and Washington, D.C., which account for slightly more than 10 percent of the country's population, contain more than half of the reported AIDS cases in the United States. (See fig. 1.1.)

The form and magnitude which the AIDS epidemic will assume over the next several years are difficult to predict precisely. Last year, the Public Health Service projected that by the end of 1991, the total number of AIDS cases in the United States would exceed 270,000, with more than 179,000 deaths. (See fig. 1.2.) WHO anticipates that 50 million to 100 million people worldwide will be infected with HIV by 1991.

Figure 1.1: AIDS: The National Picture



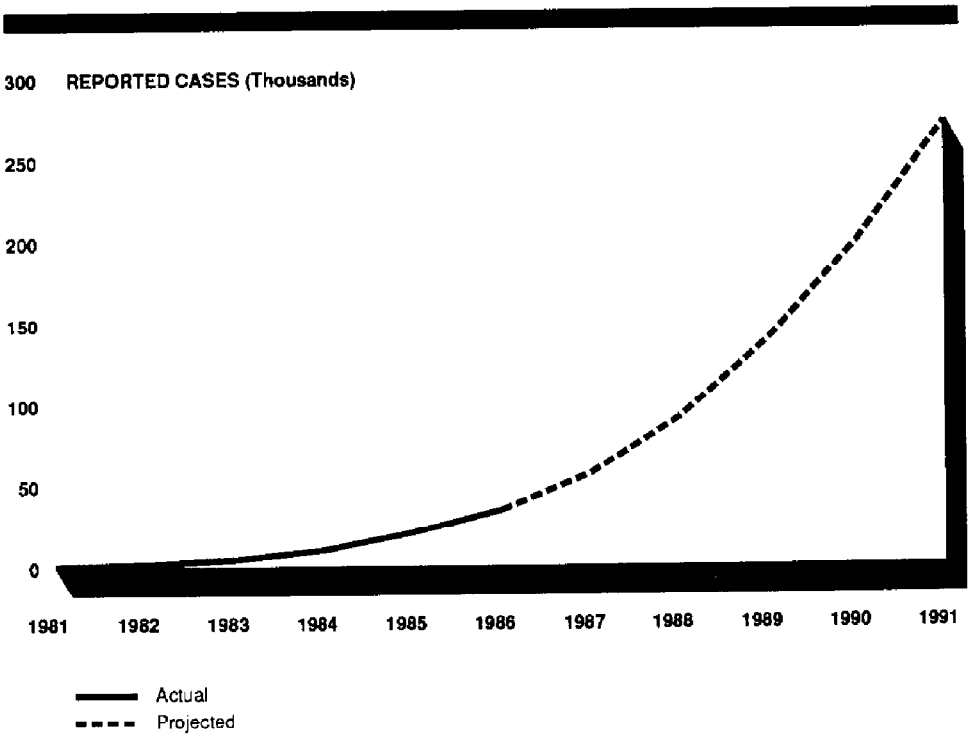
*As of August 31, 1987

SOURCE: Centers for Disease Control

These predictions may be optimistic. The WHO projection could prove to be a serious underestimate if HIV spreads rapidly in South America and Asia. Further, any forecast for the United States is clearly based on the assumptions made about the size of the population affected and the rate of spread. While there is little evidence so far that the virus has spread much beyond those persons with primary risk factors, namely homosexual and bisexual males and intravenous drug abusers, concern exists about the possible spread of AIDS among the heterosexual population. In Haiti and in Africa, the disease appears to be predominantly a heterosexually transmitted disease.

On the other hand, the predictions might be pessimistic, at least for the United States, given the three crucial uncertainties that currently cloud AIDS forecasting: (1) it is not empirically known how many people are

Figure 1.2: Cumulative Number of AIDS Cases in the United States



SOURCE: Centers for Disease Control

now infected with the virus, (2) it is not known how many of those infected will become ill and die or when that will happen in the course of the disease, and (3) it is not known at what rate AIDS will spread into the American heterosexual population. So long as scientific information in these three areas remains limited, questions regarding the future extent of the AIDS epidemic and the segments of the population that will be most seriously affected cannot be answered definitively.

Some Reasons for Hope

Society is fortunate that the AIDS virus is relatively fragile, unlike the hepatitis virus, for example. HIV does not stay alive long outside a propitious environment, and it is highly vulnerable to ordinary household cleansing agents, such as bleach. In addition, the AIDS virus is transmitted in ways that are within the control of an individual to avoid. This was not the case for bubonic plague (which was spread through insect bites), influenza (spread through coughs and sneezes), smallpox (spread through casual skin contact) or typhus (spread through contaminated water). AIDS can be prevented, and it is not transmissible through casual contact in the ordinary office workplace.

Also, the risk of getting AIDS is hardly comparable to that of getting heart disease or cancer. Although nearly 24,000 persons have died of AIDS, this figure is a cumulative total covering the 1981-87 period. By contrast, there are about 1 million deaths every year from heart disease, stroke, and related disorders, while cancer claims nearly 500,000. So the risk is not as yet very great for the general population, even though the rate of growth in the number of AIDS cases has been high.

In addition, there have been signs this past year that the spread of infection by the AIDS virus in the United States may be leveling off. In San Francisco, the increase in new infections from the virus among homosexuals, which had been 12 to 14 percent annually, has declined to about 1 percent. Also, the rate of AIDS infection among U.S. military recruits has not increased but, on the basis of 15 months' data, seems to have stabilized around the rate of 1.5 per 1,000. Still further, the rate of heterosexual incidence of the disease remains at 4 percent.

Finally, AIDS is getting the undivided attention of a very large international group of renowned researchers. The speed with which progress has already been made is quite remarkable. AIDS was recognized in 1981, the retrovirus which causes it was identified in 1984, and the ELISA test to identify the presence of HIV antibodies was ready in 1985. Now the virus' genetic code has been read, and a drug that slows the progress of AIDS is available.

It seems reasonable to hope that the disease's rate of growth will continue to slow as more people learn how AIDS is transmitted and how it can be avoided. But at the same time, the number of cases will continue to expand because of the people now carrying the virus who were infected in prior years and who will develop ARC or AIDS. Because of the long incubation period, control or containment of the epidemic may be many years away. The next year or so should bring important new information about changes in the rates of growth for the disease, especially about its heterosexual spread.

At present, for planning purposes, it can be assumed that the nation's workplaces will generally reflect the number of cases of HIV infection that exist in populations from which the workforce is drawn and that these cases will demonstrate a similar rate of progression to AIDS or ARC. Therefore, as more of the HIV-infected employees develop AIDS symptoms over the next 5 to 10 years, employees everywhere, including employees at GAO and other federal organizations and agencies, are likely to become aware, directly or indirectly, of fellow employees suffering from AIDS.

Task Force Approach to Developing an AIDS Strategy

The Task Force's specific mandate was to consider the problems AIDS poses in the workplace, to examine GAO's capabilities for dealing with them, to find out what other organizations are doing to resolve them, and to develop a plan for addressing any needs the Task Force might identify.

In planning how best to accomplish its mandate, the Task Force recognized that it first needed to define objectives for evaluating any strategy it considered. Four criteria were established, emphasizing GAO's need to do the following:

- Maintain a safe and healthful work environment. All employees should feel confident that GAO will not endanger their health and will provide whatever services they require to cope with the reality of AIDS in the workplace.
- Treat an employee with AIDS humanely. It is important that an organization be supportive to an employee who is suddenly faced with the prospect of steadily and irreversibly declining health. The AIDS patient typically confronts this major physical and emotional crisis at an age that is normally considered the prime of life.
- Avoid disruptions to GAO productivity. GAO must do what it can to deter both the spread of the disease and the rise of unnecessary fears about AIDS in the workplace. Management procedures should be in place which will allow GAO to fulfill its responsibilities to the Congress despite the advent of a certain number of AIDS cases.
- Help managers deal efficiently and sensitively with AIDS problems in the workplace. Over the next several years an increasing number of GAO managers will find themselves confronted with a staff member who has AIDS. The manager needs to be thoroughly familiar with GAO's policy on AIDS in the workplace, and to have guidance readily available to him/her on ways to translate this policy effectively in response to the concerns of both the employee with AIDS and his/her coworkers.

The Task Force determined that to develop useful recommendations, it must do five things: (1) obtain the best available current information on AIDS in the workplace; (2) examine GAO's experience with AIDS cases; (3) review GAO's benefit structure for applicability to the needs of employees with AIDS; (4) understand the likely implications for the workplace (in terms of health, civil rights, laws, costs, insurance, morale, etc.) of any policy under consideration; and (5) apply the experience of other organizations in dealing with AIDS.

To these ends, the Task Force collected and reviewed a broad spectrum of AIDS-related documents culled from both popular and professional literature and conducted a specific search for research on the problems encountered in the workplace by persons with AIDS. (See appendix IV.) Confidential studies of past AIDS cases at GAO were performed by Task Force members to identify how previous organizational responses could be improved. (See appendix III.) Benefit packages available to GAO employees were carefully reviewed regarding AIDS patients' needs. (See appendix V.) Individual papers on health, legal, and cost issues (see appendixes I, II, and VII) along with seminars from consultants on insurance concerns, the problems of testing for AIDS, and the civil rights of persons with AIDS, helped the Task Force develop an understanding of workplace implications. Finally, a survey was undertaken to learn about the experiences of other organizations having policies or guidelines on AIDS in the workplace and to obtain the advice and expertise of AIDS advocacy groups. (See appendix VIII.)

Because AIDS will affect different segments of the GAO population differently, a GAO program for dealing with AIDS in the workplace must respond to the concerns of different employee groups. Managers who will be called upon to supervise employees with AIDS must be fully aware of their responsibilities and rights and be given assistance necessary to enable them to supervise employees with AIDS both effectively and humanely. Fellow workers must understand their rights and obligations and how to find answers and assistance. The needs of the employee with AIDS must be anticipated and addressed. For this reason, the Task Force actively encouraged, solicited, and obtained input from all segments of the GAO population. This was done through comprehensive interviews with management, meetings with various employee organizations, and requests—via the "Management News"—for employee guidance.

Task Force Results

The Task Force drew upon the knowledge of its own members and their staffs, the counsel of outside experts, the extant literature, and a survey of experienced organizations to assemble the information necessary to make recommendations concerning how GAO should address AIDS in the workplace. Reports on particular aspects of AIDS at GAO were prepared by individual Task Force members and their staffs. These are presented in the appendixes and summarized in this chapter.

Public Health Considerations About AIDS in the Workplace

Regarding the first objective, maintaining a safe and healthful work environment, the Task Force requested a review of public health rules that must be considered in developing workplace guidelines on AIDS. (See appendix I.) This effort revealed that the presence of AIDS in the typical workplace is not considered a public health hazard. The Public Health Service states that "there is no known risk of AIDS virus transmission" for "persons in settings such as offices, schools, factories and construction sites."[1] Even in the case of food service workers, CDC sees no public health reason why workers infected with AIDS should be restricted from preparing or serving food and observes that following recommended standards of good personal hygiene and food sanitation suffices in this area. In contrast, CDC has issued detailed guidelines for health-care workers who are likely to come into contact with AIDS-infected blood. These workers are urged to avoid risks of accidental needlestick injury or mucous membrane exposure to contact with infected blood.

Although AIDS itself is not communicable in an office environment, AIDS patients may suffer from opportunistic infections, some of which may be communicable. In such cases, the employee with AIDS would be under the same workplace restrictions as any other person with that condition. The Task Force concluded therefore that extra health measures specific to AIDS were not required in the GAO workplace.

[1]"Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," Morbidity and Mortality Weekly Report, (Atlanta, Ga.: U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control, Vol. 34, No. 45 Nov. 15, 1985), pp. 681-95.

Suggestions From GAO Managers and Employees

As part of the Task Force's effort to obtain input to its deliberations from all segments of the GAO population and especially in support of the first objective, a survey was conducted of GAO managers and meetings were held with various employee councils and groups.[2]

Managers generally supported issuing guidelines on AIDS and suggested that the Task Force consider such issues as education for managers and staff, privacy and confidentiality, screening or testing, the right of coworkers to know about an AIDS case, health care benefits, safety of the workplace, sick leave, and disability. An overriding concern of the managers was that the existence of guidelines should not be seen as a substitute for careful consideration of each case's circumstances. Another concern was the need for continued monitoring. Given the continued uncertainties about AIDS, the Task Force should consider the need for ongoing educational updates to employees, ongoing monitoring of GAO benefit packages and their utility, and ongoing review of the development of testing and treatment for AIDS.

Task Force representatives met with many GAO groups to explain the mission and methodology of the Task Force, to identify employee concerns about AIDS in the workplace, and to obtain suggestions about how best to respond to them. Three issues were raised by several groups: coworker refusal to work with an employee with AIDS, the availability of confidential and professional counseling for both the employee with AIDS and coworkers, and an explicit definition of supervisor and supervisee rights and responsibilities when confronted with AIDS in their work environment.

When the results of the Task Force's legal review of legislation and regulations were presented, some concern was expressed that management refrain from dealing too hastily or severely with an employee refusing to work with a coworker who has AIDS. The prevailing view was that management should, on a case-by-case basis, seek reasonable accommodations which do not interfere with office productivity or with the rights of the employee with AIDS.

Counseling both for the worker who has AIDS and his/her coworkers was frequently discussed at employee council meetings. The issue most often

[2]Advisory Council on Civil Rights, Career Level Council, GS-13/14 Management and Policy Advisory Council, Women's Advisory Council, human resource managers, GAO administrative officers, and Deputy Directors for Operations.

raised was the critical need to guarantee confidentiality. Various suggestions were also made on ways to modify or expand available services. These included after-hours or off-site counseling and expansion of the contracted counseling services available in some regions. Some employee representatives also recommended against duplicating services available elsewhere in a community and suggested referrals to outside agencies. Employee groups generally favored a program that strengthened the counseling services within GAO and publicized other community resources.

At several meetings, employee representatives stressed the need for a clear and succinct statement of GAO AIDS policy. They pointed out that uncertainty about how management would react to an employee who feared working alongside an employee with AIDS or who disclosed that he/she had AIDS or had tested HIV antibody positive added unnecessarily to all employees' emotional stress and strain.

The groups' concerns about counseling and confidentiality spurred the Task Force to develop, with the aid of the Counseling and Career Development Branch (CCD) of the Office of Organization and Human Development (OOHD), a resource guide listing places, inside and outside GAO, where employees with questions or concerns about AIDS can receive information, counseling, referrals, and other services. A set of guides for GAO headquarters and for each of the regional offices has now been published.

Blood Screening for AIDS

The Task Force investigated the appropriateness of testing the blood of GAO employees or of applicants for employment for the presence of the HIV antibody. This was suggested because of various proposals for mandatory screening for certain populations, because of interest among GAO's employee groups, and because of the mandatory testing for certain groups currently practiced by the Departments of Defense and State and the Job Corps.

The Task Force has concluded that AIDS testing, whether voluntary or mandatory, is not now advisable at GAO for four reasons: (1) AIDS is not considered a health hazard in the ordinary workplace, (2) current tests do not screen for AIDS itself but rather for antibodies to HIV, (3) a positive (or negative) test result could not provide a proper basis for personnel action, and (4) testing employees or applicants for employment could be viewed as discriminatory under current law. Therefore, the Task Force decided not to pursue the idea of testing for AIDS in GAO at present.

Legal Review

As part of the effort to meet both the first and second objectives (those involving the rights of both employees with AIDS and their coworkers), the Task Force undertook a comprehensive review of the legal issues related to AIDS in the GAO workplace. (See appendix II.)

The Task Force concludes, on the basis of this review, that AIDS appears to be a handicapping condition protected from discrimination under the Rehabilitation Act of 1973. This means that no person with AIDS can be refused employment or can be terminated from employment because of AIDS, so long as he/she can do the work and presents no reasonable probability of harm to others in the workplace. It further concludes that it would be prudent to treat persons who test positive for the HIV antibody as entitled to the same protection, pending further clarification of the law on that issue. The act and the merit principles that apply to GAO appear also to preclude general mandatory testing for the presence of the HIV antibody, since its mere presence would not prevent successful job performance nor would it pose a substantial risk to others. Because AIDS is not communicable in the ordinary office environment, staff will be expected to continue working relationships with any fellow employee recognized as having AIDS. Administrative penalties would apply to a supervisor or a coworker who disclosed the condition of an employee with AIDS without official reason to do so. Regarding all these legal issues, the principles that apply to how employers, supervisors, and coworkers deal with an employee with AIDS are still evolving.

Case Studies

In keeping with its second objective to provide a humane work environment for employees with AIDS, the Task Force reviewed the experience of four AIDS cases at GAO. (See appendix III.) In planning this review, the Task Force realized that while some information might prove extremely helpful to GAO management in designing a policy sensitive to the needs of the person with AIDS, requesting information about an AIDS case could well intrude too heavily on the privacy of the employee or his/her surviving family and friends. In addition, the Task Force was concerned that it not limit its consideration of the problems that might confront the employee with AIDS at GAO solely to information gleaned from a small number of quite different cases. For these reasons, the Task Force supplemented its case study approach with a literature review to obtain empirical information concerning the problems encountered in the workplace by persons with AIDS. (See below.)

Some valuable lessons were learned from the case studies. None of the four employees who suffered from AIDS while working at GAO

approached management with that information, although one did volunteer that he had tested HIV antibody positive. In two other cases, a supervisor elicited the information from the employee. It is not believed that any of the employees experienced financial hardship due to health care expenses. On the other hand, one employee encountered a delay in the processing of his disability retirement paperwork by the Office of Personnel Management (OPM). Managers accommodated employee needs when requested, using special arrangements that included flexible work schedules and temporary reassignment. For the most part, coworkers were unaware of the existence or the nature of the disease, although speculation about AIDS tended to spread after the employee had left the workplace. In one case, fellow workers demonstrated extraordinary support and concern for a retired employee with AIDS, traveling long distances to visit him and staying in touch in other ways.

The Task Force concluded that these cases were generally well handled by management and by the employees' coworkers. However, the management of future cases would likely be improved if focal points were clearly identified where an employee with AIDS or his/her supervisor could seek counseling and assistance with workplace difficulties without fear of disclosure. Another lesson from the case studies was that an education program on AIDS in the workplace, for all GAO employees, could strengthen the likelihood that an employee with AIDS would receive emotional and physical support from colleagues. Finally, expediting the disability retirement process for all employees who are seriously ill—not just AIDS sufferers—seemed a necessity.

