

 BROWN Alpert Medical School	Medical Student Health Services, Personal Counseling, and Financial Aid Services	POL: 12-00, includes: POL No.: 12-02 POL No.: 12-04 POL No.: 12-05 POL No.: 12-08.01 POL No.: 12-08.02 POL No.: 12-08.03 Effective Dates: May; July 1; September; and November 2019 (see 9.1 below)
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1.0 Policy Purpose

The purpose of this policy is to govern effective student services, including health and financial aid, available to medical students of the Warren Alpert Medical School of Brown University (AMS). This policy relates to the following:

- Tuition Refund Policy (Element 2)
- Student Access to Health Care Services (Element 4)
- Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records (Element 5)
- Student Exposure Policies/Procedures (Element 8)

Such policies are in place to ensure compliance with Liaison Committee on Medical Education (LCME) requirements for re-accreditation and correspond to elements of Standard 12 (Medical Student Health Services, Personal Counseling, and Financial Aid Services).

2.0 To Whom the Policy Applies

All AMS community members.

3.0 Policy Statement

3.1 Tuition Refund Policy (POL No. 12-02)

Withdrawals and the Return of Title IV Funds

Students must notify the AMS Office of Records and Registration in writing to formally withdraw from the medical school. If the student received financial aid in the form of federal loans, such as the Federal Direct or Perkins Loans, then the student must also notify the AMS Office of Financial Aid as well. The student may be required to complete an exit interview and satisfy other requirements as a borrower of federal and/or institutional loans.

When a medical student withdraws from AMS or takes a leave of absence, the Office of Records and Registration must determine the date of withdrawal, based on the date of the student's last day of attendance. The Office of Records and Registration will work with the University Offices of the Registrar and Bursar to adjust tuition and other charges following the institutional withdrawal.

policy for the medical school. Please note that fees such as the health services fee, activity fee and recreation fee are not refundable once the semester starts. If a student withdraws before the start of the semester, these fees will be refunded.

Please note that the semester start dates differ for first and second year students, and for third and fourth year students. Fall semester for Years 1 and 2 starts in late July/early August and starts in late April/early May for Years 3 and 4. Spring semester for Years 1 and 2 starts in January and starts in late October for Years 3 and 4.

A student who leaves the medical school prior to the beginning of the semester shall not be charged tuition or fees for the semester.

A student who leaves the medical school during either Fall or Spring semester shall be eligible for a tuition refund during the first five weeks only, as follows:

First two weeks.....	80% refund
Third week	60% refund
Fourth week.....	40% refund
Fifth week.....	20% refund
Beyond Fifth week.....	not eligible for refund

Students who receive federal (Title IV) loan funding, such as the Direct or Perkins loans, will be subject to the Title IV Refund Policy which does not necessarily follow the University's tuition refund policy. Instead, the medical school must determine the earned and unearned portions of the eligible Title IV aid as of the date the student ceased attendance based on the amount of time the student spent in attendance. The calculation of Title IV funds earned by the student has no relationship to the student's incurred institutional charges.

Up **through the 60% point** in each semester, a pro-rata schedule is used to determine the amount of Title IV funds the student has earned at the time of withdrawal. **After the 60% point** in the semester, a student has earned 100% of the Title IV funds he or she was scheduled to receive during the period. For a student who withdraws after the 60% point-in-time, there are no unearned funds and generally, the student is able to retain the funding already disbursed.

3.2 **Student Access to Health Care Services (POL No. 12-04)**

An excused absence or exam extension may be granted if students are ill. For the student's sake and the sake of others, students should not attend classes, see patients, or take exams if you are sick. An excused absence or exam extension due to illness requires a note from Health Services or the student's treating healthcare provider.

