



ASSOCIATION
OF OCCUPATIONAL
HEALTH PROFESSIONALS
IN HEALTHCARE

Dedicated to the health and safety of healthcare workers

August 4, 2010

OSHA Docket Office
Docket No. OSHA 2010-003
U.S. Department of Labor
Room N2625
200 Constitution Avenue, NW
Washington, DC 20210

To Whom It May Concern:

The Association of Occupational Health Professionals in Healthcare (AOHP) appreciates the opportunity to provide comments on the request for information on exposure to infectious agents where health care is provided. As stated by OSHA there are many factors to be considered when mitigating the risk of exposure to infectious disease with the goal being the safety of the worker. National standards and guidelines currently exist to provide direction for healthcare workers to work safely when caring for patients with infectious disease. AOHP will be providing comments on a number of the questions that OSHA has identified in the request.

Question #1 – Type of setting

As a national association, AOHP members primarily work in acute hospital settings and provide occupational health services for all healthcare workers (HCWs) in their respective facilities. However, our members may work in any type of healthcare setting. Please note that occupational health services (OHS) or professionals (OHP) are frequently called employee health services (EHS) or professionals (EHP) in the healthcare setting. These terms will be used interchangeably throughout the comments. Two examples of sizes of hospitals include one hospital with 250 licensed beds and approximately 1500 employees and a second hospital licensed for approximately 500 beds and approximately 2500 employees. In hospitals the number of licensed beds may not be the actual number of beds that are occupied by patients on a daily basis. For example the hospital above that is licensed for approximately 500 beds on average has 300 of the beds occupied and is staffed accordingly.

Question #2 – Other healthcare settings

In addition to the other healthcare settings identified by OSHA, additional types of settings include stand-alone urgent care clinics, ambulatory surgical centers and dialysis centers. Some types of emergency medical personnel may also work in or outside of the hospital setting. These include paramedics, emergency medical technicians. Other first responders are also at risk of exposure. These workers include fire, police and coroners. Education in the form of “to go” kits or “just-in-time” materials could be developed for them.

Question #3 – Workers at risk

The determination of workers who are at risk of exposure is similar to those at risk for exposure to bloodborne pathogens. A multi-disciplinary team including infection prevention and control (IPC), EHS, hospital safety and managers provide input to identify the at-risk workers. On average, 70-80% of the workforce in acute care hospitals would have some risk of occupational exposures to infectious diseases. These workers include direct care providers such as nurses, emergency medical technicians/paramedics and patient care associates. Medical staff including physicians, interns, residents, fellows and medical students also provide direct patient care. Ancillary departments, including but not limited to, respiratory care, radiology, physical therapy, occupational therapy, speech therapy, electrocardiography and lab staff also have direct care responsibilities. Departments such as housekeeping, dietary, security, case management and pharmacy staff work intermittently in the environment of the patient with an infectious disease.

Question #7 – Adequacy of current standards

Current OSHA standards including the General Duty Clause, Respirator Program, Personal Protective Equipment and Recordkeeping adequately protect the worker who may be exposed to an infectious disease. AOHP views OSHA as the expert on employee safety and the Centers for Disease Control and Prevention



(CDC) as the expert on the spread of infectious diseases. CDC guidelines may change based on available science and what is learned about a disease. Therefore, compliance directives or other forms of direction from OSHA may be more appropriate as a disease emerges and/or changes. These directives need to be communicated in a timely fashion to those in charge of worker safety.

Question #8 – Airborne/inclusion of other infectious agents

Recommendations/requirements must be based on the best evidence that will provide the highest level of protection for the worker while providing care for a patient with an infectious agent whether the agent is spread by airborne, contact or droplet. A major concern of our members is consistency between both regulatory (OSHA) and recommending (CDC) agencies with regard to respiratory protection requirements.

Question #14 – Periodic evaluation

Programs are evaluated annually and more often as needed. An example is the 2009 novel influenza A virus outbreak, H1N1. Facilities created multidisciplinary task forces to address all areas of concern related to the outbreak. These included vaccine supply, respiratory protection, supplies of personal protective equipment including respirators, communication with staff and the community, employee absences, etc.

Question #20 – Safety culture in healthcare

Historically, safety culture in healthcare has primarily focused on the patient as stated by OSHA. AOHP members strive to work with their respective administrations to expand the culture of safety to include employees as an integral part of the safety team. A variety of mechanisms offer opportunities for employees to enhance personal safety. These include safety huddles, safety champions and non-punitive reporting of all safety issues.