Literature Review

The literature review results were disappointing in that the empirical data sought could not be found. Although much popular literature is available, no relevant survey data, published or unpublished, appear to exist. It was decided, therefore, to supplement the review with interviews to gather the best possible information from sources having extensive experience with persons with AIDS and their problems in the workplace. Appendix IV contains the report of this effort, describes the procedures employed, and lists the interview respondents.

Through the literature review and interviews, the Task Force identified five major problems that may confront employees with AIDS:

- Job discrimination: Persons with AIDS can face discrimination either in getting hired or, if already employed, at work. This discrimination usually takes the form of pressure—frequently quite subtle—to resign or to accept reassignment.
- Loss of confidentiality: Employees often think they have a right to know about any real or suspected AIDS case in the workplace; they believe that the ordinary rules of privacy do not apply in this situation.
- Stigmatization: Coworkers may refuse to work with an employee who has AIDS. Their response may be more indirect, but equally demoralizing to the employee and damaging to workplace productivity. They may simply avoid all contact with the employee and encourage others to do the same.
- Designation of nontraditional agent: The employee with AIDS may prefer that someone who is not a relative deal with the employer on his/her behalf. Employers may be unable or unwilling to cooperate in such an arrangement with a nonrelated "significant other."
- Lack of awareness regarding behavioral manifestations: As the number of persons with AIDS increases and as treatment extends their lives, it is likely that more and more of those AIDS patients who are still working will manifest psychological symptoms—depression, confusion, and hostility. Many misunderstandings can result when supervisors and coworkers do not recognize these symptoms for what they are.

The Task Force concluded that GAO could best address each of these potential problems through education and managerial guidelines. Assurances will need to be provided to employees with AIDS that their rights will be protected. Their supervisors will need precise knowledge of their rights and responsibilities and must learn what to expect of management, of the employee, and of the employee's coworkers. They must also be given the resources and support needed to implement GAO's AIDS policy. Coworkers need to understand the nature of AIDS, especially how it is transmitted, and must know what personnel practices GAO will follow in AIDS cases.

Adequacy of Existing Employee Benefits

Again with regard to the second objective of treating employees with AIDS fairly and humanely, the Task Force reviewed the adequacy of employee health benefits, including sick leave, disability retirement, and health insurance policies (see appendixes V and VI), to determine if some changes were needed to help employees with AIDS cope with the financial ramifications of their condition. At present, AIDS is an invariably fatal disease involving progressive deterioration and extended

health care. The average annual cost of health care for AIDS (see appendix VII) has been estimated at $60,000 to $140,000. On average, life expectancy for an AIDS patient is about 11 months after diagnosis. This term may be extended with new experimental medication that is expected to prolong the patient's life but not cure the disease. Such expenses can be catastrophic and cannot typically be met without health insurance.

Health Insurance

It is impossible to describe briefly the range of coverage for health care costs that is afforded the employee with AIDS by the various health insurance policies available under the Federal Employees Health Benefits Program (FEHBP). Under most plans, coverage of in-hospital expenses is good. The employee with AIDS may expect 70 to 80 percent of such costs to be covered under the typical FEHBP policy. Coverage for outpatient, hospice, custodial, or home care can be significantly less generous and varies considerably from one plan to another. Health benefits continue during all leave periods, including leave without pay (LWOP).[3]

Disability Benefits

An employee with AIDS may, if eligible, elect to apply for disability retirement under the Civil Service Retirement System (CSRS) or under the Federal Employees Retirement System (FERS) when he/she can no longer work. Under either plan, the amount of the annuity payable is calculated with a complex formula and requires the filing and processing of materials (e.g., physicians' statements), which can take several months.

Reasonable Accommodation

The Rehabilitation Act of 1973 requires federal agencies to provide "reasonable accommodation" for disabled persons in the work environment. Such accommodation can include excused leave, flexible work schedules, liberal leave approval, advance leave, and light duty. Each case of AIDS would warrant individual review and management by the focal person in the home unit in conjunction with established policies. (See p. 38.)

In summary, the Task Force has found that benefits available to the employee with AIDS are substantial. While medical costs are not completely covered under FEHBP, the potentially disastrous financial implications of an AIDS diagnosis can be greatly mitigated by taking full

[3]Benefits continue for 365 days in a nonpay status. The employee must pay his/her share of the premium.

advantage of benefits. However, the employee, like any other employee seeking health insurance, will need to examine carefully the details of available plans and choose one suited to his/her likely health care needs. Since the plans are quite complex, the employee is unlikely to be able to develop the optimal package of benefits without help. Thus it is crucial that he/she seek assistance as early as possible in the course of the disease. The Task Force concluded that it would be important to identify in writing the major health care concerns of the typical employee with AIDS and to make this information available with the plan comparison booklet distributed annually during open season. Also, employees with AIDS who are considering disability retirement need to seek counseling well in advance in order to choose appropriately and avoid unnecessary delays in receiving benefits, especially in light of the experience derived from the case studies.

Survey of AIDS Policies in Other Organizations

To meet the third and fourth objectives of avoiding disruptions in GAO productivity and helping managers deal with cases of AIDS, the Task Force decided to try to find out what the experience of other public and private organizations had been with AIDS and what advice they had on the appropriateness of AIDS-specific personnel policies. Interviews were conducted with three categories of organizations: ones having explicit personnel policies to deal with AIDS, organizations that had elected not to establish such policies, and AIDS support groups. (Appendix VIII contains a detailed summary of findings.) The purpose of the interviews was to determine how others had coped with AIDS in the workplace.

Those government agencies and private organizations with established policies have as their objectives to decrease the fear of AIDS in the workplace, to protect the rights of employees with AIDS, and to apply personnel rules consistently. They rely primarily on education to do these things. Testing was thought to be "a bad idea" except by the respondents from the three government agencies included in the interview sample. Officials from these agencies stated that they needed testing to deal with unique situations they faced. However, there was no evidence of blanket testing for all employees.

Most of the organizations have established education programs, individual counseling, and referral to community agencies.

No problems were reported in implementing AIDS policies except by the State Department, which is undergoing a lawsuit challenging its testing policy.

Organizations that have chosen not to establish formal AIDS policies have done so because they consider AIDS another instance of a major life-threatening illness that is already covered under their general personnel policies. They prefer to address each such case individually. While the organizations which have established policies also feel AIDS should be dealt with like any other life-threatening disease, they are more concerned, it appears, with the consistency corporationwide of their personnel practices as they apply to this disease.

Support groups recommended that (1) AIDS be dealt with as would any other major medical problem, (2) an education program using available materials be established as soon as possible, (3) no testing or screening of employees be done, (4) confidentiality of information concerning employees with AIDS be strictly maintained, and (5) potential discrimination be addressed through education.

The Task Force did not find the striking examples of innovative programs it had hoped for from the survey. On the other hand, general consensus emerged about the importance of having an education program and of maintaining confidentiality. However, while confidentiality was considered essential, it was clear from the survey that most organizations with policies have not specifically covered employees' rights to confidentiality.

Task Force Recommendations

On the basis of the findings detailed in the previous chapter, the Task Force offers two overall recommendations: first, that GAO guidelines concerning the rights and responsibilities of managers, of employees with AIDS and of their coworkers be promulgated, and second, that an action plan be implemented to inform GAO staff and ensure that these guidelines are followed consistently throughout the Office. This chapter provides specific details of these general recommendations.

GAO Guidelines Concerning Employees With AIDS and Their Coworkers

The Task Force recommends that the following policy be adopted at GAO and that a copy of it be distributed to every employee:

On the basis of available medical and scientific information, the U.S. General Accounting Office recognizes that acquired immune deficiency syndrome (AIDS) is a life-threatening illness that is not transmissible under ordinary GAO work conditions. Therefore, GAO has determined that the following four principles will guide its personnel procedures:

- GAO intends to maintain a safe and healthful work environment for all GAO staff. Because all medical evidence indicates that AIDS is not transmitted in a typical office environment, staff will be expected to continue working relationships with any fellow employee who is recognized as having AIDS. To help allay any coworkers' fears of catching the disease, and to prepare them to cope with its effects in the workplace, GAO will offer education and counseling to any coworkers concerned about the possibility of AIDS infection or other deleterious consequences in this situation.
- Freedom from AIDS is not a condition for hiring or continued employment. Neither a clinical diagnosis of AIDS nor the presence of the HIV antibody in the bloodstream constitutes sufficient reason to deny employment to an otherwise qualified applicant or to dismiss an employee so long as the employee can meet performance standards and medical evidence indicates that his/her condition is not a threat to others.
- An employee's health condition is private and confidential. An employee with AIDS is under no obligation to disclose his/her condition to a supervisor or to any other GAO staff. However, the employee is strongly encouraged to make the condition known as soon as possible to the proper management level in order to receive informed advice on tailoring the use of appropriate employee benefits to his/her situation. Any disclosure by an employee who has AIDS will be maintained in strict confidence in accordance with the specific guidelines for managerial focal

points (see below); the manager must take all reasonable precautions to protect this information from unauthorized disclosure.

- GAO will make every effort to offer reasonable accommodation for the employee with AIDS. These efforts will be consistent with accommodations offered to employees suffering from other serious illnesses. This accommodation may include, but will not be limited to, flexible or part-time work schedules, advance sick leave, light duty assignments, working at home, and voluntary reassignment (see appendix IX).

Action Plan

The Task Force recommends that to facilitate the consistent implementation of these guidelines, an education and counseling program be initiated and that GAO's progress toward providing both humane treatment for the employee with AIDS and a safe, healthful, and productive work environment be continually monitored.

Education Program

The Task Force believes its report can itself be one means of educating employees. Continuing educational efforts following issuance of the report should work toward three basic objectives:

1. People suffering from AIDS should understand what GAO's policy is toward them and should know how to get the support available to them.

2. Managers and staff should also understand what GAO's policy is and how to protect all employees' rights, reassure employees who are not ill, and assist employees needing help.

3. All GAO employees should have the opportunity to be well-informed about AIDS.

On the basis of inquiries to other organizations and a review of existing educational programs, the Task Force believes that GAO should have an educational approach consisting of a 1- to 2-hour session, moderated by a GAO manager at the deputy director or assistant regional manager level. During the session, a commercially produced videotape on AIDS in the workplace would be viewed and GAO's AIDS guidelines discussed. The discussion should include, but not be limited to, the following considerations:

- Managers are responsible for familiarity with current GAO policy and with the resources available within GAO for clarifying and interpreting it.

- Managers are obliged to protect the confidentiality of GAO staff's personal health information.
- Managers should provide reasonable accommodations for persons suffering from AIDS or other life-threatening illnesses.
- Managers should be familiar with information and counseling resources available within and outside GAO for employees with AIDS and concerned coworkers.
- All staff should recognize that AIDS presents no threat of infection in the ordinary workplace and that an employee with AIDS has a right to expect humane treatment from supervisors and coworkers.

The detailed curriculum and resource material for the program would be developed, and managers would be trained, under the direction of OOHD using its own staff, Task Force representatives, and consultants, as appropriate. OOHD would be responsible for scheduling and other arrangements for the program. After the initial employee education program has been completed, the trained managers would continue to serve as focal points (see below). They would also be the conduits for disseminating any new information provided by the continuing AIDS group. (See p. 39.)

Counseling

The Task Force has already taken steps to publish current lists of community resources for persons with AIDS and others concerned about AIDS. Resource lists have been developed by the Task Force working together with the OOHD's Counseling and Career Development Branch for the Washington metropolitan area, and lists have been completed as well for the metropolitan areas corresponding to each regional and subregional office. These lists should be periodically updated by CCD.

The Task Force recognizes the extreme importance of confidentiality in counseling and recommends that CCD do whatever is necessary to protect the privacy of employees with AIDS. In the regions, it may be necessary to consider independent local counseling services. The New York Regional Office has contracted for counseling services on a fixed-fee basis and has been satisfied with the quality, the reasonable cost, and the confidentiality of these services. Denver staff report satisfaction with a similar arrangement.

The Task Force further recommends that CCD review its own capabilities to deal with the difficult psychological problems of AIDS and other life-threatening illnesses and submit to the Comptroller General proposals to respond to any needs it identifies in this area.

Managerial Guidelines

The Task Force noted the suggestion derived from the case study analysis that information available to a manager confronted by an AIDS case needed to be coordinated and organized. To deal with that issue, the Task Force developed special written guidelines for the individual manager (see appendix IX) and recommends a single focal point in each unit for AIDS cases.

The Task Force's guidelines for managers address four considerations important for any manager supervising an employee with AIDS: (1) the confidential nature of employee health information, (2) reasonable accommodation for the employee, (3) the implications for the employee's coworkers, and (4) the employee benefits available to an employee with AIDS. In addition, a question-and-answer format is used to help the manager handle successfully some different workplace scenarios that could occur.

Employee Benefits

The Task Force recommends that the Office of Personnel continue to provide special consideration to requests for disability retirement by employees suffering from terminal illnesses, including AIDS, by dealing directly and expeditiously with OPM and monitoring its processing of the request until final approval.

The Task Force further recommends that Personnel review available health insurance plans for their applicability to the health care needs of AIDS patients (in particular, the plans' coverage of out-of-hospital expenses) and make this information available to managers and concerned employees during the annual open season.

Managerial Focal Points

The Task Force recommends that each unit head (i.e., assistant comptroller general, division director, regional manager, or office director) designate one staff member—at the deputy director or assistant regional manager level—to serve as a focal point for personnel issues related to AIDS. This individual would become knowledgeable about employee rights, benefit packages, and other personnel issues likely to be of concern to employees with AIDS, their supervisors, and coworkers. In addition to assuring education on AIDS for everyone in his/her unit, this person would also arrange for other meetings as needed, in which staff could raise questions about AIDS and hear the views of GAO managers, Task Force members, and/or outside experts. With the employee's consent, this individual would also serve as the intermediary between him/her and GAO management to obtain any needed policy clarifications

and to expedite special personnel arrangements, if necessary. The designee would maintain all personal health information in strict confidence. The designee would be permitted to discuss this information only with staff in a direct supervisory chain above the AIDS patient and only as needed to maintain office productivity or to help the employee obtain necessary modifications to his/her working conditions. Within these limitations, every effort will be made to prevent unauthorized disclosure of the employee's health condition.

Periodic Policy Review

The Task Force recognizes that new developments in understanding AIDS occur almost daily. The Task Force recommendations are based on the best currently available medical, scientific, and legal expertise. However, the law could change, there could be important new knowledge about AIDS, and the accelerating search for a cure for and a vaccine against this disease could well prove successful sooner than expected. Any one or a combination of these changes could in a short time produce results with profound implications for public health and workplace policy. The Task Force also recognizes that the United States can expect to know within the next few years whether the spread of AIDS in this country will be self-limiting or whether an explosion of the disease into the general population should be anticipated. This knowledge will help to determine the nature of the public policy response to the problem.

For these reasons, the Task Force recommends that scientific and legal developments related to AIDS continue to be monitored by GAO. In addition, the Task Force recommends that the implementation of the GAO guidelines on AIDS be periodically reviewed in the light of its stated objectives to provide a safe, healthful, and productive office environment for all staff, and humane treatment to the employee with AIDS. In particular, the continuing adequacy of health and other benefits needs to be watched carefully as new treatments for AIDS emerge. These tasks should be monitored by a group of three members of the present Task Force (the Director of Personnel, the Chief Medical Advisor, and the General Counsel). The Task Force would reconvene annually to receive a report on these reviews and consider modifications to its policy recommendations; it would also meet if significant developments in the AIDS situation warranted policy consideration. Employees are encouraged to communicate any problems they encounter in the implementation of GAO's policy on AIDS in the workplace to this standing group or to any Task Force member.

The Task Force believes that any personnel practices established by GAO in dealing either with an employee with AIDS or with his/her coworkers need to be applied consistently and evenhandedly throughout GAO and should be perceived as being so applied. A GAO approach to dealing with AIDS will be most effective if it is implemented from the beginning as an institutionwide effort.

In general, the Task Force's recommendations flow from the view that the major source of AIDS problems in the workplace will not be the disease itself, but fear and ignorance about it. The hope is that the program recommended here will allow GAO to continue both to fulfill its obligations to its employees—all of them—and to maintain its commitment of service to the Congress.

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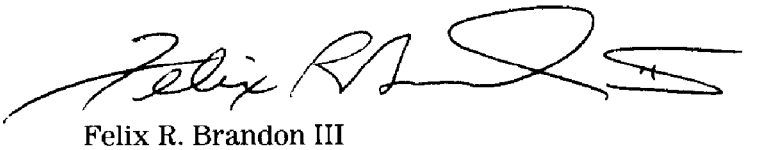

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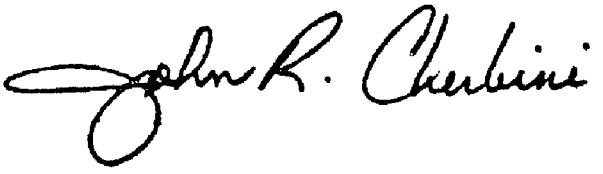

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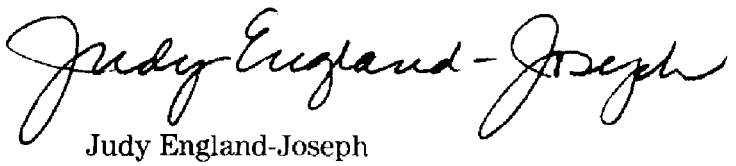

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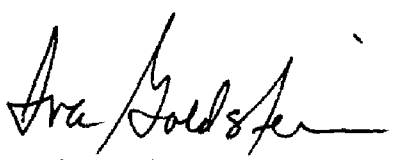

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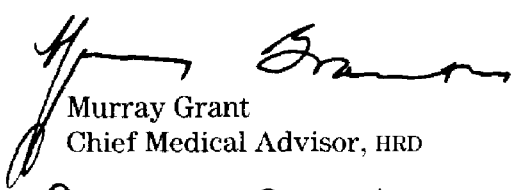

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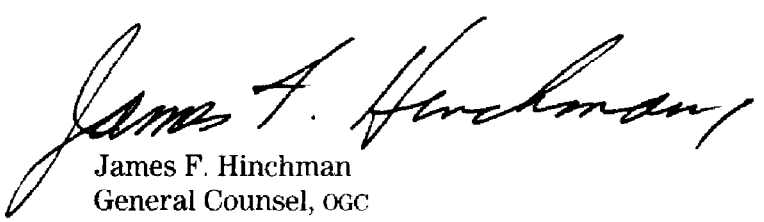

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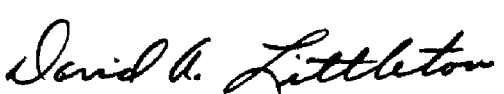

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Summary of Public Health Issues in the Workplace

What public health issues exist regarding AIDS in the GAO workplace?