Please note that medical appointments should be scheduled during non-course/rotation times whenever possible. However, we want students to be able to access appropriate health care. Regularly scheduled appointments with a healthcare provider (for example, weekly therapy appointments) are considered an academic accommodation (not an approved absence for reasons of illness) and appropriate documentation must be submitted to the Learning & Accessibility Specialist in a timely manner in order to obtain approval. The Learning & Accessibility Specialist will then provide guidance for communicating these accommodations to the appropriate course/rotation personnel.

How to Obtain an Excused Absence. The AMS policy states that students should try to schedule medical appointments during non- course/rotation times when possible, but that AMS will support them in accessing health care as needed when this is not possible. As such, one-time needs (such as an appointment with a specialist that cannot be scheduled during a non-course/rotation time) are handled on a case-by- case basis by the appropriate administrator; permission should be requested through the usual mechanisms for other absences. These requests would go to the appropriate curriculum dean in Years 1 & 2, and to the appropriate clerkship/elective/sub-internship coordinator in Year 3 & 4. If a student has concerns regarding the response received through the usual mechanisms, they can reach out to either the Associate Dean for Student Affairs or the Associate Dean for Medical Education for additional assistance.

In Years 1 & 2, all excused absences for IMS course activities must be approved by the Director of Year 1 Curriculum or the Director of Year 2 Curriculum. All excused absences for Doctoring course activities must be approved by the Assistant Director of the Doctoring Program. In order to obtain an excused absence in Year 1 or 2, students should submit a "request for an excused absence" on the Canvas website. Both to maximize learning and to help with planning, approval should be requested as far in advance as possible, two weeks at a minimum. If granted an excused absence, students must then notify their small group leader(s) and will be required to complete required make-up work. This work will be assigned by the Director of Year 1 Curriculum, the Director of Year 2 Curriculum, or the Assistant Director of the Doctoring Program. In the case of illness, an absence will be approved retroactively with appropriate documentation. The required note from Health Services or your treating healthcare provider should be submitted to the Administrative Coordinator in the Office of Medical Education and Continuous Quality Improvement, or to the Assistant Director for the Doctoring Program, within two days of return.

In order to reschedule a Doctoring mentor session, students should start by working directly with their mentor. [Note that there is a scheduled make-up mentor session at the end of each semester]. If it is not possible to reschedule a mentor session either with the regular mentor or one of the mentor's clinical colleagues, students should contact the Assistant Director of the Doctoring Program to arrange for a substitute mentor. Any physicians acting as substitute mentors who are not currently involved in the Doctoring Program must be pre-approved by the Assistant Director.

For required **clerkships**, students should email excused absence requests to the clerkship coordinator and clerkship director, with as much advance notice as possible but, at a minimum, **six weeks in advance**. Clerkships will work with the student to determine whether the absence is approved and, if so, what makeup work might be required. Information about absence requests will be entered by the clerkship coordinators into the Request for an Excused Absence link on the class Canvas page for review by the Director of the Clinical Curriculum.

For **clinical electives and sub-internships**, students should email excused absence requests to the elective or sub-internship coordinator and elective or sub-internship director, with as much advance notice as possible. It will be up to the elective or sub-internship director to determine if the absence request can be accommodated and whether appropriate make-up work is required. Information about absence requests will be entered by the coordinators into the absence link on the class Canvas page for review by the Director of the Clinical Curriculum. (See the Student Handbook, Section IV: Attendance Policy for more information on clinical electives.)

A pattern of repeated absences may be brought to the attention of the Student Support Committee and/or the Medical Committee on Academic Standing and Professionalism.

How to Obtain an Approved Exam Extension/Rescheduling. In Years 1 & 2, all extension or rescheduling requests for IMS exams must be approved by the Director of Year 1 Curriculum or the Director of Year 2 Curriculum. Extension requests for Doctoring OSCEs must be approved by

the Assistant Director of the Doctoring Program. Due to the logistical complexity of holding make-up OSCEs, unless there is an emergency or illness, students should make every effort to attend OSCEs as scheduled.

