

Docket Office
Docket H-371, Room N-2625
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20201

May 24, 2002

Dear Secretary Chao:

Thank you for the opportunity to submit comments on the final draft risk assessment, peer review comments on the risk assessment, and the report issued by the Institute of Medicine to prevent occupational exposure to tuberculosis (TB).

The Association of Occupational Health Professionals in Healthcare (AOHP) is a non-profit, voluntary organization comprised of health care professionals whose primary responsibility is protecting and enhancing the health and safety of employees in healthcare facilities. Our association represents approximately 1,000 members in the United States. Our membership is comprised of professionals such as registered nurses, nurse practitioners, licensed practical or vocational nurses, physicians, risk managers, safety officers, and human resource specialists. The members of AOHP are frequently responsible for establishing compliance efforts for OSHA standards as well as performing the testing, education, assessment, etc., as required by a standard.

Our members support any regulation that will protect our employees, but we are also cognizant of the cost benefits of complying with a standard. Our members are extremely concerned that this standard may put additional stress on an already overstressed system.

AOHP is unsure if the studies and statistics gathered by OSHA prove that healthcare workers (HCWs) are at an increased risk of developing TB infection or disease as compared to the general public. The studies cited did not adequately control for community sources of exposure. Currently in the United States, over 40% of TB cases involve people born in other countries. OSHA based estimates of risk from hospitals that serve the highest number of active TB patients during periods of peak TB incidence, which can artificially elevate incidence. TB incidence has decreased steadily since 1993 in the United States. A few states and cities have a disproportionate amount of active TB cases.

Most hospitals and health care facilities have implemented Centers for Disease Control and Prevention (CDC) recommendations for the prevention of the transmission of TB since the mid 1990's. This has significantly contributed to ending outbreaks and preventing new ones. Early recognition of symptoms and early isolation of people with

positive symptoms of TB infection is the best line of defense. Engineering controls suggested by the CDC are also effective to limiting transmission.

We support the committee's conclusions that healthcare institutions need flexibility to adopt tuberculosis control measures appropriate to the level of risk facing the HCW at the particular facility. For example, TB skin testing done at a low prevalence facility may lead to unnecessary treatment of a latent TB infection. Excessive testing and treatment efforts would waste limited resources that could be used to support other components of a TB control program.

If a standard is promulgated, AOHP supports the standard to be revised to state that OSHA requirements for skin testing will follow CDC recommendations. We also request that OSHA allow for flexibility for the respiratory protection program. We support that fit testing and education elements of the program be tailored to the risk facing the HCW. Fit testing can be done at the time of hire, when new equipment is introduced or if a physical change has occurred. Our members question the annual fit testing requirement and see it as a burden on an already overtaxed system. Our members do support required documentation of an annual TB skin test or surveillance if unable to place a skin test along with managerial support to remove the employee from work for failure to comply.

In conclusion, AOHP does not feel an inflexible standard is needed to be promulgated to effectively control TB in health care facilities. There is strong evidence that CDC guidelines are effective to control TB. AOHP recommends that the finite resources available should be used in the public health community to control TB by earlier recognition of those at greatest risk. If community cases are identified earlier, then cases coming into the health care institutions will be identified isolated and treated earlier, reducing HCW exposures. Health care facilities are facing continual cost containment pressures while trying to provide quality care with fewer resources. Health care is performing a precarious balancing act trying to treat patients in a cost effective manner while maintaining quality care as well protecting the health and safety of their employees. It is becoming too difficult to spare the resources to comply with unnecessary, burdensome regulatory requirements.

Thank you for the opportunity to offer comments on this issue. If you have any questions, please contact Denise Strobe, AOHP Executive Vice President and Governmental Affairs Chair at 309-624-8529 (denise.strobe@osfhealthcare.org) or Mary Ann Gruden, AOHP Executive President at 412/578-6792 (magaohp@yahoo.com).

Sincerely,

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AOHP Executive Vice President