Public health regulations are established at the state and local levels. Thus, to fully answer this question would require a detailed review of the health laws in each place where a GAO employee works. Within federal buildings, however, the Centers for Disease Control may make recommendations concerning disease prevention. Such recommendations have been made with regard to AIDS in the workplace. These are incorporated in the periodical published by CDC entitled Morbidity and Mortality Weekly Report (Nov. 15, 1985). (See fig. I. 1.) The specific precautions outlined suggest the avoidance of needlestick injury and the use of gloves and disinfectant (hypochlorite solution) in cleaning up a blood spill. Additional information about disease prevention has been published in the August 21, 1987, issue of the CDC report. (See fig. I. 2.)

What are the medical conditions which would allow an employee to properly refuse to work with an employee with AIDS?

Epidemiological studies indicate that AIDS is not transmitted casually from person to person by inhalation, direct personal contact (other than sexually or through contaminated needles), or by means of vectors (organisms that carry the virus). Thus, there appear to be no circumstances, from a public health viewpoint, under which an employee should refuse to work with an employee who has AIDS.

Figure I.1: Summary: Recommendations for Preventing Transmission of Infection With Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

Summary:

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does *not* recommend routine HTLV-III LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III lymphadenopathy-associated virus (HTLV-III LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III LAV infection, and children born to infected mothers. HTLV-III LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III LAV has been

Figure I.1: Continued

isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (*1*) and for dental-care personnel and persons performing necropsies and morticians' services (*2*). Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III LAV transmission in prisons, other correctional facilities, and institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (*3*).

HTLV-III LAV-infected individuals include those with AIDS (*4*); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III LAV; and those who have virologic or serologic evidence of infection with HTLV-III LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission 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/LAV infection. Neither HBV nor HTLV-III LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (*5*).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (*6-8*).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (*9-11*).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (*12,13*), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have ex-

Figure I.1: Continued

hibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (*9-11,14*). The HBV model thus represents a "worst case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III LAV or HBV. In addition to being informed of these precautions, all HCWs, including students and housestaff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk for transmission of HTLV-III LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III LAV. In these studies, 666 (44.5 %) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (*15*). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III LAV infection (*15,16*), neither had a preexposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (*17*).

In spite of the extremely low risk of transmission of HTLV-III LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace. These precautions represent prudent practices that apply to preventing transmission of HTLV-III LAV and other bloodborne infections and should be used routinely (*18*).

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective

Figure I.1: Continued

body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.

4. *To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.*
5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the preventing HTLV-III/LAV transmission (*19*).

Precautions for HCWs during home care of persons infected with HTLV-III/LAV. Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (*3*). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for *solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and* water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach; see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care. Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposures of HCWs. *If a HCW has* a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) 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 HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (*20,21*). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is neces-

Figure I.1: Continued

sary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients. Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients. Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS

Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients. These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs. Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV. HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents (*18,19*). The HCWs' personal physician(s) in conjunction with their institutions' personnel health services or medical directors should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments if indicated. In making

Figure I.1: Continued

this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

STERILIZATION, DISINFECTION, HOUSEKEEPING, AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV III/LAV

Sterilization and disinfection procedures currently recommended for use [22,23] in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire [24] and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III LAV at concentrations much lower than are used in practice [25]. When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the U.S. Environmental Protection Agency (EPA) as "sterilants" can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C., 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide [25]. Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste [23] are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

CONSIDERATIONS RELEVANT TO OTHER WORKERS

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal service settings, indicating that any

Figure I.1: Continued

risk for HTLV-III LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III LAV and HBV. Such education should emphasize principles of good hygiene, antisepsis, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs). FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (*26*). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

Routine serologic testing of FSWs for antibody to HTLV-III LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach; see above) should be used to wipe the area after cleaning.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III LAV infection. The diagnosis of HTLV-III LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials; Conference of State and Territorial Epidemiologists; Association of State and Territorial Public Health Laboratory Directors; National Association of County Health Officials; American Hospital Association; United States Conference of Local Health Officers; Association for Practitioners in Infection Control; Society of Hospital Epidemiologists of America; American Dental Association; American Medical Association; American Nurses' Association; American Association of Medical Colleges; American Association of

Figure I.1: Continued

Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

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Source: Morbidity and Mortality Weekly Report (Atlanta, Ga.: U.S. Dept. of Health and Human Services, Public Health Service, CDC, vol. 34, no. 45, Nov. 15, 1985), pp. 681-686,691-695.

Figure I.2: Recommendations for Prevention of HIV Transmission in Health Care Settings

Recommendations for Prevention of HIV Transmission in Health-Care Settings

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Introduction

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (*1*) and precautions for health-care workers and allied professionals (*2*); recommendations for preventing HIV transmission in the workplace (*3*) and during invasive procedures (*4*); recommendations for preventing possible transmission of HIV from tears (*5*); and recommendations for providing dialysis treatment for HIV-infected patients (*6*). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (*7*) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (*8*). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

Figure I.2: Continued

Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons – representing 5.6% of the U.S. labor force – were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (*9*). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had only a convalescent-phase serum sample obtained and tested ≥90 days post-exposure, one – for whom heterosexual transmission could not be ruled out – was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351

Figure I.2: Continued

with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (*10*). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (*11*). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (*12*).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (*13-15*). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (*16,17*). The other three were health-care workers with non-needlestick exposures to blood from infected patients (*18*). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (*19*).

Precautions To Prevent Transmission of HIV

Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients. This approach, previously recommended by CDC (*3,4*), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of all patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (*20*).

Figure I.2: Continued

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC [7] for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [7]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

Precautions for Invasive Procedures

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries [1] in an operating or delivery

Figure I.2: Continued

room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.
2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Precautions for Dentistry*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (8).

Figure I.2: Continued

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

Precautions for Dialysis

Patients with end-stage renal disease who are undergoing maintenance dialysis and who have HIV infection can be dialyzed in hospital-based or free-standing dialysis units using conventional infection-control precautions (21). Universal blood and body-fluid precautions should be used when dialyzing all patients.

Strategies for disinfecting the dialysis fluid pathways of the hemodialysis machine are targeted to control bacterial contamination and generally consist of using 500-750 parts per million (ppm) of sodium hypochlorite (household bleach) for 30-40 minutes or 1.5%-2.0% formaldehyde overnight. In addition, several chemical germicides formulated to disinfect dialysis machines are commercially available. None of these protocols or procedures need to be changed for dialyzing patients infected with HIV.

Patients infected with HIV can be dialyzed by either hemodialysis or peritoneal dialysis and do not need to be isolated from other patients. The type of dialysis treatment (i.e., hemodialysis or peritoneal dialysis) should be based on the needs of the patient. The dialyzer may be discarded after each use. Alternatively, centers that reuse dialyzers—i.e., a specific single-use dialyzer is issued to a specific patient, removed, cleaned, disinfected, and reused several times on the same patient only—may include HIV-infected patients in the dialyzer-reuse program. An individual dialyzer must never be used on more than one patient.

Precautions for Laboratories[7]

Blood and other body fluids from all patients should be considered infective. To supplement the universal blood and body-fluid precautions listed above, the following precautions are recommended for health-care workers in clinical laboratories.

[7]Additional precautions for research and industrial laboratories are addressed elsewhere (22,23).

Figure I.2: Continued

1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.
2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.
5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.
6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste (*24*).
8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Implementation of universal blood and body-fluid precautions for **all** patients eliminates the need for warning labels on specimens since blood and other body fluids from all patients should be considered infective.

Environmental Considerations for HIV Transmission

No environmentally mediated mode of HIV transmission has been documented. Nevertheless, the precautions described below should be taken routinely in the care of **all** patients.

Sterilization and Disinfection

Standard sterilization and disinfection procedures for patient-care equipment currently recommended for use (*25,26*) in a variety of health-care settings—including hospitals, medical and dental clinics and offices, hemodialysis centers, emergency-care facilities, and long-term nursing-care facilities—are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body fluids from persons infected with blood-borne pathogens including HIV (*21,23*).

Figure I.2: Continued

Instruments or devices that enter sterile tissue or the vascular system of any patient or through which blood flows should be sterilized before reuse. Devices or items that contact intact mucous membranes should be sterilized or receive high-level disinfection, a procedure that kills vegetative organisms and viruses but not necessarily large numbers of bacterial spores. Chemical germicides that are registered with the U.S. Environmental Protection Agency (EPA) as 'sterilants' may be used either for sterilization or for high-level disinfection depending on contact time.

Contact lenses used in trial fittings should be disinfected after each fitting by using a hydrogen peroxide contact lens disinfecting system or, if compatible, with heat (78 C-80 C [172.4 F-176.0 F]) for 10 minutes.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specifications for compatibility of the medical device with chemical germicides be closely followed. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, SW, Washington, D.C. 20460.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice (*27-30*). Embalming fluids are similar to the types of chemical germicides that have been tested and found to completely inactivate HIV. In addition to commercially available chemical germicides, a solution of sodium hypochlorite (household bleach) prepared daily is an inexpensive and effective germicide. Concentrations ranging from approximately 500 ppm (1:100 dilution of household bleach) sodium hypochlorite to 5,000 ppm (1:10 dilution of household bleach) are effective depending on the amount of organic material (e.g., blood, mucus) present on the surface to be cleaned and disinfected. Commercially available chemical germicides may be more compatible with certain medical devices that might be corroded by repeated exposure to sodium hypochlorite, especially to the 1:10 dilution.

Survival of HIV in the Environment

The most extensive study on the survival of HIV after drying involved greatly concentrated HIV samples, i.e., 10 million tissue-culture infectious doses per milliliter (*31*). This concentration is at least 100,000 times greater than that typically found in the blood or serum of patients with HIV infection. HIV was detectable by tissue-culture techniques 1-3 days after drying, but the rate of inactivation was rapid. Studies performed at CDC have also shown that drying HIV causes a rapid (within several hours) 1-2 log (90%-99%) reduction in HIV concentration. In tissue-culture fluid, cell-free HIV could be detected up to 15 days at room temperature, up to 11 days at 37 C (98.6 F), and up to 1 day if the HIV was cell-associated.

When considered in the context of environmental conditions in health-care facilities, these results do not require any changes in currently recommended sterilization, disinfection, or housekeeping strategies. When medical devices are contaminated with blood or other body fluids, existing recommendations include the cleaning of these instruments, followed by disinfection or sterilization, depending on the type of medical device. These protocols assume 'worst-case' conditions of

Figure I.2: Continued

extreme virologic and microbiologic contamination, and whether viruses have been inactivated after drying plays no role in formulating these strategies. Consequently, no changes in published procedures for cleaning, disinfecting, or sterilizing need to be made.

Housekeeping

Environmental surfaces such as walls, floors, and other surfaces are not associated with transmission of infections to patients or health-care workers. Therefore, extraordinary attempts to disinfect or sterilize these environmental surfaces are not necessary. However, cleaning and removal of soil should be done routinely.

Cleaning schedules and methods vary according to the area of the hospital or institution, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (e.g., bedside tables and hard-surfaced flooring) in patient-care areas are usually cleaned on a regular basis, when soiling or spills occur, and when a patient is discharged. Cleaning of walls, blinds, and curtains is recommended only if they are visibly soiled. Disinfectant fogging is an unsatisfactory method of decontaminating air and surfaces and is not recommended.

Disinfectant-detergent formulations registered by EPA can be used for cleaning environmental surfaces, but the actual physical removal of microorganisms by scrubbing is probably at least as important as any antimicrobial effect of the cleaning agent used. Therefore, cost, safety, and acceptability by housekeepers can be the main criteria for selecting any such registered agent. The manufacturers' instructions for appropriate use should be followed.

Cleaning and Decontaminating Spills of Blood or Other Body Fluids

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body fluids. Strategies for decontaminating spills of blood and other body fluids in a patient-care setting are different than for spills of cultures or other materials in clinical, public health, or research laboratories. In patient-care areas, visible material should first be removed and then the area should be decontaminated. With large spills of cultured or concentrated infectious agents in the laboratory, the contaminated area should be flooded with a liquid germicide before cleaning, then decontaminated with fresh germicidal chemical. In both settings, gloves should be worn during the cleaning and decontaminating procedures.

Laundry

Although soiled linen has been identified as a source of large numbers of certain pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic and common-sense storage and processing of clean and soiled linen are recommended [26]. Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in patient-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed

Figure I.2: Continued

with detergent in water at least 71 C (160 F) for 25 minutes. If low-temperature(≤70 C [158 F]) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.

Infective Waste

There is no epidemiologic evidence to suggest that most hospital waste is any more infective than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission. The most practical approach to the management of infective waste is to identify those wastes with the potential for causing infection during handling and disposal and for which some special precautions appear prudent. Hospital wastes for which special precautions appear prudent include microbiology laboratory waste, pathology waste, and blood specimens or blood products. While any item that has had contact with blood, exudates, or secretions may be potentially infective, it is not usually considered practical or necessary to treat all such waste as infective (*23,26*). Infective waste, in general, should either be incinerated or should be autoclaved before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer.

Implementation of Recommended Precautions

Employers of health-care workers should ensure that policies exist for:

1. Initial orientation and continuing education and training of all health-care workers – including students and trainees – on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal blood and body-fluid precautions for all patients.
2. Provision of equipment and supplies necessary to minimize the risk of infection with HIV and other blood-borne pathogens.
3. Monitoring adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, counseling, education, and/or re-training should be provided, and, if necessary, appropriate disciplinary action should be considered.

Professional associations and labor organizations, through continuing education efforts, should emphasize the need for health-care workers to follow recommended precautions.

Figure I.2: Continued

Serologic Testing for HIV Infection

Background

A person is identified as infected with HIV when a sequence of tests, starting with repeated enzyme immunoassays (EIA) and including a Western blot or similar, more specific assay, are repeatedly reactive. Persons infected with HIV usually develop antibody against the virus within 6-12 weeks after infection.

The sensitivity of the currently licensed EIA tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for ≥12 weeks. Optimal laboratory conditions include the use of reliable reagents, provision of continuing education of personnel, quality control of procedures, and participation in performance-evaluation programs. Given this performance, the probability of a false-negative test is remote except during the first several weeks after infection, before detectable antibody is present. The proportion of infected persons with a false-negative test attributed to absence of antibody in the early stages of infection is dependent on both the incidence and prevalence of HIV infection in a population (Table 1).

The specificity of the currently licensed EIA tests is approximately 99% when repeatedly reactive tests are considered. Repeat testing of initially reactive specimens by EIA is required to reduce the likelihood of laboratory error. To increase further the specificity of serologic tests, laboratories must use a supplemental test, most often the Western blot, to validate repeatedly reactive EIA results. Under optimal laboratory conditions, the sensitivity of the Western blot test is comparable to or greater than that of a repeatedly reactive EIA, and the Western blot is highly specific when strict criteria are used to interpret the test results. The testing sequence of a repeatedly reactive EIA and a positive Western blot test is highly predictive of HIV infection, even in a population with a low prevalence of infection (Table 2). If the Western blot test result is indeterminant, the testing sequence is considered equivocal for HIV infection.

TABLE 1. Estimated annual number of patients infected with HIV not detected by HIV-antibody testing in a hypothetical hospital with 10,000 admissions/year*

Beginning prevalence of HIV infection	Annual incidence of HIV infection	Approximate number of HIV-infected patients	Approximate number of HIV-infected patients not detected
5.0%	1.0%	550	17-18
5.0%	0.5%	525	11-12
1.0%	0.2%	110	3-4
1.0%	0.1%	105	2-3
0.1%	0.02%	11	0-1
0.1%	0.01%	11	0-1

*The estimates are based on the following assumptions: 1) the sensitivity of the screening test is 99% (i.e., 99% of HIV-infected persons with antibody will be detected); 2) persons infected with HIV will not develop detectable antibody (seroconvert) until 6 weeks (1.5 months) after infection; 3) new infections occur at an equal rate throughout the year; 4) calculations of the number of HIV-infected persons in the patient population are based on the mid-year prevalence, which is the beginning prevalence plus half the annual incidence of infections.

Figure I.2: Continued

When this occurs, the Western blot test should be repeated on the same serum sample, and, if still indeterminant, the testing sequence should be repeated on a sample collected 3-6 months later. Use of other supplemental tests may aid in interpreting of results on samples that are persistently indeterminant by Western blot.

Testing of Patients

Previous CDC recommendations have emphasized the value of HIV serologic testing of patients for: 1) management of parenteral or mucous-membrane exposures of health-care workers, 2) patient diagnosis and management, and 3) counseling and serologic testing to prevent and control HIV transmission in the community. In addition, more recent recommendations have stated that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at highest risk of infection (*32*).

Adherence to universal blood and body-fluid precautions recommended for the care of all patients will minimize the risk of transmission of HIV and other blood-borne pathogens from patients to health-care workers. The utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. Results of such testing may not be available in emergency or outpatient settings. In addition, some recently infected patients will not have detectable antibody to HIV (Table 1).

Personnel in some hospitals have advocated serologic testing of patients in settings in which exposure of health-care workers to large amounts of patients' blood may be anticipated. Specific patients for whom serologic testing has been advocated include those undergoing major operative procedures and those undergoing treatment in critical-care units, especially if they have conditions involving uncontrolled bleeding. Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions. In addition, when deemed appropriate, testing of individual patients may be performed on agreement between the patient and the physician providing care.

In addition to the universal precautions recommended for all patients, certain additional precautions for the care of HIV-infected patients undergoing major surgical operations have been proposed by personnel in some hospitals. For example, surgical procedures on an HIV-infected patient might be altered so that hand-to-hand passing of sharp instruments would be eliminated, stapling instruments rather than

TABLE 2. Predictive value of positive HIV-antibody tests in hypothetical populations with different prevalences of infection

	Prevalence of infection	Predictive value of positive test*
Repeatedly reactive enzyme immunoassay (EIA)†	0.2%	28.41%
	2.0%	80.16%
	20.0%	98.02%
Repeatedly reactive EIA followed by positive Western blot (WB)§	0.2%	99.75%
	2.0%	99.97%
	20.0%	99.99%

*Proportion of persons with positive test results who are actually infected with HIV.
†Assumes EIA sensitivity of 99.0% and specificity of 99.5%.
§Assumes WB sensitivity of 99.0% and specificity of 99.9%.