In Year 3, students may request an extension for a clerkship exam or OSCE. If due to a medical reason, students must have a note from a physician or other treating healthcare provider documenting an illness and why this extension would be appropriate, especially if a student is able to meet the other requirements of the clerkship. All extensions must be approved by the Director of the Clinical Curriculum, in consultation with the clerkship director. If a written exam extension is approved, students may only take the written exam during their next non-clerkship block period, including elective or vacation time. OSCE make-ups must be arranged with the clerkship coordinator and may be taken within a subsequent clerkship block if space allows. Students will receive a grade of Incomplete in the clerkship until the written exam or OSCE is taken. Students may also request exam extensions for unpredictable major life events, such as a death in the family. These and all other requests will be considered on a case-by-case basis by the Director of the Clinical Curriculum and Clerkship Director. Repeated exam extension requests may result in a discussion about whether the student is able to continue with the curriculum or if there is a need for time off.

3.3 **Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records (POL No. 12-05)**

Providers of health and psychiatric/psychological services to a medical student will have no involvement in the academic assessment of or in decisions about the promotion of that student.

3.4 **Student Exposure Policies/Procedures (POL No. 12-08.01, POL No. 12-08.02, and POL No. 12-08.03)**

3.4.1 **Education of Medical Students About Methods of Prevention (POL No. 12-08.01)**

Year 1 students have an 80-minute lecture on Infection Control in Year 1, Semester 2 which includes information about healthcare-associated infections in general, as well as strategies to mitigate risk of these infections. In Year 2, students receive Universal precautions (bloodborne pathogen) and N95 training/education in the Clinical Skills Clerkship.

Students are required to attend an Infection Prevention training during Orientation (Year 1) and again at the beginning of Year 3. The training is given by the Director of Infection Prevention at one of AMS's affiliated hospitals.

A number of the required clerkships in Year 3 cover infection prevention during clerkship-specific sessions:

- *Surgery*: Orientation includes a slide on needle sticks/exposures and what to do if this occurs. During scrub workshop, students try on gloves, and double gloving is recommended as a protective strategy against bloodborne illness. A trauma lecture during orientation covers gloves/mask/face shield/gown as part of practitioner preparation prior to patient arrival.
- *Internal Medicine*: Didactics include a one-hour Problem-Based Learning session, "Needlestick", which covers the following learning objectives:
 - Describe the factors involved in needlestick injuries;
 - Describe the risks for needlestick transmission of HIV, hepatitis B and

- hepatitis C;
 - Describe the principles of HIV post-exposure prophylaxis following needlestick injury; and
 - Describe the healthcare worker role in transmission of influenza, pertussis, vancomycin resistant enterococcus, methicillin-resistant *Staphylococcus aureus*, and *Clostridioides difficile*.
- *Obstetrics and Gynecology*: Orientation includes a slide on needle sticks/exposures and what to do if this occurs, and is reviewed in the simulation session during orientation. This session includes a review of universal precautions, needlestick prevention, and what to do in the event of a needlestick.

Students receive a final N95 training in Year 4 of medical school.

3.4.2 The procedures for care and treatment after exposure, including definition of financial responsibility (POL No. 12-08.02)

Needlestick/Bloodborne Pathogen Exposure Guidelines

If students experience a needlestick or sharps injury or are exposed to the blood or other body fluid of a patient during the course of their clinical work, students should **immediately** follow these steps:

- Ensure that the team knows that a sharp/needle is contaminated and must be discarded - this can be an issue for the patient as well as for the student. If the student is in the OR, the student's supervisor and the circulating nurse should be made aware.
- Wash needlesticks and cuts with soap and water (15 minutes); splashes to the nose, mouth, or skin flushed with water (15 minutes) or eyes irrigated with clean water, saline, or sterile irrigants (eyewash - may require help).
- Seek medical treatment in the Emergency Department closest to where you are rotating - students should make sure that the triage team in the ED knows that they are presenting for an issue of exposure. Also, students should remember that they are presenting as **students**, ***NOT*** as employees. As such, any treatment should go through students' health insurance plans (students would not be eligible for worker's compensation).

