Association of Occupational Health Professionals in HEALTHCARE

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Centers for Disease Control and Prevention
Division of Tuberculosis Elimination
1600 Clifton Road, NE.
Mailstop E10
Atlanta, Georgia 30333.

RE: Public comment on Draft Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-care Settings, 2005

To Whom It May Concern:

On behalf of the Association of Occupational Health Professionals in Healthcare (AOHP), I am writing regarding Draft Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-care Settings, 2005.

AOHP's public comments regarding this document are as follows:

II. B.3.4. TB screening risk classifications. Page 32

The determination of risk level for Tuberculosis (TB) hazard is defined as greater than or less than three cases of TB seen per 12 months. This fails to consider both the denominator and the potential for encounters with unrecognized patients with active TB disease.

AOHP strongly urges consideration of using the per capita rate of TB in a community as the indicator of risk to Emergency Medical Services (EMS), other first responders, and police personnel not included in B.3.6 as it is much simpler to determine and more reliable as an indicator of risk.

AOHP also urges the inclusion of more specific language for police personnel. "Correctional facilities" does not adequately describe the many police departments without any holding facilities. Exposure to TB in the field is a real hazard that appears overlooked when only correctional facilities are discussed.

Police and fire departments vary in size within the same geographic and demographic boundaries. By using the three patient standard you could have a small department designated very low risk in the same area as one designated higher risk merely due to number of patients seen or transported. In reality, the personnel of both departments could be seeing the same number of patients/suspects per worker and individual workers have equal chance of seeing active cases of TB.

The description in B.3.6 clarifies correctional facilities with medical infirmaries with TB isolation cells but leaves all other correctional occupations with trying to determine the

three patient encounter level. This means they have the same problem as in determining risk.

Police officers encounter TB hazards in the field, in six hour and seventy two hour holding facilities as well as in local city jails without regular medical staff. In short term correctional facilities police often rely on EMS should medical concerns arise. This does not always result in adequate evaluation of detainees with active TB.

In addition, contact investigation of identified cases of active TB does not always uncover prior contact with EMS or police. EMS and police personnel do not always follow up on potential cases to determine if TB was ruled in. While ideally they are supposed to, it just doesn't happen consistently. Tuberculin Skin Tests are an important surveillance tool for these workers who don't always have the same training, skills, or medical backup as in regular medical settings.

"B.3.4 For outpatient, outreach, and home-based health-care settings B.3.4a Classify those with a TB patient count of less than three for the past year as low risk. B.3.4b Classify those with a TB patient count of greater than three for the past year as medium risk.

B.3.6 For correctional facilities where inmates with TB disease are cared for or are housed Classify these settings as medium risk."

II. B. 4.1-4.5. TB Risk Assessment. Page 45. The definitions and explanations in this section are quite complicated. It would be helpful if the information in this section were presented more clearly with some possible examples to further explain the points being made.

G.5.3g. Workplace restrictions. Page 93. AOHP feels it is unnecessary for employees who leave employment to be counseled upon termination of employment since they have already received annual tuberculosis screening and education in the hospital setting. It is quite difficult and unrealistic to capture these employees prior to leaving. Therefore, we feel this is placing an undue burden on such facilities.

K.- K.4.8. Respiratory Protection. Pages 109-114. and Supplement 4: Respiratory Protection. Pages 184-192.

The decision to withdraw the proposed Tuberculosis (TB) standard and require that respirators for occupational exposure to TB be covered by the General Industry Respirator Standard, 29 CFR 1910.134 presents significant concern to our members.

Our concern lies in two areas. They are outlined as follows:

- The General Industry Standard for Respiratory Protection was originally developed for airborne chemical hazards not biological hazards.
- Lack of proof that annual fit testing will in fact reduce transmission of TB when occupational exposure occurs.

Our position on these matters is that the health and safety requirements be based on current scientific outcomes. Annual fit testing has not been proven to be effective in decreasing the spread of TB when occupational exposure occurs.

- **First, the General Industry Standard for Respiratory Protection was originally developed for airborne chemical hazards not biological hazards.**

The original General Industry Standard for Respiratory Protection when published in 1971 and later revised in 1998 was developed for airborne chemical hazards. Protecting healthcare workers from occupational exposure to airborne diseases is different from protecting workers against particulate and/or chemical hazards. Adequate protection for healthcare workers involves a variety of infection control measures that have been recommended by the Centers for Disease Control and Prevention (CDC). These measures have been effective in reducing the transmission of TB to healthcare workers and have not required annual fit testing in the past.