Figure I.2: Continued

hand-suturing equipment might be used to perform tissue approximation; electrocautery devices rather than scalpels might be used as cutting instruments; and, even though uncomfortable, gowns that totally prevent seepage of blood onto the skin of members of the operative team might be worn. While such modifications might further minimize the risk of HIV infection for members of the operative team, some of these techniques could result in prolongation of operative time and could potentially have an adverse effect on the patient.

Testing programs, if developed, should include the following principles:

- Obtaining consent for testing.
- Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
- Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
- Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
- Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.

Testing of Health-Care Workers

Although transmission of HIV from infected health-care workers to patients has not been reported, transmission during invasive procedures remains a possibility. Transmission of hepatitis B virus (HBV)—a blood-borne agent with a considerably greater potential for nosocomial spread—from health-care workers to patients has been documented. Such transmission has occurred in situations (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (*33,34*).

The hepatitis B experience indicates that only those health-care workers who perform certain types of invasive procedures have transmitted HBV to patients. Adherence to recommendations in this document will minimize the risk of transmission of HIV and other blood-borne pathogens from health-care workers to patients during invasive procedures. Since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed. If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results—as previously outlined for testing programs for patients—must be addressed.

Figure I.2: Continued

Management of Infected Health-Care Workers

Health-care workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., measles, varicella). Any health-care worker with an impaired immune system should be counseled about the potential risk associated with taking care of patients with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (*7,35*). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating health-care workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV – especially those who perform invasive procedures – can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Management of Exposures

If a health-care worker has a parenteral (e.g., needlestick or cut) or mucous-membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood – especially when the exposed skin is chapped, abraded, or afflicted with dermatitis – the source patient should be informed of the incident and tested for serologic evidence of HIV infection after consent is obtained. Policies should be developed for testing source patients in situations in which consent cannot be obtained (e.g., an unconscious patient).

If the source patient has AIDS, is positive for HIV antibody, or refuses the test, the health-care worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. The health-care worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness – particularly one characterized by fever, rash, or lymphadenopathy – may be indicative of recent HIV infection. Seronegative health-care workers should be retested 6 weeks post-exposure and on a periodic basis thereafter (e.g., 12 weeks and 6 months after exposure) to determine whether transmission has occurred. During this follow-up period – especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert – exposed health-care workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (*36,37*).

No further follow-up of a health-care worker exposed to infection as described above is necessary if the source patient is seronegative unless the source patient is at high risk of HIV infection. In the latter case, a subsequent specimen (e.g., 12 weeks following exposure) may be obtained from the health-care worker for antibody

Figure I.2: Continued

testing. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be available to all health-care workers who are concerned that they may have been infected with HIV.

If a patient has a parenteral or mucous-membrane exposure to blood or other body fluid of a health-care worker, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source health-care worker and the exposed patient.

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Figure I.2: Continued

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Source: Morbidity and Mortality Weekly Report (Atlanta, Ga.: U.S. Dept. of Health and Human Services, Public Health Service, CDC, vol. 36, no. 2S, Aug. 21, 1987), pp. 3S-18S.

Legal Issues of AIDS in the Workplace

What constraints apply under handicap discrimination laws with regard to an AIDS policy?

For reasons that are discussed in detail below, it appears prudent for GAO to treat AIDS, ARC and testing positive for HIV antibodies as handicapping conditions protected by the Rehabilitation Act of 1973.

AIDS and the Rehabilitation Act

The GAO Personnel Act at 31 U.S.C. § 732(f)(2) preserves for GAO employees and applicants for employment the rights and remedies available under laws prohibiting discrimination based on handicapping conditions. GAO is thus bound by 29 U.S.C. § 794, which prohibits discrimination against an otherwise qualified handicapped individual under "any program or activity conducted by an Executive agency."[1] GAO's regulations on employing the handicapped are included in GAO Order 2306.1, "Selective Placement Programs."

For purposes of the antidiscrimination provisions of the Rehabilitation Act, a "handicapped individual" is defined at 29 U.S.C.A. § 706(8)(B) (West Supp. 1987) as:

". . . any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment. . . ."

The terms used in this definition are amplified at 29 C.F.R. § 1613.702, as follows:

"(a) 'Handicapped person' is defined for this subpart as one who: (1) Has a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

"(b) 'Physical or mental impairment' means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin;

[1]Also, the GAO personnel system is required by 31 U.S.C. § 732(b)(1) to include provisions akin to 5 U.S.C. §§ 2301(b) and is required by 31 U.S.C. § 732(b)(2) to prohibit practices prohibited by 5 U.S.C. § 2302(b). The merit systems principles at subsection 2301(b)(2) provide that "all applicants for employment should receive fair and equitable treatment in all aspects of personnel management without regard to handicapping conditions." Subsection 2302(b)(1)(D) lists as a prohibited personnel practice "discriminating for or against any employee or applicant for employment . . . on the basis of handicapping conditions, as prohibited under section 501 of the Rehabilitation Act of 1973."

and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"(c) 'Major life activities' means functions, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"(d) 'Has a record of such impairment' means has a history of, or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

"(e) 'Is regarded as having an impairment' means (1) has a physical or mental impairment that does not substantially limit major life activities but is treated by an employer as constituting such a limitation; (2) has a physical or mental impairment that substantially limits major life activities only as a result of the attitude of an employer toward such impairment; (3) or has none of the impairments defined in (b) of this section but is treated by an employer as having such an impairment."

In School Board of Nassau County v. Arline, 107 S. Ct. 1123 (1987), the Supreme Court held that tuberculosis (a "physiological disorder or condition . . . affecting [Ms. Arline's] . . . respiratory [system]") is a handicap within the meaning of section 706 of the Rehabilitation Act. In so holding, the Court specifically rejected the argument that the Act did not protect Ms. Arline against dismissal from her teaching position where that dismissal was based not on any physical incapacity but on the employer's fear that the disease would be transmitted to others. Under the Arline decision, the issue of contagion comes into play in making the two-part determination of whether the handicapped individual is "otherwise qualified" to perform the job in question. That determination is to be made first on the basis of a factual finding concerning the nature of the risk, the severity of the risk, and the probability that the disease will be transmitted. In light of these medical findings, a determination then must be made as to whether reasonable accommodation by the employer is possible.

The Arline case appears to establish ARC and clinically defined AIDS as handicaps covered by the Rehabilitation Act.[2] The Court left open, however, the question of the Act's coverage of a person who suffers no physical impairment but who is simply a carrier of a contagious disease. The Court stated:

[2]This is consistent with the holding in Thomas v. Atascadero Unified School District, 662 F. Supp. 376 (C.D. Cal. 1987) in which the court held that a child with AIDS is a handicapped person within the meaning of § 504 of the Rehabilitation Act.

"The United States argues that it is possible for a person to be simply a carrier of a disease, that is, to be capable of spreading a disease without having a 'physical impairment' or suffering from any other symptoms associated with the disease. The United States contends that this is true in the case of some carriers of the Acquired Immune Deficiency Syndrome (AIDS) virus. From this premise the United States concludes that discrimination solely on the basis of contagiousness is never discrimination on the basis of a handicap. The argument is misplaced in this case, because the handicap here, tuberculosis, gave rise both to a physical impairment and to contagiousness. This case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act." 107 S. Ct. at 1128, note 7.

Notwithstanding that the Supreme Court sidestepped that particular issue, legal commentators generally believe that the Rehabilitation Act will be held to cover employees who merely test positive for exposure to AIDS and, thus, are regarded as AIDS virus carriers. They cite the statutory definition of a "handicapped person" as covering one who is merely regarded as having a physical impairment and the following language contained in the Supreme Court's Arline decision:

"Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504, which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others. By amending the definition of 'handicapped individual' to include not only those who are actually physically impaired, but also those who are regarded as impaired and who, as a result, are substantially limited in a major life activity, Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious. The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments . . . ." Id. at 1129.

While the Arline case does not deal directly with AIDS and specifically leaves the status of individuals who test positive somewhat in doubt, prudence would suggest that GAO should treat clinically defined AIDS, ARC, and exposure to the AIDS virus as protected handicaps. This means GAO should not conduct tests for presence of the AIDS antibody. GAO should not terminate an employee or refuse to hire an applicant who tests positive or who exhibits symptoms of AIDS, and GAO should make reasonable accommodations on the job to employees with clinically defined AIDS and ARC. These three obligations are discussed below.

Testing

The Rehabilitation Act places a major constraint on the use of AIDS-screening tests, even when the screening occurs as part of a medical examination given to all employees or applicants. The regulations implementing the act provide that an agency may not use any employment test or other selection criterion that screens out or tends to screen out qualified handicapped persons unless the test score is shown to be job related and there is no less discriminatory test or criterion. (29 C.F.R. § 1613.705(a)) As a practical matter, the regulations prohibit the use of preemployment medical examinations aimed at discovering an applicant's handicapping condition. An employer "may not conduct a preemployment medical examination and may not make preemployment inquiry of the applicant as to whether the applicant is a handicapped person or as to the nature or severity of a handicap." (29 C.F.R. § 1613.706(a)) An agency that screens current employees or applicants for AIDS runs a serious risk of violating the Rehabilitation Act. Given the lack of medical evidence that AIDS is communicable in the office environment, for an agency to demonstrate that a test for exposure to the AIDS virus is job related would be difficult.

The fact that the military and the Department of State are currently testing for AIDS warrants some comment. The Department of Defense (DOD) has readiness requirements that may well support its test program as applied to military officers and enlisted personnel. In cases involving the military's AIDS policy, plaintiffs have not even questioned the military's refusal to accept recruits who test positive.[3]

The career foreign service also presents a special case. On January 5, 1987, the Department of State began to test all foreign service officers and applicants for exposure to AIDS. This program has been challenged in the U.S. District Court by the AFGE Local 1812 on the basis that it violates the Rehabilitation Act and the Fourth Amendment. The Department's rationale for its AIDS-screening program is based, in part, on the fact that readiness for assignment overseas is a condition of foreign service employment. More pragmatically, it is based on the fact that certain foreign countries where there is a significant U.S. military or diplomatic presence have expressed a hesitance to grant visas in the absence of some assurance that the applicant has not been exposed to the AIDS virus. In April, a U.S. District Court denied the union's request for a preliminary injunction to bar the testing of State Department employees

[3]Batten v. Leham, No. 85-4108 Civ. (D.D.C. Jan. 18, 1986) (order denying preliminary injunction) involved 11 new recruits who were segregated and then dismissed when found to test positive. The U.S. District Court denied an injunction against the Navy, in part, on the basis that the plaintiffs were not likely to prevail on the merits.

for the AIDS virus. In so doing, the Court stated that AIDS testing appears rational and closely related to fitness for duty. (Local 1812, Am. Fed. of Gov. Emp. v. Department of State, 662 F. Supp. 50 (D.D.C. 1987).

As a matter of particular significance to GAO, it should be recognized that the Department of State conducts medical examinations for GAO employees and for employees of 36 other agencies who are selected to be stationed abroad. Department officials have advised that they will be testing for AIDS in these examinations and will recommend that an individual who tests positive not be assigned abroad.

Hiring and Firing

The Rehabilitation Act prohibits discrimination solely by reason of handicap under any program or activity conducted by an executive agency. (29 U.S.C. § 794) Under this provision, an agency may not discriminate against a qualified physically or mentally handicapped person (29 C.F.R. § 1613.703) In general, an employer's only defense to a handicap discrimination complaint is that the handicapped person is not qualified, i.e., either (1) the individual cannot or can no longer do the job or (2) hiring or continuing to employ the individual presents a "reasonable probability of substantial harm to others in the workplace."

Ability to perform. The Supreme Court has held that an "otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap." (Southeastern Community College v. Davis, 442 U.S. 397, 406 (1979)) Lower federal courts have held that a determination that a handicapped individual is not qualified must be based on a showing that his/her present job performance is affected. (E.E. Black, Ltd. v. Marshall, 497 F. Supp. 1088 (D. HI. 1980)) An individual who merely tests positive will, in all likelihood, be able to perform his/her duties; an individual with clinically defined AIDS or ARC may be able to perform his/her duties. Thus, there appears to be no basis under the Rehabilitation Act to terminate or to refuse to hire an individual who tests positive or even one who evidences symptoms of clinically defined AIDS or ARC that have not substantially affected his/her performance.

Risk of harm to others. Given reassurances from the medical community that AIDS is not communicable in a work environment such as that presented at GAO, to demonstrate that an individual with AIDS who can perform his/her duties is not a "qualified" handicapped person would be difficult. In general, an agency's reliance on risk of contagion as a justification for denying federal employment will fail unless the employer can

demonstrate a "reasonable probability" that the employee would pose a danger to himself or others. (Mantolete v. Bolger, 767 F.2d 1416 (9th Cir. 1985)) In the Arline case, discussed above, the Supreme Court called for findings of fact based on reasonable medical judgments given the state of medical knowledge about the nature and severity of risk of a disease and the probability that it would be transmitted. This case is evidence that the courts will look not only to the fact that a disease is communicable but to how the disease is spread to determine whether it presents a reasonable probability of danger to others in the particular work environment.[4]

Several arguments have been advanced by employers for not hiring or for terminating individuals who test positive. In general, legal commentators believe these arguments will fail as defenses to Rehabilitation Act claims of discrimination. The Supreme Court's decision in the Arline case establishes that mere "fear of AIDS" is not a defense to a handicap complaint. This holding seems to apply to adverse coworker and customer reactions to members of a protected class that have been rejected as a basis for sustaining employer actions in race and sex discrimination cases. By the same token, a defense based on the likelihood that a handicapped individual will in the future have a high rate of absenteeism or will subject the employer to high insurance costs probably is not viable. A Wisconsin court has, for example, rejected that rationale for refusing to hire an individual with leukemia, holding it immaterial that the individual may at some future date be unable to perform the duties of his position. (Chrysler Outboard Corp. v. Wisconsin Dept. of Industry, Labor and Human Relations, 14 FEP 344 (Wis. Cir. Ct. 1976)) The "altruistic" defense—that the job in question will further endanger the AIDS victim—is doomed by medical evidence that the AIDS victim will be as likely to contract opportunistic diseases at home as in the office environment.

Risk of harm to others may be a basis for appropriate action concerning an individual whose AIDS condition is accompanied by a particular opportunistic or secondary disease that itself presents a reasonable probability of danger to others. However, the two most common opportunistic diseases, Kaposi's sarcoma and pneumocystis carinii pneumonia, do not appear to involve a risk of harm to others.

[4]See New York State Association for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979), holding that the segregation of retarded children with hepatitis B virus was improper where the risk of transmission in their classroom setting was but a remote possibility. The court noted that there had never been proof that the disease could be communicated by nonparenteral routes, such as saliva.

Accommodation

The Rehabilitation Act obliges the employer to make "reasonable accommodation." Specifically, 29 C.F.R. § 1613.704 requires an agency to:

". . . make reasonable accommodation to the known physical or mental limitations of a qualified handicapped applicant or employee unless the agency can demonstrate that the accommodation would impose an undue hardship on the operation of its program.

"(b) Reasonable accommodation may include, but shall not be limited to: (1) Making facilities readily accessible to and usable by handicapped persons, and (2) job restructuring, part-time or modified work schedules, acquisition or modification of equipment or devices, appropriate adjustment or modification of examinations, the provision of readers and interpreters, and other similar actions.

"(c) In determining pursuant to paragraph (a) of this section whether an accommodation would impose an undue hardship on the operation of the agency in question, factors to be considered include: (1) The overall size of the agency's program with respect to the number of employees, number and type of facilities and size of budget; (2) the type of agency operation, including the composition and structure of the agency's work force; and (3) the nature and the cost of the accommodation."

As a practical matter, an individual who merely tests positive will require little or no accommodation. An individual with ARC and clinically defined AIDS may require no greater accommodation than government agencies make as a matter of course to many seriously ill employees. In general, an employer need not make a highly costly accommodation to a handicapped person. In the case of an employee with clinically defined AIDS or ARC, appropriate accommodation appears to include such things as: part-time work schedules; liberal use of annual and sick leave; advance leave, if appropriate; counseling; administrative leave for counseling; assignments that are not physically taxing; and permitting the employee to work at home.

Most of these types of accommodation would not appear to be any more costly or to involve any more disruption to the work environment than accommodations that have been made for other employees who are ill.

The Arline case suggests that GAO may be required to look to the particular opportunistic or secondary diseases that affect employees with AIDS to determine if any other accommodation is appropriate.

Are there statutes that make the testing for AIDS of applicants illegal when combined with a general medical examination?

Both the Rehabilitation Act of 1973 and the merit principles of GAO's Personnel Act bear on this issue. There are also constitutional considerations that must be taken into account.

The Rehabilitation Act

As discussed above in response to the first question, to conduct a preemployment medical examination to test for a handicap is a violation of the Rehabilitation Act. It would even be improper to test for a handicap as part of a general medical examination required of all applicants if the results were used to discriminate against handicapped persons. Thus, on the assumption that all three forms of AIDS (i.e., AIDS, ARC, and testing positive for HIV antibodies) are handicapping conditions, the Rehabilitation Act makes it illegal to test for AIDS, even as part of a general medical examination if that test were used to discriminate against those who tested positive in the absence of medical evidence that AIDS posed a health hazard to others in the ordinary office environment.

Merit Principles

The GAO Personnel Act, 31 U.S.C. § 732, requires GAO to ensure that officers and employees are appointed, promoted and assigned only on the basis of merit and fitness and requires GAO to include in its personnel system at least those merit principles and prohibited personnel practices set forth in 5 U.S.C. §§ 2301 (b) and 2302 (b). In general, these require selection, advancement, and retention decisions to be made on the basis of merit and without regard to handicapping conditions. The merit principles alone may preclude testing without regard to whether any particular form of AIDS, such as testing positive, is a handicapping condition.