For students with the Brown student health insurance plan, two additional steps may be involved to ensure that the insurance plan covers the appropriate portion of the bill:

Coordination of Benefits: The insurer may contact a student to determine whether there is coverage under any other health insurance plans. Confirmation can be made online at www.uhcsr.com/MyAccount or by calling UHCSR customer service at 1-800-767-0700. If a bill reaches \$1,000, UHCSR will automatically send an email asking for this information. Another email reminder will be sent after 30 days. After an additional 30 days, claims will be denied and an Explanation of Benefit (EOB) sent. If this happens, students will need to provide the "other insurance" information online at www.uhcsr.com/MyAccount or, by calling UHCSR customer service at 1-800-767-0700, so that a denied claim can be reopened and re-processed. The easiest way to resolve this issue is to download the UHC StudentResources app or to go to <https://www.uhcsr.com> and create an account. Once this "action item" is completed, bills will be paid.

Additionally, if the bill reaches \$1,000, an accident detail report is required. It is important

that on this report it is indicated that the exposure was NOT due to an accident “on the job.” (If a student states that this occurred “on the job”, health insurance plans will think that the bill should be covered by worker’s compensation, for which students are not eligible).

OSA will consider paying for costs related to occupational exposures that are not covered by a student’s insurance company (a submission to insurance must be made in order to qualify for financial support from OSA). To submit a request for payment, students should notify OSA in person or via email at medstudentaffairs@brown.edu with the subject line “Reporting exposure - private and confidential.” Information needed is the student’s name, contact number, a brief report of the incident, a copy of the hospital bill/invoice, and the Benefits Statement from the insurance company indicating what, if any, portion of the bill has been covered by the plan. OSA will review and, if approved, pay the treating provider directly.

3.4.3 **The effects of infectious and/or environmental disease or disability on medical student learning activities (POL No. 12-08.03)**

All Alpert Medical School students are required to follow standard protocol (such as hand washing before and after patient contact and adherence to universal protocol) when engaging in patient care. Students who have been diagnosed with a bloodborne disease (such as Hepatitis C, Hepatitis B, or HIV) do not have to disclose this information. However, in an effort to minimize the risk of provider to patient bloodborne pathogen transmission, students are encouraged to refer to the Lifespan policy, found in Attachment 1 attached hereto.

4.0 **Definitions**

For the purpose of this policy, the terms below have the following definitions:

- 4.1 **AMS:** The Warren Alpert Medical School of Brown University (also referred to as “we” herein)
- 4.2 **COLE:** Committee on the Learning Environment. This committee affirms the medical school’s commitment to shaping a culture of teaching and learning that is rooted in respect for all.
- 4.3 **MCC:** The Medical Curriculum Committee oversees the review of curricular content and integration, and evaluation of the medical education program to ensure continuous oversight of such program. (Formerly “MDCC.”)
- 4.4 **OASIS:** Registration and evaluation system designed specifically for medical student information into which student evaluations and grades are submitted electronically.
- 4.5 **OFA:** Office of Financial Aid
- 4.6 **OSA:** Office of Student Affairs
- 4.7 **OSCE:** Objective Structured Clinical Examination

5.0 Responsibilities

All individuals to whom this policy applies are responsible for becoming familiar with and following this policy. University supervisors are responsible for promoting the understanding of this policy and for taking appropriate steps to help ensure compliance with it.

Responsibilities include the department/office of the subcommittee responsible for the Standard; for Standard 12, this is primarily OSA and OFA.

6.0 Consequences for Violating this Policy

Failure to comply with this and related policies is subject to disciplinary action, up to and including suspension without pay, or termination of employment or association with the University, in accordance with applicable (e.g., staff, faculty, student) disciplinary procedures.