We concur with our colleagues from the Association for Professionals in Infection Control and Epidemiology (APIC) in their 1/21/04 comments to OSHA that "health care facilities cannot measure or accurately determine the potential for exposure and/or the relevance when dealing with patients who may or may not have an infection; who may or may not have an infectious load capable of being transmitted; who may or may not have a way to disseminate their organisms; and who may or may not have an organism that is capable of being transmitted via airborne spread, etc."

To clarify APIC's comments when caring for patients there are many variables that must be considered, unlike chemical hazards. A patient who is coughing up blood does not necessarily have TB. There are other possible reasons for the cough, for example, lung cancer or a blood clot to the lungs. These are the everyday clinical decisions that healthcare practitioners make and that is why the general industry standard should not apply to healthcare.

- **Second, lack of proof that annual fit testing will in fact reduce transmission of TB when occupational exposure occurs.**

Respiratory fit testing was addressed in the Institute of Medicine (IOM) report commissioned by Congress in 2000, "Tuberculosis in the Workplace." The report states "in facilities that admit only the occasional individual with tuberculosis or that have a policy of transferring such individuals, workers are likely to see no or very marginal additional protection from an extensive respiratory protection program." The report also discusses the costs of such a program. It reports that the direct costs estimated in the *Federal Register* are significantly lower than the actual cost of implementing a program.

We are especially concerned about small healthcare facilities in areas where there is a very low incidence of TB. Implementing a full respiratory protection program would be a significant burden in time and resources when the facility may never have a TB patient.

Facilities should be able to determine the need for a TB respirator program based on the annual TB assessment recommended by the CDC.

In addition to the direct costs, the indirect cost of implementing such a program and its impact on the ability of healthcare workers to adequately provide patient care must also be considered. Such a program could 1) impact patient care services, 2) be labor intensive and 3) be a logistical challenge for the most seasoned manager. Given the current scientific evidence the cost/benefit of an annual fit testing program for TB cannot be supported.

We request continued research and updates of standards to reflect the research as it relates to fit testing and tuberculosis transmission. We also believe that the guidance in this draft document needs to be clearer regarding periodicity of fit testing.

Page 187 states that "data on protections against transmission of M. TB in health-care settings are not available and in C.1. Paragraph 2 "Studies have found that a respirator's fit characteristics can be more important than the accuracy of the fit test" further define the problems with making a case for annual fit testing. We believe there are other ways to ensure the health and safety of healthcare workers with more periodic fit testing (i.e. every 2-5 years) with annual education and user seal-checking. Also request clarification on what the definition is of "periodic fit testing". This document refers to both annual and periodic fit testing. It needs to be clearer what is being advised.

Supplement 2: A.6. -A.6.2. Quality Control (QC) Program for techniques of TST administration and reading TST results. Pages 129-131.

We find this area burdensome, costly and beyond what is needed to ensure that healthcare workers who administer and read the TST are competent. There is a large concern for who will train the TST trainers and how they are to remain competent on an annual basis. There is also a concern for the support of hospitals to authorize healthcare workers to be trained due to the cost and the amount of nonproductive time for the employee to become and remain competent. Having healthcare workers trained in nursing departments and elsewhere in the hospital has been one of the main reasons that compliance has become consistently higher. The testing is more readily available, especially as Employee Health Services continue to be moved offsite. We believe that the number of hours for lecture, demonstration, practical work and coaching for both the placement and reading of the TST is far beyond that necessary to administer such testing. AOHP would recommend that for combined placing and reading that the lecture, demonstration be one hour with procedural work and coaching taking place concurrently.

Supplement 4: Respiratory Protection. II. Implementing a Respiratory Protection Program. C. Screening, Page 190

Recommend language change to reflect OSHA language of who can perform the medical screening prior to fit testing. The CDC draft document states that the screen needs to be done by a medical doctor. The OSHA document states a "physician or licensed health care professional (LHCP)" can perform. AOHP recommends that the CDC document

read as follows: a “physician or licensed health care professional can perform”. This would provide consistency between the two organizations.

We thank you for this opportunity to communicate our comments and look forward to an opportunity to collaborate in the development of a standard that would be appropriate for healthcare. Please contact Sandra Prickitt at 415/492-4790 or *prickis@sutterhealth.org* for additional information.

AOHP, a national association of approximately 1000 members, is dedicated to promoting the health and safety of workers in healthcare. This is accomplished through:

Advocating for employee health and safety
Occupational health education and networking opportunities
Health and safety advancement through best practice and research
Partnering with employers, regulatory agencies and related associations.

Sincerely,

Denise Strode, BSN, COHN-S/CM
Executive President