For the purpose of describing the personnel practices that are prohibited by 5 U.S.C. § 2302 (b), OPM defines "employment practice" to include the "use of examinations, qualification standards, tests and other measurement instruments." (5 C.F.R. § 300.101) To ensure that employment determinations are made on the basis of merit, OPM requires that any employment practice be based on a job analysis to identify the requirements, skills, and other factors important in evaluating candidates. 5 C.F.R. § 300.103 (a)) In addition, OPM imposes a requirement of "relevance": There must be a rational relationship between performance in the position to be filled and the test or employment practice to be used. (5 C.F.R. § 300.103 (b)) These requirements are implicit in the language of GAO Order 2330.1, chapter 6, paragraph 4, which states that GAO selecting officials will not solicit or consider any information not bearing on the merit and fitness of candidates.

On the subject of medical determinations related to employability, OPM defines the conditions under which medical examinations may be conducted as follows:

"(a) An agency may require an individual who has applied for or occupies a position which has physical/medical standards for selection or retention, or which is part of an established program of medical surveillance related to occupational or environmental exposure or demands, to report for a medical evaluation:

"(1) Prior to appointment or selection (including reemployment on the basis of full or partial recovery from a medical condition);

"(2) On a regularly recurring, periodic basis; and

"(3) Whenever there is a direct question about an employee's continued capacity to meet the physical or medical requirements of the position." 5 C.F.R. § 339.301(a)

Because a "medical standard for selection or retention" would appear to be a "qualification standard" within OPM's definition of the term "employment practice," the use of a medical standard that is not job related appears to constitute a prohibited personnel practice.

The merit principles require that an agency test only for a factor that is shown to be directly related to the position in question. The government in general, and GAO in particular, has not required medical examinations for regular office positions, in part because physical or medical standards for selection would be difficult to justify. To begin to require physical examination for all applicants might violate the merit principles, even without AIDS testing. Since there is no definitive evidence that past exposure to the AIDS virus affects current employability in most office positions, an agency that conducts preemployment AIDS screening for ordinary office positions would run the risk of committing a prohibited personnel practice.

The Fourth Amendment

Although it is a constitutional rather than a statutory authority, the Fourth Amendment raises a question concerning the legality of testing for AIDS as part of a general medical examination administered to all applicants. The Department of State's AIDS-testing policy is being challenged on Fourth Amendment grounds, as well as under the Rehabilitation Act.

The Fourth Amendment guarantees the right of the people to be secure in their persons against unreasonable searches and seizures. The Supreme Court has recognized that taking of blood from the body to determine the presence of alcohol is a search and seizure within the meaning of the Fourth Amendment. (Schmerber v. California, 384 U.S. 757, 767 (1966)) In the last few years, the Fourth Amendment has been argued with mixed results in a number of cases seeking to enjoin urinalysis drug testing. A program to test all applicants for exposure to the AIDS virus would surely raise questions under the Fourth Amendment. As long as the medical community supports the position that AIDS is not communicable in the ordinary office environment, an employer will be hard-pressed to advance the public safety arguments that have served to validate certain of the drug testing programs addressed by the courts.

Would refusal to hire an applicant because of failure to pass a medical examination be challenged?

Yes. Refusal to hire an applicant who tested positive in a preemployment medical examination would be subject to challenge on the same statutory bases that the test itself would be susceptible to challenge. Specifically, the Rehabilitation Act, 29 U.S.C. § 794, prohibits discrimination solely by reason of handicap. Viewing each of the three states of AIDS as a covered handicapping condition, the Rehabilitation Act would prohibit an agency from rejecting an applicant for no reason other than that he/she tested positive. This is discussed more fully in response to the first question. As discussed in response to the second question, the merit principles require an agency to make selection decisions on the basis of merit and prohibit the use of qualification standards that are not related to performance in the position to be filled. Rejection of an applicant simply because he/she tests HIV antibody positive could be found to violate the merit principles.

If employees became so afraid of AIDS that they refused to do their jobs, what options would be legally available to GAO?

Without medical evidence that AIDS is communicable in the ordinary office environment, a coworker who refused to work with or in proximity to an employee with AIDS, ARC, or one who tested positive would be subject to disciplinary action. Legal commentators generally agree that defenses traditionally available under labor and health and safety laws for declining to work in the face of dangerous conditions would be

unsuccessful. In general, the coworker would be hard-pressed to present objective evidence that proximity to an employee with AIDS endangered his/her health or safety, unless the person with AIDS had an opportunistic or a secondary disease that itself was communicable in the workplace.

There are cases suggesting that assignment of the fearful coworker to counseling in the form of an AIDS education program may be an appropriate response to an initial refusal to work with an employee who has AIDS.

What other legal issues should concern GAO?

Two issues are worthy of note in this context: privacy considerations and unwarranted disclosure.

Privacy Considerations

One major legal issue posed by AIDS in the workplace relates to the victim's right to privacy in employer-maintained information about his/her health. One widely reported case, Cronan v. New England Telephone and Telegraph Co., No. 80332 (Suffolk County Supreme Court, Aug.15, 1986), involved an action brought by an employee with AIDS partly on the basis of his supervisor's breach of a promise to keep his AIDS-related condition confidential. The case was settled out of court in favor of the employee.

Within the federal government, the confidentiality of information such as individual medical histories contained in systems of records is generally protected by the Privacy Act. (5 U.S.C. § 552a) To the extent an executive branch agency maintains information such as AIDS test results in a system of records, that information would not be subject to disclosure except for certain specified purposes. The act provides for disclosure within the agency maintaining the record only to those who have a "need for the record in the performance of their duties." There is a serious question as to whether a supervisor or any other agency official needs the information that an individual tests positive without medical evidence that AIDS is communicable in the ordinary office environment. Without some particular work-related reason for the disclosure, revelation of such information could subject individual government officials to criminal penalties and the agency to civil damages.

GAO is not subject to the Privacy Act as such. As a matter of policy, GAO has, however, issued privacy regulations. (50 Fed. Reg. 13161, Apr. 3, 1985) These regulations cover essentially the same types of records as are covered by the Privacy Act, and they permit disclosure within GAO to those employees who have an official need for the information in the record and for routine uses. Under GAO's regulations, an employee who improperly discloses protected information is subject to disciplinary action.

Unwarranted Disclosure

The Supreme Court has indicated that the government's right to collect data normally is limited by a duty that "arguably has its roots in the Constitution" to avoid unwarranted disclosure of the information collected. (Whalen v. Roe, 429 U.S. 589 (1977)) There is at least one case indicating that the courts will be vigilant in finding a monetary remedy for an individual who has suffered an unwarranted disclosure of personal information. (Doe v. U.S. Civil Service Commission, 483 F. Supp. 539, 567 (S.D.N.Y. 1980)).

GAO Case Studies

This appendix looks at the results of four confidential case studies conducted by Task Force members to help gain an understanding of what happens when an employee gets AIDS. All the subjects are men. All were between 29 and 38 years old when management became aware of their situation.

How Managers Learned of the AIDS Cases

None of the employees volunteered that they had AIDS. In one case, the employee told the unit manager he had tested positive for the HIV virus; a friend later told the manager that the employee actually had AIDS. In two cases, the supervisor prompted the employee's disclosure by sharing with him his own conjecture that the employee might be suffering from AIDS. In the fourth case, management was made aware directly only by seeing the death certificate (in order to reconcile the staffer's pay account). Unit managers were unaware of employees' hospitalization in three cases.

Medical Information

The following infections and ailments were involved in these four cases: lung disease (nonspecific), brain lymphoma, severe pneumonia (in two cases), stomach cancer, hepatitis, and Kaposi's sarcoma. In addition, managers noted fatigue, weight loss, mental and physical deterioration, and "interpersonal problems." Although managers were not aware of the AIDS diagnosis early in these cases, they did have knowledge of obviously serious illness.

In two cases, the employees died 1 to 2 months after entering the hospital. In another case, after 2 months' hospitalization, the employee returned to work with limited capacities. After a little over a year, he recovered strength and capability and has been fully performing since. In the fourth case, the employee died almost 2 years after managers had become aware of his disease.

Most of the men were involved at some point in experimental drug and/or treatment programs.

Disease Progression

Two cases progressed quickly from the time of hospitalization until death. In one case, although the employee had been "a relatively heavy user of leave" in the preceding months, he was fully performing his duties up to the time he entered the hospital. In the other case, the employee notified managers that he had tested positive for the HIV virus and was hospitalized 5 months later. Both individuals died about 2

months after entering the hospital. In a third case, the person took disability retirement about 2 months after notifying managers of a "terminal illness"; he survived about 20 months in retirement. The fourth case study shows a man who is on the job and fully performing after notifying management he was terminally ill.

Job Performance

There seems to be great variation in the extent to which employees with AIDS show degraded performance more than a month or two before showing signs of serious illness. In half of the cases, the subjects were performing well when they notified managers of serious illness; in one case, the employee consistently made the Best Qualified List and the unit head felt that he would have been promoted in the year that he grew gravely ill.

Deterioration was visible earlier in the other two cases. Managers in one case noticed "physical and mental deterioration" for several months before the employees notified them of a problem. In the other case, an extended hospitalization and many months of problematic performance preceded notification by the employee that a grave illness was involved.

Staff Awareness and Reactions

Except for one case in which no direct discussions appear to have taken place with the employee, the case study subjects asked for and received assurances of confidentiality. It was clearly important to them but difficult to maintain. In one case, staff realized AIDS was involved when, upon his departure, the employee asked that his desk and office belongings be cleaned. In another case, there was early speculation among coworkers of the employee's condition. In a third case, rumors began to circulate that the employee was suffering from AIDS when he failed to respond to hospital treatment.

In no case, however, was either panic or disturbance of major proportion evident. Only a few reactions from surrounding staff were considered significant enough to mention. In general, people asked aloud if, or speculated aloud that, AIDS was the ailment. They resorted to talking among themselves when no direct information was forthcoming from management.

Not all reactions were self-protective. In one case, staff sent the retired AIDS patient copies of the Management News, local newsletters, reports of interest, etc. Staff traveled a long distance to visit him at home and, ultimately, to attend his funeral.

Management Actions

No extraordinary management actions were called for in any of the cases. In several situations, assistance that would be considered standard for serious illness was provided. In one case, the individual received chemotherapy treatments for cancer for about 18 months before the situation became an "AIDS case." Unit management approved a flexible work schedule for those treatments. In another case, the employee's request for a temporary assignment of a less demanding nature was honored.

Important actions were also taken by supervisors and GAO staff offices to help employees with AIDS handle various bureaucratic procedures and requirements: Personnel provided disability retirement and other benefit information to the subject employees and managers and to numerous third parties acting for them. These included family, friends, and hospital social workers. A GAO management official spoke with one patient's physician—with the patient's consent—obtaining the disease's identity orally, so GAO could make a required determination about workplace safety without forcing the staff member to provide a written statement that he had AIDS. In other cases, the Assistant Comptroller General for Operations was apparently notified and/or involved and other senior managers were sometimes involved informally.

Employee Benefits

As is made clear in appendix V, benefits available to federal employees with AIDS are those available under an employee's typical health insurance, life insurance, and disability entitlements. In three of the cases involving deceased employees with AIDS, two had Federal Employee Group Life Insurance (FEGLI) coverage and the other had declined it. Three subjects' health plans were identified: American Federation of Government Employees (AFGE) (301); Mutual of Omaha, Alliance (high option); and George Washington University (high option).

Disability retirement was not a major issue in three of the four cases studied. Two employees declined and died too quickly for disability coverage to become relevant. In a third case, the individual never applied for disability benefits. The employee seemed uninterested in abandoning the workplace, with its professional relationships and social support systems.

The case that resulted in a disability retirement provides some insights into necessary management vigilance and actions. OPM's approval of the disability request took about 3 months, which was longer than GAO managers expected. Further, OPM did not notify the employee of the effective

date. His first two checks were late, and unit management had to contact OPM to straighten out the situation.

It is not believed that the employees with AIDS had financial difficulties as a result of any health coverage or retirement pay inadequacies.

Suggestions

AIDS education. Information available to the manager of an employee with AIDS (or a staff inquiry regarding one) should be coordinated or organized. GAO needs a "focal point" for such help—for the manager, for the AIDS patient, and for other concerned and/or affected staff.

Persons with AIDS often do not volunteer the nature of their ailment; yet, identifying it confidentially can be helpful. GAO needs to educate its staff and to have a few trained specialists to assist in such situations. Trust and compassion are essential in such a role. Specialists could help employees and managers identify their rights, responsibilities, and options.

The case studies illustrate the critical role that work relationships can play to help the terminally ill at their time of great need. GAO's policy and educational program could identify and support ways in which professional colleagues can safely provide important emotional and physical support to AIDS-stricken employees.

Confidentiality. There is a potential conflict between AIDS employees' desire for confidentiality and GAO's need for assurance that an undisclosed, serious illness poses no imminent workplace threat. In one case, the employee declined to provide a doctor's note identifying the disease (and stating that it was not communicable), expressing fear regarding GAO's reactions. This problem was solved by having the employee's physician identify the ailment (with the employee's consent) to a GAO physician. The latter then assured division management that he knew the identity of the ailment and could provide assurance that it was not a threat to workplace safety. This was acceptable to the employee—it was based upon his acceptance of physician confidentiality—and met GAO's need. It is a model GAO may wish to consider for general use.

Paperwork. The disability retirement process for employees with AIDS should be shortened and made to run more smoothly.

Review of the Literature on AIDS-Related Problems in the Workplace

Overview

Employees who continue to work after developing AIDS have, in many cases, encountered problems affecting their performance and interaction with colleagues. The most visible evidence regarding such problems is anecdotal, primarily journalistic accounts of individual cases. For this reason, the evidence may not represent the full range of problems that people have experienced and it cannot tell us how frequently each problem has occurred. The purpose of this review was to identify other sources of evidence (for example, representative surveys of AIDS victims or health-care providers) concerning the nature and extent of AIDS-related problems in the workplace.

The Task Force found no relevant survey data, published or unpublished. Working from alternative sources, the Task Force identified five major problems: job discrimination, loss of confidentiality, stigmatization, nonrecognition of significant others, and a lack of awareness regarding behavioral manifestations of the disease.

In addition, these problems extend well beyond people with AIDS, reaching others who are antibody positive, have been diagnosed with ARC, are in high-risk groups, are related to people with AIDS, live in the same household with an AIDS victim, have had casual contact with an AIDS victim, or are rumored to fit any of these descriptions.

Procedure

The review began with an automated search of the literature in public opinion, public health, social services, and other fields. It also examined recent issues of several publications and the bibliographies appended to articles on related subjects. These efforts produced no representative survey data on the nature or extent of AIDS-related problems at work.

Next, academicians in sociology, public health, and psychiatry, as well as representatives of advocacy groups, social service agencies, and clinics, were contacted. None was aware of any published source for the data sought. Some are now conducting surveys of AIDS patients, but their questions do not cover the nature and extent of workplace problems.

Consequently, findings were drawn from two sources. The first is a published report[1] on AIDS-related issues now being litigated—issues arising in the workplace and several other domains (such as housing, schools, and domestic relations). Stein identified these issues through a literature

[1]Robert E. Stein, The Settlement of AIDS Disputes (Washington, D.C.: Environmental Mediation International, Jan. 1987).

search and interviews with advocates, lawyers, and others. The sample of respondents was not drawn systematically, and in focusing on legal disputes, the report may have missed problems that are unsuited for litigation.

The second source is a set of interviews conducted from January to April 1987. Academicians, advocates, and service providers in Washington, D.C., and several other cities were contacted.

In short, no source could furnish a comprehensive and precise account of AIDS-related problems in the workplace. The review provides instead a distillation of the anecdotal evidence, as interpreted by people with much firsthand experience in the AIDS crisis.

Workplace Problems

As already noted, some workplace problems can have ramifications for employees who are not suffering from AIDS, including people who are HIV antibody positive, are in high-risk groups, are relatives or housemates of people with AIDS, have ARC, have had casual contact with an AIDS victim, or are rumored to fit any of these descriptions. Thus, in the following discussion of problems, the word "employees" includes those who do not have AIDS, as well as those who do.

Job discrimination. As is widely known, employees can face discrimination at work, often in the form of pressure to resign or to accept reassignment. Employees also face difficulties in getting hired. At Project Hope's conference on AIDS (Mar. 1987), Saul Milles of General Electric cited this problem but said that there was no way to document the extent of it. Stein (1987) implied that the problem was in fact widespread.

To handle AIDS-related discrimination effectively, workplace policy needs to be proactive. First, the pressure to resign or accept reassignment can be quite subtle. Second, if their self-esteem or energy level is not high, employees (here, mainly those who do have AIDS) may accept discrimination without complaint. Thus, even if supervisors deal quickly and firmly with any case brought to their attention, they may miss many other cases.

Loss of confidentiality. Word gets out in any number of ways, many of them beyond the control of supervisors. One complication is that

coworkers often believe they have a right to know about any real or suspected AIDS case nearby; they believe that the ordinary rules of privacy just do not apply here.

Stigmatization. Often the impetus for job discrimination, this problem reportedly is hard to pinpoint. People may not directly refuse to work with another employee and may not say anything derogatory. They may merely keep a polite distance, with or without encouraging others to do so. In any event, productivity may decline and the work environment may get unpleasant, not just for the stigmatized employee but for others nearby. Notably, the problem can reach beyond the immediate work station, as when the employee uses the building cafeteria or health clinic.

The Task Force's sources noted that AIDS may reverse the linkage generally expected between knowledge and fear. People assume that providing information will reduce fear and thereby reduce stigmatization. But in this case, unusually high levels of fear and ill-will may preclude the reassuring effects of information.

Nonrecognition of significant others. This problem pertains to employees who have AIDS in its advanced stages. An employee may wish for someone who is not a relative to step in when it is time to handle personnel matters, clean out desks, designate beneficiaries, and so on. But employers may be unable or unwilling to cooperate with this kind of significant other. Moreover, fearing discrimination, nonrelatives may not make themselves known. Relatives may preempt the employee's wishes. Task Force sources acknowledged the legal complications but said that an employer must find ways to accommodate. Perhaps the first step, they said, is to train supervisors to recognize and handle this very sensitive matter well before the employee leaves work or becomes too weak to manage his/her own affairs.

Lack of awareness regarding behavioral manifestations. This last problem is not yet widespread, but sources fear that it will become so. As the number of AIDS cases goes up and as treatment extends their lives, there will probably be more and more AIDS patients, still working, who manifest psychological or neurological symptoms—depression, confusion, and hostility. Sources stressed that supervisors must be able to recognize these symptoms for what they are. The appropriate responses may include a more liberal application of leave policy or work load reductions. More generally, workplace education efforts should cover this matter, so that coworkers will understand the reason for behavioral problems.