Brown's Ethics and Compliance Reporting System allows anonymous and confidential reporting on matters of concern, including privacy issues, through the EthicsPoint platform.

Failure to comply with this policy will be referred to either the COLE executive committee or the Medical Curriculum Committee.

7.0 Related Information

The following information complements and supplements this document. The information is intended to help explain this policy and is not an all-inclusive list of policies, procedures, laws and requirements.

7.1 Related Forms:

- Data Collection Instrument for Standard 12: Medical Student Academic Support, Career Advising, and Educational Records, as submitted to the LCME in July 2020.
- Lifespan policy regarding bloodborne pathogen-infected healthcare workers (attached hereto as [Attachment 1](#))

7.2 Other Related information:

- **LCME Standard 12: Medical Student Academic Support, Career Advising, and Educational Records.** A medical school provides effective student services to all medical students to assist them in achieving the program's goals for its students. All medical students have the same rights and receive comparable services.
 - Standard 12, Element 2: Tuition Refund Policy. A medical school has clear policies for the refund of a medical student's tuition, fees, and other allowable payments (e.g., payments made for health or disability insurance, parking, housing, and other similar services for which a student may no longer be eligible following withdrawal).
 - Standard 12, Element 4: Student Access to Health Care Services. A medical school provides its medical students with timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.
 - Standard 12, Element 5: Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records. The health

professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion of the medical student receiving those services, excluding exceptional circumstances. A medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.

- Standard 12, Element 8: Student Exposure Policies/Procedures. A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following:
 - The education of medical students about methods of prevention
 - The procedures for care and treatment after exposure, including a definition of financial responsibility
 - The effects of infectious and environmental disease or disability on medical student learning activitiesAll registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.

8.0 Policy Owner and Contact(s)

8.1 **Policy Owners:** Subcommittee Standard Offices related to this policy: OSA, OFA

8.2 **Policy Approved by:** Medical Curriculum Committee

8.3 **Subject Matter Contact:** Same as 8.1.

9.0 Policy History

9.1 **Policy Effective Date:** November 2019 (POL No. 12-01 and 12-02), May 2019 (POL No. 12-05), September 2019 (POL No. 12-08.02), July 2019 (for all other policies herein)

9.2 **Policy Last Reviewed:** March 2020

9.3 **Policy Update/Review Summary:** Formatted to comply with the new University Policy template. *Policy No. 12-05 was approved on May 14, 2019; Policy Nos. 12-08.01 and 12-08.03 were approved on February 26, 2020; and Policy Nos. 12-04 and 12-08.02 were approved on March 18, 2020, by the MCC. Policy No. 12-02 is formulated and approved by Brown University's Bursar Office, and was approved as a formality by the MCC on February 26, 2020.*

Key Words: tuition, exposure, health care, excused, disease

ATTACHMENT 1

Lifespan Policy Regarding Bloodborne Pathogen-infected Healthcare Workers

(see following pages)

Rhode Island Hospital
Policy Manual

Subject:
Management of bloodborne
pathogen (HBV, HCV, or HIV)
infected healthcare providers

File Under:

Administration

Admin-69

Issuing Department:

Epidemiology & Infection
Control

Endorsement:

Infection Control Committee

Revision Dates:

9/93;8/99;4/02;8/08;11/10;9/13;
9/15

Original Policy Date:

2/89

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I. Purpose

This policy addresses bloodborne pathogen-infected healthcare workers (HCW) (ie, individuals with direct patient care responsibilities) in an effort to minimize the risk of provider-to-patient bloodborne pathogen transmission.

II. Policy

Although the risk of transmission of HBV, HCV or HIV from HCW to patient is extremely low, a bloodborne pathogen-infected HCW has the responsibility to take appropriate precautions to prevent pathogen transmission. The risk of transmission is related to the HCW's viral load as well as the nature of the clinical activities being performed.