Interview Respondents

Mitch Bart, San Francisco AIDS Foundation
Jay Coburn, National AIDS Network
Janice Dudley, Los Angeles Men's Study
Fawzy I. Fawzy, University of California at Los Angeles, Neuropsychiatric Institute
Gilberto Gerald, National AIDS Network
Miguel Gomez, AIDS Action Council
Jim Graham, Whitman-Walker Clinic
Harold Jaffe, Centers for Disease Control
Jeff Levi, National Gay and Lesbian Task Force
John Martin, Epidemiology Department, Columbia University
Mauro Montoya, Whitman-Walker Clinic
Peter Nardi, Sociology Department, Pitzer College
Stewart Nichols, AIDS Task Force for the American Psychiatric Association
Gary Noble, AIDS Coordinator, U.S. Public Health Service
Paul O'Malley, San Francisco City Clinic
Karen Pataky, Library of Congress
Jim Ringer, Whitman-Walker Clinic
Caitlin Ryan, Public Health Consultant
Phil Sheley, AIDS Project Los Angeles
Robert Stein, Environmental Mediation International
George Swales, Whitman-Walker Clinic
Lydia Temashok, Psychiatry Department, University of California, San Francisco
Susan Tross, Sloan-Kettering Cancer Center
Robert Whirry, AIDS Project Los Angeles

Summary of Benefits Available to GAO Employees

What benefits is an employee with AIDS eligible to receive?

As a federal employee, an AIDS patient is eligible for Federal Employee Group Life Insurance benefits, may be eligible for disability retirement benefits, and is eligible for medical benefits if enrolled in a federal health program. The employee may also be eligible for benefits from the social security income disability program and from Medicaid.

How do the various plans under the Federal Employees Health Benefits Program handle AIDS?

Fee-for-service plans, as summarized in figure V.1, generally provide

- medical-surgical care,
- inpatient/outpatient care,
- mental health services,
- physician and other health care professional services,
- hospice care,[1] and
- catastrophic coverage.

As for comprehensive medical plans/health maintenance organizations under FEHBP, they usually have similar provisions, but the number of such plans precludes a brief summary.

AIDS is not singled out and treated differently from any other disease included in FEHBP. OPM currently does not plan to write an AIDS-specific policy.

FEHBP does not relate to any particular illness. It helps to protect eligible employees and their families against the cost of illness, and this guaranteed protection cannot be canceled by FEHBP, which provides coverage without medical examination or restrictions due to such factors as age or physical condition.

What other resources can be used to help the AIDS patient during treatment?

This issue can be explored with the GAO's Counseling and Career Development Branch. Also, some assistance may be offered by the Public Health Service facility in the headquarters building. Beyond this, the patient should refer to the resource list issued by the Task Force.

[1]The availability and coverage of hospice care varies by plan.

What disability retirement benefits are available to federal employees?

Disability retirement is a benefit provided to protect the employee who is no longer employable at his/her current grade or pay level because of a medical condition.

Under the Civil Service Retirement System, the employee is guaranteed an annuity equal to 40 percent of the employee's average pay over the 3 highest salary years.

Under the Federal Employees Retirement System, there is no single formula. In the first year, the disability annuity will equal 60 percent of the high-3 average pay minus 100 percent of any social security benefit to which the employee is entitled. After the first year and until age 62, the annuity equals 40 percent of the high-3 average pay minus 60 percent of the initial social security benefit to which the employee is entitled. At age 62, the disability annuity is recomputed and equals the lesser of the following: (1) 40 percent of the high-3 salary minus 60 percent of an assumed social security disability benefit (regardless of whether the benefit is actually received) or (2) the amount payable for a nondisability annuity.

Who is eligible for disability retirement?

To be eligible for disability retirement under CSRS, an employee must have at least 5 years' creditable service. To be eligible under FERS, an employee must have at least 18 months of creditable service. There is no age requirement under either system.

Disability retirement may be based on the progression of a disease that causes continued employment to be incompatible with the employee's medical condition. Diagnosis of a progressive potentially incapacitating or perhaps fatal disease is, by itself, insufficient to qualify an employee for disability retirement. A retiree is not precluded from engaging in other employment to supplement the disability benefits.

How does the disability retirement process work?

GAO's Office of Personnel counsels the employee on the retirement decision and provides appropriate information upon which to base it. The average employee avoids applying for disability retirement until no other choice is possible, usually because the guaranteed minimum of 40

percent of the employee's high-3 average pay is not adequate for the cost of living.[2]

Once a decision is made to apply for retirement, the employee submits an application for disability retirement to the Office of Personnel Management through GAO. GAO must document the effect the disability has on GAO and efforts to accommodate the employee's medical condition. OPM will allow the claim if, on the basis of documentary evidence, it confirms that an employee cannot render useful and efficient service because of disease or injury.

What are the trade-offs for an AIDS patient to consider in deciding on sick leave versus disability? Are disability payments adequate in an AIDS situation?

The most obvious trade-off is that the amount of sick leave or advance sick leave available is limited. Specifically, the amount of advance sick leave legally allowable is limited to 240 hours of leave on the books at any time. Therefore, this would quickly dissipate and the employee would have no other income.

Of course, if the employee has a considerable amount of sick leave, it is advantageous to use sick leave first. The employee earns sick leave and annual leave while using sick leave. If an employee with AIDS applied for disability retirement and had a large sick leave balance remaining, upon approval of disability retirement, he/she may continue to use sick leave until exhausted and then retire. Typically, however, disability applicants usually have exhausted most of their sick leave by the time they realize that they must consider disability retirement.

The disability retirement would provide income, although it is not full salary. An employee applying for disability retirement may use advance sick leave and request to have the repayment of the leave waived upon approval of the disability retirement. The disability retirement provides continuous, unbroken compensation of some kind even in the case of leave without pay being used since upon approval of a disability retirement, the employee is compensated retroactive to the first day of continuous LWOP.

[2]An applicant for disability retirement is typically a person with few years of federal service. As a federal employee grows older and attains creditable service, the advantages of disability retirement decrease because other, preferred types of retirement are available. Applicants for disability retirement usually have no other retirement choices.

What are the life insurance benefits?

Federal Employee Group Life Insurance benefits are payable in the event of death of an eligible employee or a family member if death occurs while insured, no matter how caused. Basic coverage for federal employees is equal to the greater of (1) the annual basic pay (rounded to the next $1,000) plus $2,000, or (2) $10,000. Also, life insurance continues without cost to the employee while in a nonpay status for up to 12 months, at which time the insurance is terminated. The 12-month nonpay status may be continuous or may be broken by periods of less than 4 consecutive months in a pay status.

Figure V.1: FEHB Plan Comparison Chart

FEHB Plan Comparison Chart — For Benefits Beginning in January 1987

- The calendar year deductible shown is the per person amount. Under a Self and Family enrollment, generally no more than two or three family members, depending on the plan, must meet this deductible. For a few plans, which have established a family deductible, the per person amount shown applies to just one person; the difference between it and the family deductible can be met by any or all of those covered.
- The other cost-sharing amounts you pay for primary care are identified by type—coinsurance, inpatient deductible and/or inpatient copayment. Inpatient deductible may be a charge per admission or a charge per year.
- *There is no dollar or day limit on the primary inpatient care* charges that Plans pay unless otherwise noted.

Fee-for-Service Plans

Plan Name and Option		Enrollment Code		1987 Monthly Premium Your Share		1987 Biweekly Premium Your Share		Medical—Surgical Primary Care		
								You Pay		
		Self	Family	Self	Family	Self	Family	CY DED	Catastrophic Limit (max. covered out of pocket) person/family	Other
Aetna (Indemnity Benefit)	High	201	202	$80.78	$130.26	$37.28	$60.12	$200	$1,500/$3,000	CI/IP DED
	Stnd	204	205	18.69	39.99	8.63	18.46	$250	$1,500/$3,000	CI/IP DED
AFGE	High	301	302	40.41	83.46	18.65	38.52	$200	$1,500/$1,500	CI/IP DED
	Stnd	304	305	11.27	24.50	5.20	11.31	NA	$2,500[d]	CI/IP DED
Alliance	High	461	462	39.80	131.51	18.38	60.70	$200	$1,000/$2,000	CI/IP DED
	Stnd	464	465	10.34	27.85	4.77	12.85	$300	$2,000/$2,000	CI/IP DED
APWU		471	472	26.52	50.83	12.24	23.46	$175	$1,500/$1,500	CI
Blue Cross-Blue Shield (Service Benefit)	High	101	102	73.65	159.81	33.99	73.76	$200	$1,500/$1,500	CI/IP DED
	Stnd	104	105	18.49	41.14	8.53	18.98	$250	$2,500/$2,500	CI/IP DED
GEHA		311	312	26.31	49.20	12.14	22.71	$200	$2,000/$2,000	CI
Mail Handlers	High	451	452	15.16	39.15	7.00	18.07	NA	$2,500/$5,000	IP DED
	Stnd	454	455	12.77	30.22	5.90	13.95	NA	$2,500/$5,000	IP DED
NAGE	High	YJ1	YJ2	42.90	107.62	19.80	49.67	$200	$1,000/$2,000	CI/IP DED
	Stnd	YJ4	YJ5	14.87	35.46	6.86	16.37	$250	$2,000/$3,000	CI
NALC		321	322	44.55	76.66	20.56	35.38	$150	$1,000/$1,000	CI/IP CP
NFFE	High	YR1	YR2	41.06	98.58	18.95	45.50	$200	$2,000/$2,000	CI/IP DED
	Stnd	YR4	YR5	17.58	41.29	8.11	19.05	$250	$1,000/$2,000	CI/IP DED
NTEU	High	YT1	YT2	60.24	143.67	27.80	66.31	$200	$1,500/$2,000	CI/IP DED
	Stnd	YT4	YT5	12.65	28.57	5.84	13.19	$250	$2,000/$2,000	CI
Postal Supervisors		YV1	YV2	27.30	74.19	12.60	34.24	$200	$1,000/$1,000	CI/IP DED
Postmasters	High	361	362	59.82	125.99	27.61	58.15	$200	$2,000/$2,500	CI/IP DED
	Stnd	364	365	15.43	37.61	7.12	17.36	$250	$2,500/$2,500	CI/IP DED
ACT*		Y31	Y32	17.46	50.94	8.06	23.51	$200	$1,500/$3,000	CI/IP DED
BACE*		Y21	Y22	19.24	52.43	8.88	24.20	$200	$1,500/$1,500	CI
Federal Managers Assoc.*		Y81	Y82	37.64	95.07	17.37	43.88	$200	$1,000/$1,000	CI/IP DED
Foreign Service*		401	402	36.92	102.74	17.04	47.42	$125	See Brochure	CI
Foreign Service Overseas*		Y41	Y42	10.33	31.43	4.77	14.50	$125	See Brochure	CI
GEBA*	High	411	412	69.29	185.94	31.98	85.82	$200	$1,000/$1,000	CI
	Stnd	414	415	15.88	38.37	7.33	17.71	$250	$2,000/$2,000	CP/IP DED
NAPUS*		YP1	YP2	28.49	54.23	13.15	25.03	$200	$500/$1,000	CI
NATA*		Y51	Y52	16.60	42.11	7.66	19.44	$200	$1,500/$1,500	CI/IP DED
Panama Canal Area*		431	432	43.77	92.49	20.20	42.69	NA	$1,000[de]	CP/IP DED
Rural Carriers*		381	382	61.06	97.87	28.18	45.17	$200	$1,000/$1,000	CI/IP DED
SAMBA*		441	442	19.39	68.10	8.95	31.43	$200	$700/$1,400	CI/IP DED
Secret Service*		Y71	Y72	18.51	55.83	8.54	25.77	$200	$1,000/$2,000	CI/IP DED

*Plans are open ONLY to specific groups

ABBREVIATIONS: CI —Coinsurance; CP —Copayment; C & R—Customary & Reasonable; CY —Calendar Year; DED —Deductible; ECF —Extended Care Facility; HHC —Home Health Care; IP —Inpatient; NA —Not Applicable; SA —Scheduled Allowance

Do Not Rely on This Chart Alone — See Plan Brochures for Details

- The mental health inpatient catastrophic limit is the maximum amount of covered out-of-pocket expenses you pay up to the lifetime maximum per person. The lifetime maximum is the amount up to which plans pay per person for covered mental health inpatient services.
- While not shown on the Chart, virtually all of the fee-for-service plans provide:
  - — Mental health outpatient care benefits, which usually have dollar and/or visit limits, and you share costs to these limits.
  - — Inpatient and outpatient hospice care benefits, which have a dollar maximum that varies by plan.

  See plan brochures for details.

Medical—Surgical Primary Care							Mental Health Services		Other Benefit Features				
Plan Pays													
Inpatient Care				Outpatient Care			Inpatient Care						
Hospital Charges		Physicians Charges		Physicians Charges		Diagnostic Tests (C & R)	You Pay	Plan Pays	ECF and/or HHC	Dental Care	Rx Drugs	Substance Abuse Care	Chiro-practor
Room & Board	Other Hosp. Exp.	Surgeons (C & R)	Other Drs (C & R)	Surgeons (C & R)	Other Drs (C & R)		Catastrophic Limit[d]	Lifetime Maximum[d]					
80%[b]	80%	80%[e]	80%	80%[e]	80%	80%	$5,000[b]	$50,000	HHC	Yes	Yes	Yes	No
75%[b]	75%	75%[e]	75%	75%[e]	75%	75%	$5,000[b]	$50,000	HHC	Yes	Yes	Yes	No
100%	100%	100%[ce]	80%	100%[ce]	80%	80%	$6,000	$50,000	HHC	No	Yes	Yes[e]	Yes[e]
100%[a]	80%	SA[ce]	SA	SA[ce]	SA	SA	$5,000	$25,000[f]	No	Yes	No	Yes	No
100%	80%	80%[c]	80%	100%	80%	80%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
75%	75%	75%[c]	75%	100%	75%	75%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
100%[b]	80%	85%[a]	85%[a]	100%	85%[a]	85%[a]	$8,000	$25,000	No	Yes	Yes	Yes	No
100%	100%	80%	80%	80%	80%	80%	$4,000	$75,000[f]	HHC[be]	No	Yes	Yes	No
100%	100%	75%	75%	75%	75%	75%	$8,000	$50,000[f]	No	Yes	Yes	Yes	No
100%	80%	80%	80%	85%	85%	85%	$8,000	$50,000	HHC	Yes	Yes	Yes	Yes
100%	100%	SA	SA	SA	SA	SA	$5,000	$25,000	No	Yes	No	Yes	Yes
100%	100%	SA	SA	SA	SA	SA	$5,000	$25,000	No	No	No	Yes	Yes
100%[b]	100%[b]	90%[be]	80%	100%	80%	80%	$7,500	$50,000[f]	Both	Yes	Yes	Yes	Yes
75%[b]	75%[b]	75%[be]	75%	100%	75%	75%	$8,000	$50,000[f]	Both	Yes	Yes	Yes	Yes
100%[e]	100%	90%[e]	75%	100%	75%	75%	$8,000	$50,000	No	Yes	Yes	Yes	No
100%[e]	100%	90%[bc]	75%	100%[e]	75%	100%[a]	$5,000	$50,000	Both	Yes	Yes	Yes	Yes
100%[e]	100%	75%	75%	75%	75%	75%	$8,000	$40,000	HHC	Yes	Yes	Yes	Yes
100%	80%	80%	80%	100%	80%	80%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
75%	75%	75%	75%	100%	75%	75%	None	None	Both	Yes	Yes	Yes	Yes
100%[e]	100%[e]	80%[e]	75%	100%	75%	75%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
100%[e]	80%[e]	100%[e]	80%	100%	80%	80%	$8,000	$40,000	Both	Yes	Yes	Yes	Yes
a	80%	SA[e]	80%	SA	80%	100%[e]	$8,000	$40,000	Both	Yes	Yes	Yes	Yes
100%	100%	80%[b]	80%	80%	80%	80%	$5,000	$25,000	No	Yes	Yes	Yes	Yes
100%[e]	80%	80%[e]	80%	100%	80%	80%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
100%	100%	90%[e]	75%	100%	75%	75%	$8,000	$40,000	Both	Yes	Yes	Yes	Yes
100%[ae]	100%[ae]	90%[ce]	80%	100%	80%	80%	See Brochure		Both	Yes	Yes	Yes	No
100%[ae]	100%[ae]	90%[ce]	80%	100%	80%	80%	See Brochure		Both	Yes	Yes	Yes	No
100%[b]	95%[e]	100%[c]	90%[e]	100%[c]	90%[e]	80%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
100%[b]	85%[e]	85%[e]	85%[e]	95%[e]	85%[e]	75%	$10,000	$25,000	Both	Yes	Yes	Yes	Yes
100%	100%	75%	75%	75%	75%	75%	$4,000	$50,000	Both	Yes	Yes	Yes	Yes
100%	80%	75%	75%	100%	75%	75%	$8,000	$50,000	Both	Yes	Yes	Yes	Yes
80%[e]	80%[e]	100%[b]	SA	100%[b]	80%	80%[e]	None	None	No	Yes	No	Yes	Yes
100%[a]	100%[a]	100%[c]	80%	100%	80%	80%	$8,000	None	Both	Yes	Yes	Yes	Yes
100%[be]	100%	100%[c]	100%[e]	100%	80%	100%	$6,500	$50,000	Both	Yes	Yes	Yes	Yes
100%	100%	80%	80%	80%	80%	80%	$4,000	$50,000	Both	Yes	Yes	Yes	Yes

FOOTNOTES: a — To dollar and/or day limit, then less (see brochure)
b — Preadmission approval/ precertification required
c — With second opinion
d — Per person
e — Subject to conditions specified in brochure
f — Also applies to outpatient care

Source: 1987 Enrollment Information Guide and Plan Comparison Chart (1986 Open Season) for Federal Civilian Employees, U.S. Office of Personnel Management (Washington, D.C.: 1986).

GAO Personnel Policies Germane to AIDS

What options exist at GAO for accommodating the workplace needs of an employee with AIDS?

- Jobs may be restructured to part-time. GAO Order 2340.1, "Part-Time Employment Program," describes various ways of using part-time employees, highlights designations and responsibilities, outlines procedures, and discusses the impact of part-time employment on fringe benefits. Decisions addressing the desirability and practicality of part-time employment rest with the individual manager.
- The employee may be allowed to work at home. Personnel's policy on working at home was established through a series of internal memorandums issued in 1981. These memorandums set the following conditions for work at home:

  1. Staff participating in this type of arrangement must have either an excepted or an excepted-conditional appointment.

  2. The work to be done at home must lend itself to measurement.

  3. The grade of the individual working at home must be commensurate with the work being done.

  4. Work under this arrangement will be done intermittently with the employee having no regularly scheduled tour of duty. Generally the arrangement will be temporary.

  The fourth condition requires a full-time employee to change to intermittent duty status and thus sacrifice certain benefits of full-time employment. These sacrifices include the requirement that the employee take a lump sum payment of all annual leave and not accrue annual leave during the time he/she has an intermittent appointment and hold accrued sick leave in abeyance for 3 years.

  Should the employee return to a covered (full- or part-time) position before the 3-year limitation expires, the leave would be restored. Intermittent employees do not accrue sick leave.

  These guidelines do not constitute GAO policy, but a task group is currently studying the issues. Managers have been advised that they may allow the employee to work at home on a very short-term basis if management deems it necessary and that this arrangement may be accommodated without change to intermittent status.

The final report of the task group will consider the implication of the work-at-home policy for individuals with AIDS or other life-threatening diseases.

- Work tasks may be adjusted to accommodate medical conditions. When assignments involve physically taxing work, supervisors may try to change the work requirements.
- Access to and use of facilities and equipment may be modified to accommodate employees' needs. When feasible, the workplace may be adapted to the physical limitations of an employee. GAO Order 2306.1, "Selective Placement Programs," discusses some of the relevant issues.
- Liberal sick and annual leave may be granted. Chapter 6 of GAO Order 2630.1, "Leave Policies and Procedures," describes the current policies and procedures on the request and approval of leave, including advance sick leave. Overall, GAO policy is that an advance of not more than 30 days of sick leave may be made to an employee of GAO when there is serious incapacity and when required by the situation. Procedures for requesting and granting annual leave, including that which will be earned at a later time, are covered in the same GAO Order.
- The employee's salary may be lowered for a reduced work load. Under current policies, an employee may voluntarily request a change to a lower grade level. However, from a position classification standpoint, grade is based on the complexity of work as opposed to the quantity of work performed.
- Leaves of absence may be granted when needed. Granting LWOP is permissible under current policies and procedures as described in chapter 12 of GAO Order 2630.1. The chapter describes the concept in general, addresses the rationale for granting LWOP, describes the application and approval procedures for LWOP, discusses extended LWOP, and describes types of cases for which approval of extended LWOP would be proper.
- Others may be allowed to share job duties. Current policy on job-sharing is in GAO Order 2340.1. Two people divide one permanent position between them. Responsibilities, hours, salary, and other benefits are shared. Full-time coverage of the work is provided, but each individual is responsible for only half of the work. This arrangement works well when employees can work on separate projects or on a different group of assignments.
- The amount of overtime may be increased to permit other staff to perform part of the work of the employee with AIDS. This is a budget issue and would be determined by funds for each unit obligated to overtime. There might also be an issue of overtime pay versus compensatory time in light of the limitations placed on the hourly rate of overtime pay.

- Part-time help may be used to perform part of the work of the employee with AIDS. This also would be a budget and staff-year issue for each unit.
- Counseling is available. Employees who wish to explore possible workplace accommodations and related issues can seek advice on a confidential basis from the Counseling and Career Development Branch. If additional counseling is warranted, the employee may be referred to an outside agency. Supervisors have the authority to grant administrative leave for counseling.

Probable Cost of Treatment for AIDS

What is the cost of treatment for AIDS?

Available cost studies have looked mainly at hospital costs and usually do not include other services, such as skilled nursing, counseling, and hospice and home health care, which may be needed in some cases. The studies have been based on hospital services from a few hospitals in a few cities and have not included costs borne by the patient or support groups. Given the uncertainty about AIDS hospital treatment costs, it is not surprising that no attempts have been made to calculate the non-hospital-based costs.

Estimates of hospital-based costs range from $70,000 to $140,000. Estimates of about $30,000 have been cited, but the studies on which they are based point out the shortcomings in such figures and offer $60,000 to $80,000 as more realistic figures.

Current projections of the AIDS caseload in the next few years indicate that hospitals carrying the bulk of the cases will shortly be overwhelmed. In addition, current research on medicines is pointing to some drugs that will prolong the life of some victims but will not cure the illness. Thus, as the number of cases goes up, it will be accompanied by lengthened periods of treatment and concomitant increases in the need for nonhospital treatment. These trends could certainly increase costs to employees with AIDS.

Will federal health plan benefits be sufficient to cover medical costs?

The answer depends, in part, upon the details of the employee's health plan. Plan benefits are dissimilar. For hospital costs, treatment costs are not likely to exceed lifetime benefits. However, in most instances, some copayment will be required. According to the 1987 Consumer Checkbook Guide to Health Insurance Plans for Federal Employees, a single employee is unlikely to have out-of-pocket expenses greater than $3,000 so long as the bills are for traditional doctor, hospital, and medicine charges.

In the area of nonhospital treatment, federal health insurance benefits become less generous. For example, outpatient mental health treatment coverage is generally limited to $300 to $2,625 annually, with most plans in the lower half of the range. Also, coverage is often limited to a small number of visits and can require 50 percent coinsurance. Limits on inpatient mental care are generally higher but not generous. There is

often a $50,000 lifetime limit and the catastrophic care limit may be as high as $8,000. Again, coverage may include a sizable deductible and high coinsurance requirements.

Similarly, no plan pays for custodial care, where one's principal needs are to be fed, bathed, and clothed and where nursing is needed not to help one recover but to help one with ordinary life tasks. These are the kinds of care many AIDS patients may need at some time. Most plans pay for at least 90 days of home health care or visits, and about half offer such care in a skilled nursing facility, limited to 60 days per confinement. Given the nature of AIDS, these limits could cause significant catastrophic costs for some patients, especially if lives are prolonged but not significantly improved through new drugs. Of course, some AIDS patients could face significant costs if they were in a plan not covering skilled nursing in a facility.

Another area where AIDS patients could face significant costs would be in the area of prescription drugs and blood transfusions. Limited or no coverage of these items is more likely to be encountered under health maintenance organizations than under other insurance plans. This could be significant given the side effects of AZT and other potential drugs that may require many blood transfusions. Drug treatment for a single person with AZT may cost $10,000. Similar costs are predicted for other AIDS drugs as they are developed.

Careful selection of a plan by an employee with AIDS could reduce personal expenses considerably. Persons at risk should consider these issues during open seasons.

AIDS Policies in Other Organizations

The Task Force conducted interviews in ten organizations that had addressed problems posed by AIDS in the workplace. The purpose of the interviews was to determine what others had done to address these issues and what advice they would give on the appropriateness of establishing formal personnel policies beyond existing ones.

The interviews were conducted with three government agencies and four private employers. Interviews with three AIDS support groups were also conducted to determine what factors they considered important in an AIDS policy. Two of the private employers interviewed also provide support services for AIDS.

Following is a summary of responses to our interviews, together with a table detailing each organization's answers to individual items. With one exception, a structured interview form was used to guide the interviews and to maintain consistency in the data collected. Interviews conducted at the Department of Defense did not lend themselves to the use of the structured data collection form due to the nature of the DOD approach and the responses of the interviewees. For this reason the DOD responses have not been included in the table.

Summary of Responses

What formal policies and programs have other organizations adopted?

Of the seven employers interviewed, six have specifically and formally addressed AIDS as part of their personnel policies. However, each organization interviewed (including the support groups) feels that AIDS should be treated like other major illnesses and should be covered as part of a broad health insurance and disability plan. Consistent with this thinking, many of the organizations interviewed do not have health and disability programs specifically for employees with AIDS. Rather, they consider AIDS in their overall plan for dealing with employees with major and life-threatening illnesses and address each case individually.

DOD has a special policy for dealing with active duty members who test positive for HIV. In developing this policy in 1985, DOD also considered developing a policy for civilian employees, but to date none has been developed because DOD has no basis to require screening. Also, the potential problem of civilians overseas with positive readings has not come up. DOD officials feel that OPM or a designated agency should take the lead on the AIDS issue regarding civilian personnel.

Under DOD's initial policy, the services screened all recruit applicants. If applicants tested positive, they were not admitted into the military. The policy has been extended to all active duty members deployed overseas or scheduled to be so deployed. The test includes a blood sample, a full workup if the test is positive, and a full evaluation to determine the status of the infection. Service members found to have AIDS will be returned to or kept in the United States and permitted to stay on active duty if able to perform duties. If they cannot perform their duties, they are given honorable discharges for medical reasons.

DOD's policy is reviewed each year to determine if changes are needed. The 1986 and 1987 reviews resulted in very little change. The policy has not required testing of civilian or contract employees; however, a recommendation recently made to the Secretary of Defense would require testing for those employees accompanying military personnel overseas.

Among the organizations queried, most policies dealing with AIDS are less than 2 years old.

What specific components have been implemented?

The primary objectives of the personnel policies that have been established are to decrease fear of AIDS, to protect the rights of employees with AIDS, and to apply personnel rules consistently. In line with these objectives, each person interviewed said that education and information are the major goals of their AIDS policies. All the employee education programs include such topics as the transmission of AIDS, coworker fear, and health risks.

Testing is universally thought to be a bad idea except in the government agencies. The government agencies believe that in certain unique situations, testing of certain employees—that is, members of the foreign service or members of the armed services—is necessary to protect the individual and coworkers. Although testing is used in some cases at these agencies, there is no evidence of blanket testing.

The organizations interviewed have not taken specific steps to prevent discrimination against employees with AIDS other than education programs. They generally believe that the employees have a right to confidentiality. However, most of the organizations with policies have not specifically covered employee rights to confidentiality, nor have they specifically defined supervisor actions when they become aware that an employee has tested HIV positive.

Support services are provided or recommended by most of the organizations. The predominant services are education, individual counseling, and referral to community agencies.

Accommodation of employees with AIDS depends more on the severity of the illness and the individual's continued ability to perform duties than it does on set criteria related to AIDS.

What has been the experience regarding each component?

Two of the seven employers interviewed indicated that they had received positive feedback on their policies. The remaining five indicated that they had received no feedback.

What problems have been encountered in developing or implementing the policy?

The only major problem encountered in implementing a policy has been experienced by the State Department. A lawsuit is now in progress brought by the American Federation of Government Employees, challenging the agency's testing policy.

What lessons have been learned by these organizations that GAO could apply?

The organizations believe that AIDS should be dealt with just like any other life-threatening disease. They also recommend that information regarding AIDS be disseminated as soon as possible and education programs established. The programs should include a channel for expressing fears and emotion about AIDS and should be flexible enough to keep up with current developments.

What do AIDS support groups feel are the needed components of policies and programs addressing AIDS in the workplace?

The groups feel that education should be a major component of any AIDS policy. They also have indicated that management support, acceptance, and confidentiality would assist the person with AIDS. In addition, the groups feel that employees with AIDS need flexibility in their benefits and quick claims processing due to the nature of the complications and changing situations that they face.

How do the support groups' recommendations match what the organizations are doing?

The recommendations correlate closely with the approaches taken by the organizations that have addressed AIDS in the workplace. However, this correlation is to be expected since most of the organizations with policies worked closely with support groups to develop them.

Which promising practices from either the organizations or the support groups could GAO adopt?

Advice and recommendations included:

- dealing with AIDS as with any other major medical problem,
- establishing an educational program as soon as possible and using existing materials,
- avoiding testing and screening of employees,
- keeping information regarding employees with AIDS confidential, and
- dealing with discrimination through education.

No striking examples of innovative projects were reported.

Table VIII.1: Summary of Interviews

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
I. Description of Policy:									
Policy (related to AIDS)	Yes	Yes	Yes	Yes	Yes	No	Yes	NA	Yes
Policy written	Yes	Yes	Yes	Yes	Yes	Yes (general)	NA	NA	NA
Other program, plans, or methods	Yes	Yes	NA	No	No (training)	Yes	NA	NA	Yes
Policy/program/plan goals:									
Stop spread of AIDS	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Decrease fear	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Control/eliminate rumors	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes
Protect rights of employees with AIDS	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Protect coworkers	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes
Manage staff	Yes	No	No	Yes	Yes	Yes	No	Yes	No

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
Consistently apply personnel rules	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reduce legal liability	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Other	Educate	Educate	NA	NA	NA	NA	Yes	NA	Yes
Regulations or guidelines considered in developing policy:									
Federal Rehabilitation Act of 1973	Yes	No	No	Yes	No	Yes	No	Yes	Yes
Federal Employee Retirement Insurance Act	Yes	No	No	No	No	Yes	No	Yes	Yes
State and local antidiscrimination laws	No	No	No	Yes	No	Yes	Yes	Yes	Yes
Justice Department memorandum	No	No	No	No	No	Yes	Yes	Yes	No
Public Health Service guidelines	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No
Management and/or labor union articles	No	Yes	No	Yes	No	No	No	Yes	Yes
Policies from other organizations	Yes	No	No	No	No	No	No	Yes	No
Other	Other countries' policies	CDC guidelines		No	No	No	No	NA	No
II. Focus of Policy (1 (not addressed) to 5 (very great extent))									
Asymptomatic HIV infected	4	0	0	0	5	0	4	1	1
ARC	4	0	0	0	5	0	5	5	5
AIDS (not hospitalized)	4	0	0	0	5	0	5	5	5
AIDS (debilitated)	4	0	0	0	0	0	5	5	5
Associated with known risk groups	5	0	0	0	0	0	4	0	1
Focus on risk groups:									
Intravenous drug users	No	No	No	No	No	No	NA	Yes	No
Homosexuals or bisexuals	Yes	No	No	No	No	No	NA	Yes	No
Hemophiliacs	No	No	No	No	No	No	NA	Yes	No

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
How policy treats groups (0 = not addressed, 1 = case by case, and 2 = other):									
Asymptomatic HIV infected	1	2	0	0	0	0	NA	1	2
ARC	1	2	0	0	0	1	NA	1	2
AIDS (not hospitalized)	2	2	0	0	0	1	NA	1	2
AIDS (debilitated)	1	2	0	0	0	1	NA	1	2
Associated with known risk groups	0	2	0	0	0	0	NA	1	2
III. Specific Program Components									
Education program topics (1 = HIV infected employees, 2 = coworker, and 3 = manager):									
Transmission of AIDS	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3
Rumor control	No	No	1,2,3	No	No	1,2,3	1,2,3	1,2,3	1,2,3
Coworker fear and health risks	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3	1,2,3
Benefits	1,2,3	No	1,2,3	No	No	1,2,3	1	1	1,2,3
Other components	Yes	No	No	Yes (employee assist.)	Yes (needle-stick)	Yes	No	No	No
HIV screening and testing:									
Preemployment testing	Yes	No	No	No	No	No	No	No	No
Voluntary testing	Yes	Yes	No	No	No	No	No	Yes	No
Routine testing as part of physical	Yes	Yes	No	No	No	No	No	No	No
Mandatory testing-specific jobs	Yes	Yes	No	No	No	No	No	No	No
Mandatory testing-all employees	No	No	No	No	No	No	No	No	No
Other	NA	NA	No	No	No	No	No	No	No
Addresses management of HIV positive employee	No detail	Referred	No	No	No	No	No	NA	No
Monitors for secondary infections	Yes[a]	No	No	No	No	No	No	No	No

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
Supervisor actions when aware of HIV positive employee:									
Keep information to himself/herself	Yes	No	Yes	No	No	NA	Yes	Yes	Yes
Inform supervisor	No	No	No	No	Yes	NA	No	No	No
Inform health unit	No	No	No	No	Yes	Maybe	No	No	Yes
Inform personnel	No	No	No	No	No	Maybe	No	No	No
Explain situation to coworkers	No	No	No	No	No	No	No	No	No
Other	No	Yes	No	No	No	No	No	No	No
None of the above	NA	NA	NA	Yes	NA	NA	NA	NA	NA
How conflict between OSHA disclosure and OPM regulations on confidentiality is handled:									
Disclose	No	NA	NA	NA	NA	NA	NA	NA	NA
Do not disclose	Yes	NA	NA	NA	NA	NA	NA	NA	NA
Prevention of discrimination:									
Criteria for work tasks	No	No	No	No	No	No	No	Yes	No
Criteria for disability status	No	No	No	No	No	No	No	Yes	No
Procedures to minimize discrimination	No	No	No	No	No	No	No	Yes	No
Other	Education	No	No	Yes	No	No	Yes	Yes	No
None of the above	NA	NA	Yes	NA	Yes	Yes	NA	NA	Yes
Employees considered handicapped/disabled:									
Asymptomatic HIV infected	No	No	No	No	No	No	NA	No	No
ARC	No	No	No	Yes	Yes	Yes	NA	Yes	Yes
AIDS (not hospitalized)	No	No	No	Yes	Yes	Yes	NA	Yes	Yes
AIDS (debilitated)	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Associated with known risk groups	No	No	No	No	No	No	NA	No	No
Criteria for accommodation	None	NA	Case by case	Yes	Yes	Case by case	Yes	Job performance	Same as others
Criteria differ from those for other life-threatening illness	No	NA	No	No	Yes	No	No	Yes	No

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
Managers can request work certification/ examination	No	NA	No	Yes	No	Yes	No	Yes	No
Accommodation of HIV positive employees not able to perform current duties:									
Placed on disability	Yes	No	NA	Yes	No	Yes	Yes	Yes	Yes
Laid off with disability	No	No	NA	No	No	No	No	No	No
Reassigned	Yes	No	NA	Yes	No	Yes	No	No	Yes
Other	NA	Referred	Released	NA	No	Yes	No	No	No
None of the above	NA	NA	NA	N NA	Yes	NA	NA	NA	NA
Special benefits for HIV positive employees	No	NA	Grant	No	No	No	No	No	No
Benefits available for preexisting condition	NA	NA	Normal health insurance	NA	No policy	NA	NA	NA	NA
Support services provided:									
Educational information	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Individual counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Support group	No	No	No	No	No	Yes	Yes	Yes	Yes
Referral to community agencies	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Other	Yes	No	No	No	Yes	No	No	No	No
None of the above	NA	NA	NA	NA	NA	NA	NA	NA	NA
IV. Program Implementation and Feedback									
Policy/program/plan has been in effect:									
Less than 1 year	NA	Yes	NA	NA	NA	NA	NA	NA	NA
1 to 2 years	NA	NA	Yes	Yes	Yes	Yes	Yes	NA	NA
More than 2 years	Yes	NA	NA	NA	NA	NA	NA	NA	NA
Estimated cost of policy	None	None	None	No extra costs	None	NA	NA	NA	NA
Difficulties in implementation	Testing	NA	No	None	No	Yes	NA	NA	Yes
Feedback received	Positive	None	Positive	None	None	None	Positive	NA	Positive
Changes or modifications made	None	None	None	None	None	None	None	NA	NA