Healthcare workers will not be refused employment or be terminated unless their illness interferes with job performance and/or poses a hazard to patients or other HCWs.

To assist bloodborne pathogen-infected HCWs in managing the risk of transmission to patients, Lifespan provides an Expert Review Panel consisting of specialists in Healthcare

Epidemiology, Infectious Diseases and/or Hepatology, Occupational Medicine and others as needed. The panel will also obtain the expertise of a practitioner in the same specialty as the infected HCW to understand the nature of the HCW's practice. The panel will carry out their responsibilities with strict confidentiality.

Practitioners may access the Expert Review Panel by contacting the Medical Director of Lifespan Employee & Occupational Health or the Department of Epidemiology and Infection Control at their affiliate.

The Expert Review Panel will also be consulted if there is suspicion of a HCW to patient transmission in order to determine the appropriate actions to be taken, including patient notification. There is an expectation that patients should be informed in the case of a possible transmission. All staff is expected to follow the policy on Management of Patients/Visitors Exposed to Possible Bloodborne Pathogens by notifying the Department of Epidemiology and Infection Control and the Risk Management Department.

The Expert Review Panel will use the guidelines in Appendix A to this policy for their recommendations. Appendix B contains answers to questions that infected HCWs may have.

Appendix reference:

Henderson DK, Dembry L, Fishman NO, Grady C, Lundstrom T, Palmore TN, Sepkowitz KA, Weber DJ; Society for Healthcare Epidemiology of America. SHEA guideline for management of healthcare workers who are infected with hepatitis B virus, hepatitis C virus, and/or human immunodeficiency virus. *Infect Control Hosp Epidemiol.* 2010;31:203-232.

Appendix A

TABLE 1. Summary Recommendations for Managing Healthcare Providers Infected with Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and/or Human Immunodeficiency Virus (HIV)

Virus, circulating viral burden	Categories of clinical activities ^a	Recommendation	Testing
HBV			
<10 ⁴ GE/mL	Categories I, II, and III	No restrictions ^b	Twice per year
≥10 ⁴ GE/mL	Categories I and II	No restrictions ^b	NA
≥10 ⁴ GE/mL	Category III	Restricted ^c	NA
HCV			
<10 ⁴ GE/mL	Categories I, II, and III	No restrictions ^b	Twice per year
≥10 ⁴ GE/mL	Categories I and II	No restrictions ^b	NA
≥10 ⁴ GE/mL	Category III	Restricted ^c	NA
HIV			
<5 × 10 ² GE/mL	Categories I, II, and III	No restrictions ^b	Twice per year
≥5 × 10 ² GE/mL	Categories I and II	No restrictions ^b	NA
≥5 × 10 ² GE/mL	Category III	Restricted ^d	NA

NOTE. These recommendations provide a framework within which to consider such cases; however, each such case is sufficiently complex that each should be independently considered in context by the expert review panel (see text). GE, genome equivalents; NA, not applicable.

^a See Table 2 for the categorization of clinical activities.

^b No restrictions recommended, so long as the infected healthcare provider (1) is not detected as having transmitted infection to patients; (2) obtains advice from an Expert Review Panel about continued practice; (3) undergoes follow-up routinely by Occupational Medicine staff (or an appropriate public health official), who test the provider twice per year to demonstrate the maintenance of a viral burden of less than the recommended threshold (see text); (4) also receives follow-up by a personal physician who has expertise in the management of her or his infection and who is allowed by the provider to communicate with the Expert Review Panel about the provider's clinical status; (5) consults with an expert about optimal infection control procedures (and strictly adheres to the recommended procedures, including the routine use of double-gloving for Category II and Category III procedures and frequent glove changes during procedures, particularly if performing technical tasks known to compromise glove integrity [eg, placing sternal wires]), and (6) agrees to the information in and signs a contract or letter from the Expert Review Panel that characterizes her or his responsibilities (see text).

^c These procedures permissible only when viral burden is <10⁴ GE/mL.