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
V. General Advice									
Deal with as other major medical problems	Yes		Yes						
Use San Francisco AIDS Foundation film			Yes						
Continue task force approach			Yes						
Do not implement AIDS-specific policy				Yes					Yes
Disseminate information on AIDS as soon as possible				Yes					
Do not implement screening program					Yes		Yes		
Keep information about employees confidential					Yes				
Have a policy about employees with AIDS					Yes				
Extend policy only to employees with AIDS and ARC									Yes
Do not have policy that reinforces fear							Yes		
Permit expression of fears and emotion						Yes			
Provide for flexibility						Yes			
VI. Community or Health Groups									
Advocate employer policy					Yes	Yes	Yes	Yes	Yes
Components of policy should include:									
Education					Yes	Yes	Yes		Yes
Management training									Yes
Confidentiality assurance					Yes				
Support services					Yes				
Employment guarantees					Yes				
Antidiscrimination policy									Yes
When AIDS will be disclosed by employee:									
Only when necessary if fear of discrimination					Yes				
When diagnosed									Yes

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
When symptoms become obvious							Yes		
Should be sensitive to isolation						Yes			
When job performance is impaired								Yes	
Conditions or limitations in workplace:									
None					Yes		Yes		
Same as for other handicapped employees						Yes			Yes
Awareness of mental problems associated with AIDS								Yes	
How managers/employees can assist:									
Accept and support					Yes	Yes	Yes		Yes
Do not discriminate									Yes
Deal with employee and family							Yes		
Demonstrate concern in workplace						Yes			
Maintain confidentiality								Yes	
Obtain knowledge								Yes	
How medical expenses are covered:									
Many costs not covered					Yes				
Medicaid and Medicare								Yes	
Private insurance								Yes	
Estimate of total costs to AIDS patient:									
$50,000 to $80,000 (10% to 80% covered)						Yes			
Areas where employee benefits are lacking:									
Lack of flexibility						Yes			
Programs providing coverage for only permanent disability when coverage for temporary disability is needed						Yes			
Overly long claims processing								Yes	

(continued)

	Government Agency Employer	Government Agency Employer	Private Sector Employer	Private Sector Employer	Private Sector Employer and Support Group	Private Sector Employer and Support Group	Support Group	Support Group	Support Group
Problems in obtaining help:									
Physician refusal to treat					Yes				
Hospital refusal to accept					Yes				
Insurance cancellation					Yes				
Little support outside major cities						Yes			
Overall discrimination								Yes	
Type of health care facilities available:									
Outpatient					Yes	Yes	Yes	Yes	
Inpatient					Yes	Yes	Yes	Yes	
Home					Yes	Yes	Yes	Yes	
Hospice					Yes	Yes	Yes	Yes	
Home support available:									
Personal care aide					Yes				
Skilled nursing					Yes				
Shanti emotional support					Yes		Yes		Yes
Never enough						Yes			
Family								Yes	
Work-related issues/ solutions:									
Discrimination/education							Yes		Yes
Anticipating problems before they occur						Yes			
Breaches of confidence								Yes	
Rumors								Yes	
Lack of information								Yes	

[a]Except for personnel assigned overseas.

Managers' Guidelines for Dealing With Individual Cases of AIDS

GAO recognizes that employees with life-threatening illnesses, including cancer, heart disease, and AIDS, may wish to continue to engage in as many of their normal activities as their condition allows, including work.

Managers who supervise employees with these conditions need to be fully aware of employee rights, as well as their own responsibilities. GAO will provide all assistance necessary to enable managers to carry out their responsibilities appropriately, effectively, and humanely. Other employees supervised also need to feel confident that their health will not be endangered and that GAO will provide whatever services are required to help deal with the reality of AIDS and any other life-threatening illness in the workplace.

Consistent with this concern, GAO offers the following guidelines for managers. They are intended to be published separately from the present report, which is why they may present some areas of redundancy with other appendixes. In addition, they should be viewed as iterative: to be completed, updated, and corrected as future managerial experience dictates.

Personal and confidential. The first thing for a manager to keep in mind is that an employee's health condition is personal and private. A manager must take reasonable precautions to keep health information confidential if disclosed by an employee. A manager is subject to administrative penalties for disclosing the condition of an employee with AIDS without official reason to do so. Of course, a manager should not under any circumstances engage in rumors about the health of any staff member. Also, employees are not required to tell their managers if they have AIDS or other life-threatening illnesses. However, a manager who has been informed by a staff member that he/she has AIDS and wishes special assistance or cannot perform normal duties, may advise appropriate superiors and ask for specific guidance on how to manage an employee with a terminal illness.

A manager is not obligated or permitted without consent to tell other staff supervised if one of their coworkers has taken a test for AIDS, has tested HIV antibody positive, has ARC, or has another life-threatening illness. All available medical data indicate that AIDS is not communicated among employees working in GAO or in another office environment.

Assistance network. An employee with AIDS may need several kinds of assistance and may thus need to turn to a number of people both inside

and outside GAO. To help the employee's efforts in making contact with appropriate persons in the assistance network, each GAO division, staff office, and regional office will designate one staff member—the operations deputy or assistant regional manager—to serve as a focal point for personnel issues related to AIDS. That person will know about employee rights, benefit packages, support groups, and other matters likely to be of concern to employees with AIDS, their supervisors, and coworkers. The employee may also turn to an immediate supervisor or go directly to the designated focal point in Personnel or the Counseling and Career Development Branch for confidential advice and assistance.

Behavioral manifestations of AIDS. In advanced stages of the disease, the AIDS victim may display uncharacteristic signs of depression, confusion, or hostility. These may be a product of neurological damage caused by the disease or the intense psychological trauma of confronting the diagnosis of an incurable illness. The manager must recognize such behavior as manifestations of the illness. He/she should review the possible accomodations to the employee's condition included in the following section.

Continued employment and job discrimination. An employee with AIDS or any related illness may continue to work as long as he/she can perform his/her job. A manager must make all reasonable accommodations to assist the employee.

An individual who tests positive may require little or no accommodation. An employee with ARC or clinically defined AIDS may require no greater accommodation than government agencies make to most seriously ill staff members. As long as an employee with AIDS can meet reasonable and acceptable performance standards—and his/her condition is not a threat to others—he/she should be treated like any other employee. If warranted, a manager may make reasonable accommodations for an employee with AIDS as long as those accommodations do not hamper the business needs of the unit. Some accommodations are as follows:

- flexible work hours;
- part-time work schedules;
- liberal approval of annual and sick leave and appropriate approval of administrative leave;
- advance leave, if appropriate, usually not to exceed 30 days;
- counseling time within GAO;
- administrative leave for outside counseling;

- light duty assignments;
- seeking permission from the appropriate authority for the employee to work at home;
- making facilities and equipment readily accessible and usable by the handicapped;
- restructuring the job;
- voluntary downgrading or reassignment to a more appropriate job in another qualified series;
- granting LWOP; and
- job sharing, in which two people divide one permanent position between them.

Clearly, many accommodations are feasible, but care should be taken not to isolate the employee from the normal work environment in any way that could be interpreted as discriminatory.

Contagious Nature and Coworkers' Concerns. No data have been presented to show that AIDS constitutes a health risk for office workers. The AIDS virus cannot be passed through the air or by sneezing, breathing, crying, or coughing. Also, touching or holding or shaking hands does not spread AIDS. Studies have shown that people in the same family with AIDS have played, eaten, and slept together and shared the same toothbrushes and have not transmitted AIDS to each other. Fortunately, AIDS, whether detected or undetected, is not spread through casual contact.

Managers must learn enough about AIDS to responsibly attend to subordinates' concerns. They must be thoroughly aware of GAO's policy on AIDS and other AIDS-related illnesses.

The fact remains, however, that some employees will continue to be uncomfortable with a coworker's life-threatening illness. In such a case, a manager may feel the need to ask for a meeting of his/her staff with representatives from the ongoing AIDS task group, chaired by the Director of Personnel. That group can also arrange for an outside expert on AIDS to talk with concerned managers and staff. However, in the final analysis, staff will be expected to continue working relationships with any fellow employee recognized as having AIDS.

Employee benefits. Basically, employee benefits related to AIDS are the same as for other life-threatening illnesses. For example, AIDS is not singled out from any other disease included in federal health benefit programs. Open season usually is held once each year, and employees are

free to select the most appropriate insurance plan to meet their anticipated health conditions. The Office of Personnel will help with this selection.

Health benefits continue during all leave periods, including leave without pay. However, during any nonpay status, the employee must pay a share of the premium for each period in which coverage continues. The enrollment of an employee continues in nonpay status for up to 365 days. If an employee has at least 4 consecutive months in pay status, he/she is entitled to begin the 365 days continuation of enrollment anew.

Life insurance benefits are payable in the event of death of an eligible employee or family member if death occurs while insured, no matter how caused. Basic coverage for federal employees is equal to the annual basic pay (rounded to the next $1,000) plus $2,000, and if applicable, the additional optional $10,000. Also, life insurance continues without cost to the employee while in a nonpay status for up to 12 months, when the insurance is terminated. If the employee has at least 4 consecutive months in a pay status, he/she is also entitled to begin the 12-month period of insurance enrollment anew.

Survivor benefits are the same for survivors of AIDS patients as for any other cause of death. The health benefits coverage continues if the surviving spouse is eligible for coverage under a family plan and elects continuation. The life insurance is payable to the beneficiary designated or in the order of precedence required by law. If a retirement annuity is payable, the surviving spouse receives a monthly annuity; otherwise a lump-sum payment is made.

An employee may also qualify for disability retirement if no longer able to adequately perform the job. The average employee avoids applying for disability retirement until no other choice is available because the guaranteed minimum of 40 percent of the high-3 average yearly pay is usually not adequate for a normal standard of living. To be eligible for disability retirement under the Civil Service Retirement System, the employee must have a minimum of 5 years creditable service, and under the Federal Employees Retirement System, an employee must have at least 18 months creditable service.

Testing. GAO does not support a routine testing program for employees. However, staff being transferred to overseas offices will, in this as in other cases, follow the normal State Department guidelines and will be

given the same health tests as State Department employees, including AIDS testing.

Employee counseling and outside assistance. An employee who has the AIDS virus or becomes sick with AIDS should be encouraged to seek assistance from GAO's counseling services and from established community support organizations for medical testing, treatment, and counseling. The Task Force on AIDS developed resource lists of many organizations and community services in the relevant GAO locations that can provide anonymous or confidential assistance. These lists have been distributed to all GAO employees, and further copies can be obtained from the Counseling and Career Development Branch.

It is not easy to feel comfortable with issues of death and dying, and these are thrust suddenly and obtrusively into the work environment with the advent of a case of AIDS. Managers, coworkers, and staff dealing with life-threatening illness are all at high risk of excessive stress. To assist employees in getting help, advice, and counseling when they need it is a manager's responsibility.

In summary, the manager needs to draw on the assistance and counsel of all GAO resources to

- consistently and correctly apply personnel rules and GAO policy;
- avoid legal liabilities;
- protect the rights of all employees, including those who have life-threatening illnesses and those who do not;
- control or eliminate rumors;
- decrease the fear of AIDS; and
- carry out his/her responsibilities humanely, appropriately, and effectively.

The following likely questions and possible responses have been prepared to help managers cope with problems that could arise in dealing with AIDS and employees in the workplace.

Manager. When a staff member informs me that he or she has AIDS or ARC or has tested HIV antibody positive, what should I do?

Response. Realize that an employee with AIDS has the following fears:

- My coworkers will isolate me.
- I will lose my job.
- I will be given another job that will not appropriately use my skills, knowledge, and abilities, or I will be put in a closet and isolated.

Explain that GAO treats employees with AIDS the same as any other employee with a life-threatening illness not contagious in the workplace. GAO will not terminate his/her employment because of AIDS nor discriminate against the employee in any way. Explain you will keep the information confidential, but also explain the advantages and disadvantages of being candid with coworkers. Explain that frankness allows an opportunity for open discussion, reduces tension, and can create a supportive and understanding atmosphere by eliminating suspicions or unwarranted fears that AIDS can be transmitted casually in the workplace.

Manager. If the employee informs me he/she has AIDS but does not want to make it known to others, what should I do?

Response. Assure him/her that the information will be kept confidential. An employee's health condition is personal and private. However, explain that if the employee becomes unable to perform normal duties or needs special assistance and accommodations, then discussions with appropriate superiors must take place.

Manager. What is GAO's policy on granting special accommodations?

Response. Realize the physical effects of AIDS and treatment will likely affect the employee's energy level and stamina at some point. Explain to the employee that in GAO, AIDS is treated as a disability. GAO's policy is that employees may work as long as they can perform their jobs. All reasonable accommodations to assist them will be made. Educate yourself to effectively answer the employee's questions about GAO's policy on accommodations for employees with long-term or life-threatening illness.

Manager. Because of special accommodations for an employee with AIDS, several coworkers have begun to complain that their work loads have increased to compensate for the employee's accommodations and reduced work capacity. How can I accommodate everyone's rights?

Response. Start by explaining that making accommodations for a person's illness did not start with AIDS. GAO's policy covers all other illnesses

that less fortunate employees may acquire, including heart disease and cancer. The day-to-day course of any illness is usually unpredictable. Explain that coworkers need to be understanding at times when the work load cannot be predicted or evenly distributed. Discuss the staff's concerns with superiors if an accommodation is likely to result in a disproportionate distribution of work over an extended period. Additional resources may be possible on a temporary basis. Recognize that the length of the illness will not be known but that it may last several years during which the employee will experience good days and bad days.

Manager. What if the employee asks me for advice on where to get help?

Response. The Task Force on AIDS has prepared a brochure showing where to get help, listing community resources and the types of assistance they provide. This information can be obtained by the manager or the employee from our CCD. Also, offer to contact an appropriate Personnel staff member to obtain up-to-date information on all potential employee benefits, such as leave without pay, health and life insurance, disability retirement, survivor benefits, and possible work accommodations. Also, point out that GAO's confidential counseling service is available.

Manager. What if a staff member comes to me and says, "Does Sam have AIDS? It seems to me he does, and I do not want to work with him."

Response. Whether you have knowledge in fact or not that "Sam" does or does not have AIDS, you must keep your knowledge of his medical information confidential and you may not confirm or deny whether anyone has AIDS without his/her permission. Your reply should point out that managers are not obligated or permitted, without the employee's consent, to discuss another person's medical condition, i.e., to tell other staff members if one of their coworkers has taken a test for AIDS, has tested positive for HIV antibodies, or has AIDS-related complex or any other illness.

The manager should explain that AIDS is not spread by the kind of general contact that occurs among people in office settings. Point out that studies have demonstrated the AIDS virus is not passed to another person through the air or by sneezing, breathing, crying, coughing, touching, or holding and shaking hands. Also, point out that AIDS is not spread through casual contact and that there is no need to fear or avoid working with any staff member who either has AIDS or is only suspected of

having AIDS. You may want to emphasize that although there is no guarantee that one can never under any circumstances catch the AIDS virus, the Centers for Disease Control have no documented cases in which the virus has been passed on through casual contact between two people.

Manager. What if I notice a decline in an employee's work performance and note that he/she has been taking a lot of sick leave lately. Let's say I have also heard rumors that the employee could have AIDS. What should I do?

Response. You may inform the employee that rumors are circulating and ask how you should respond. You may not ask if the employee in fact has AIDS or imply it in any way. You may explain your observations about the sick leave and performance decline and ask if there is some explanation for it. Ask also if there is anything you can do to help. Make it clear that anything said will be kept confidential. You can explain that the GAO policy is to make all reasonable accommodations if a physician certifies there is a medical disability. This will allow the employee to decide whether it is in his/her interest to reveal a medical disability, if there is one.

Manager. What if the rumors turn out to be false and the employee does not have AIDS?

Response. You still have rumors to deal with at work, and the manager is responsible for safeguarding the health and safety of his/her employees, including those who may have AIDS and those who do not. The manager can alleviate these concerns by providing facts and dealing with any rumors as they arise. The manager can arrange for a staff meeting, coordinated with superiors, attended by someone from the AIDS Task Force or an outside expert, or both, to discuss the medical evidence that, as already noted, there are no known cases in which AIDS has been transmitted through casual contact. The best way to alleviate employee fears is to educate staff on the medical details of AIDS, especially how it is transmitted.

Manager. How can I deal with my own stress and that of others who are working with a staff member who is dying of AIDS?

Response. Encourage a discussion so that coworkers can express their feelings about working with an employee who has AIDS and who may over time become weaker and weaker as the illness progresses. Recognizing the considerable discomfort that goes with watching the gradual

physical or mental decline of a colleague, advise staff to act naturally, to speak about their feelings with the ill employee, and to be sympathetic but not pitying.

Manager. If a concerned staff member wants to know more about what AIDS is and what health problems to expect when a person is said to "have AIDS," what do I say?

Response. AIDS stands for acquired immune deficiency syndrome. In referring to the AIDS virus, scientists have used several abbreviations, such as HIV (human immunodeficiency virus), HTLV-III (human T-lymphotropic virus type III), and LAV (lymphadenopathy associated virus).

When the AIDS virus enters the blood stream, it begins to attack certain white blood cells called T-lymphocytes and damages the person's immune system and his/her ability to fight other diseases. Without a well-functioning immune system to ward off bacteria, the person becomes vulnerable to other infections. Some of these may cause life-threatening illness, such as pneumonia and meningitis. The AIDS virus may also attack the nervous system and cause damage to the brain reflected in symptoms such as memory loss, loss of coordination, and partial paralysis.

AIDS antibodies can be detected by a blood test usually 2 weeks to 3 months or longer after infection. Some people remain apparently well after infection with the AIDS virus for long periods.

ARC, or AIDS-related complex, is a condition caused by the AIDS virus; however, the symptoms may be less severe than those of clinically defined AIDS. Symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, and swollen lymph nodes. These are also symptoms of many other diseases; therefore, a physician should be consulted if they appear.

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