^d These procedures permissible only when viral burden is <5 × 10² GE/mL.

TABLE 2. Categorization of Healthcare-Associated Procedures According to Level of Risk for Bloodborne Pathogen Transmission

<p>Category I: Procedures with de minimis risk of bloodborne virus transmission</p> <ul style="list-style-type: none"> • Regular history-taking and/or physical or dental examinations, including gloved oral examination with a mirror and/or tongue depressor and/or dental explorer and periodontal probe • Routine dental preventive procedures (eg, application of sealants or topical fluoride or administration of prophylaxis^a), diagnostic procedures, orthodontic procedures, prosthetic procedures (eg, denture fabrication), cosmetic procedures (eg, bleaching) not requiring local anesthesia • Routine rectal or vaginal examination • Minor surface suturing • Elective peripheral phlebotomy^b • Lower gastrointestinal tract endoscopic examinations and procedures, such as sigmoidoscopy and colonoscopy • Hands-off supervision during surgical procedures and computer-aided remote or robotic surgical procedures • Psychiatric evaluations^c
<p>Category II: Procedures for which bloodborne virus transmission is theoretically possible but unlikely</p> <ul style="list-style-type: none"> • Locally anesthetized ophthalmologic surgery • Locally anesthetized operative, prosthetic, and endodontic dental procedures • Periodontal scaling and root planing^d • Minor oral surgical procedures (eg, simple tooth extraction [ie, not requiring excess force], soft tissue flap or sectioning, minor soft tissue biopsy, or incision and drainage of an accessible abscess) • Minor local procedures (eg, skin excision, abscess drainage, biopsy, and use of laser) under local anesthesia (often under bloodless conditions) • Percutaneous cardiac procedures (eg, angiography and catheterization) • Percutaneous and other minor orthopedic procedures • Subcutaneous pacemaker implantation • Bronchoscopy • Insertion and maintenance of epidural and spinal anesthesia lines • Minor gynecological procedures (eg, dilatation and curettage, suction abortion, colposcopy, insertion and removal of contraceptive devices and implants, and collection of ova) • Male urological procedures (excluding transabdominal intrapelvic procedures) • Upper gastrointestinal tract endoscopic procedures • Minor vascular procedures (eg, embolectomy and vein stripping) • Amputations, including major limbs (eg, hemipelvectomy and amputation of legs or arms) and minor amputations (eg, amputations of fingers, toes, hands, or feet) • Breast augmentation or reduction • Minimum-exposure plastic surgical procedures (eg, liposuction, minor skin resection for reshaping, face lift, brow lift, blepharoplasty, and otoplasty) • Total and subtotal thyroidectomy and/or biopsy • Endoscopic ear, nose, and throat surgery and simple ear and nasal procedures (eg, stapedectomy or stapedotomy, and insertion of tympanostomy tubes) • Ophthalmic surgery • Assistance with an uncomplicated vaginal delivery^e • Laparoscopic procedures • Thoracoscopic procedures^f • Nasal endoscopic procedures^g • Routine arthroscopic procedures^h • Plastic surgeryⁱ • Insertion of, maintenance of, and drug administration into arterial and central venous lines • Endotracheal intubation and use of laryngeal mask • Obtainment and use of venous and arterial access devices that occur under complete antiseptic technique, using universal precautions, “no-sharp” technique, and newly gloved hands
<p>Category III: Procedures for which there is definite risk of bloodborne virus transmission or that have been classified previously as “exposure-prone”</p> <ul style="list-style-type: none"> • General surgery, including nephrectomy, small bowel resection, cholecystectomy, subtotal thyroidectomy other elective open abdominal surgery • General oral surgery, including surgical extractions,^j hard and soft tissue biopsy (if more extensive and/or having difficult access for suturing), apicoectomy, root amputation, gingivectomy, periodontal curettage, mucogingival and osseous surgery, alveoplasty or alveoectomy, and endosseous implant surgery

TABLE 2. (Continued)

- Cardiothoracic surgery, including valve replacement, coronary artery bypass grafting, other bypass surgery, heart transplantation, repair of congenital heart defects, thymectomy, and open-lung biopsy
- Open extensive head and neck surgery involving bones, including oncological procedures
- Neurosurgery, including craniotomy, other intracranial procedures, and open-spine surgery
- Nonelective procedures performed in the emergency department, including open resuscitation efforts, deep suturing to arrest hemorrhage, and internal cardiac massage
- Obstetrical/gynecological surgery, including cesarean delivery, hysterectomy, forceps delivery, episiotomy, cone biopsy, and ovarian cyst removal, and other transvaginal obstetrical and gynecological procedures involving hand-guided sharps
- Orthopedic procedures, including total knee arthroplasty, total hip arthroplasty, major joint replacement surgery, open spine surgery, and open pelvic surgery
- Extensive plastic surgery, including extensive cosmetic procedures (eg, abdominoplasty and thoracoplasty)
- Transplantation surgery (except skin and corneal transplantation)
- Trauma surgery, including open head injuries, facial and jaw fracture reductions, extensive soft-tissue trauma, and ophthalmic trauma
- Interactions with patients in situations during which the risk of the patient biting the physician is significant; for example, interactions with violent patients or patients experiencing an epileptic seizure
- Any open surgical procedure with a duration of more than 3 hours, probably necessitating glove change

NOTE. Modified from Reitsma et al.¹

^a Does not include subgingival scaling with hand instrumentation.

^b If done emergently (eg, during acute trauma or resuscitation efforts), peripheral phlebotomy is classified as Category III.

^c If there is no risk present of biting or of otherwise violent patients.

^d Use of an ultrasonic device for scaling and root planing would greatly reduce or eliminate the risk for percutaneous injury to the provider. If significant physical force with hand instrumentation is anticipated to be necessary, scaling and root planing and other Class II procedures could be reasonably classified as Category III.

^e Making and suturing an episiotomy is classified as Category III.

^f If unexpected circumstances require moving to an open procedure (eg, laparotomy or thoracotomy), some of these procedures will be classified as Category III.

^g If moving to an open procedure is required, these procedures will be classified as Category III.

^h If opening a joint is indicated and/or use of power instruments (eg, drills) is necessary, this procedure is classified as Category III.

ⁱ A procedure involving bones, major vasculature, and/or deep body cavities will be classified as Category III.

^j Removal of an erupted or unerupted tooth requiring elevation of a mucoperiosteal flap, removal of bone, or sectioning of tooth and suturing if needed.²

Appendix B

Q. Should HCWs be routinely tested for HIV infection?

A. A HCW who conducts Category III procedures should strongly consider being tested for HBV, HCV, and HIV. EOHS will provide such voluntary confidential testing.

A HCW who knows that he or she is the source of a patient exposure (ie, as defined by the CDC—a percutaneous, mucous membrane or non-intact skin exposure) to his or her blood or hazardous blood or body fluid should report the exposure and should undergo testing for infection with bloodborne pathogens.

Q. Are there any medical settings in which a bloodborne pathogen-infected HCW should be routinely required to notify patients of his or her bloodborne pathogen status; and, if so, what are the specific types of circumstances requiring notification?

A. Bloodborne pathogen-infected HCWs who are adhering to this policy are not required to disclose their infection status to a patient unless the HCW is the source of an exposure for a patient (i.e., exposed to blood or other potentially contaminated bodily fluid of the HCW).

Q. Should an inadvertently exposed patient be notified of the exposure?

A. A patient who has been exposed (ie, by way of percutaneous, mucous membrane, or non-intact skin exposure) to the blood or potentially contaminated body fluid of any HCW should be notified of the exposure promptly and given clear options for follow-up testing and management (see policy Admin 67).