One model for safety huddles involves members of the hospital safety committee representing general safety, employee safety, patient safety and other representatives visiting various clinical and ancillary departments to speak with front-line staff about all safety issues. Issues identified then have a follow-up plan developed.

Safety champions are another strategy that can be implemented to enhance employee safety on the front line. Safety champions are peer leaders that serve as safety advocates within a department. They serve as a resource when new policies and procedures are implemented and when questions arise and they are the eyes and ears for all safety issues. Non-punitive reporting of injuries/exposures is promoted with use of the above strategies. Challenges with implementing safety strategies include time constraints of direct care clinical staff to provide safe patient care while maintaining a focus on personal safety.

EHS works closely with the IPC department of the facility. Infection Preventionists work with staff with the goal of early identification of infectious conditions of patients. They develop, educate and monitor staff compliance with practices to reduce exposure/spread of infectious diseases. If an exposure to an infectious disease occurs, ICP notifies EHS and a plan is developed for follow-up of the exposed worker.

Question #21 – Adherence

Maintaining adherence to infection control practices is an ongoing challenge. Most healthcare facilities have made hand sanitizers and handwashing stations available in patient care areas. Blind observation of handwashing practices is one method to measure compliance of this critical practice to reduce the spread of infections. These observations can then be shared with the department staff. Often, healthcare workers believe that if they go into a room only to talk with a patient that handwashing does not need to occur. Individual clinical departments may also develop process improvement projects targeting reduction in infection rates.

Question #23 – NIOSH testing-facemasks

AOHP agrees that there should be a more rigorous independent certification/approval process for facemasks to determine the level of protective properties. Respiratory protection is a key intervention in preventing the spread of airborne illness to healthcare workers. NIOSH should be the testing body for facemasks as it is for respirator certification.



Question #24 – Healthcare worker impaired health

Pre-placement health assessments afford an opportunity for employees to disclose health problems that may interfere with their ability to provide care to certain patient groups. In addition, EHS monitors the status of worker health by return to work programs where employees are evaluated by a clinician prior to return to work. During both pre-placement and return to work visits, employees are afforded an opportunity to relate any infectious disease. The employee can then be counseled about the implications of his/her disease as it relates to their care of patients with infectious diseases. If needed, with the employee's permission, EHS may need to contact the HCW's treating clinician and determine the need for an accommodation.

Question #26 – Recordkeeping for vaccines

AOHP advocates that members follow the CDC recommendations for immunizations of HCWs. We also recommend that vaccination records be maintained routinely for all HCWs. Vaccine recipients are required to review a Vaccine Information Statement (VIS) prior to the administration of any vaccine. The VIS includes relevant standardized vaccine information. Documentation of vaccine administration may be maintained manually or electronically depending on the capability of the EHS office. Follow-up blood work to determine the individual's response after vaccine administration is recommended based on CDC recommendations. Some facilities may require immunity to measles, mumps, rubella and varicella (chickenpox) as a condition of employment. Other facilities may require declination forms (example: influenza) in lieu of receiving the vaccine and counsel HCWs regarding precautions if exposed. If an unprotected HCW is exposed to one of these or another infectious illness, EHS would collaborate with IPC regarding post-exposure prophylaxis, infectivity and removal from work.

Question #27 – Post exposure evaluation and prophylaxis

AOHP recommends that CDC or American Public Health Association guidelines be followed when a HCW is exposed to an infectious disease. If the exposure occurs in the workplace, EHS would collaborate with IPC to identify the HCWs at risk and develop a plan for post exposure prophylaxis (PEP) including exclusion from work. If the exposure occurs outside the workplace, IPC would be contacted to determine appropriate treatment prior to return to work. EHS would clear the employee to return to work based on the recommendations of IPC and assessment of the employee's health status at the time of the return to work visit. It is worthwhile to note that many of the infectious diseases that an employee may be exposed to in the workplace are also prevalent in the community. Therefore, it takes a thorough investigation involving EHS and IPC to determine the etiology of the infectious disease.

Question #29 – Evaluation of health status of HCWs

As a national organization AOHP has taken the lead in educating the new OHP since 1981, the year the association was founded. A full day workshop, "Getting Started: Occupational Health in Healthcare" is held every year as a pre-conference offering at the national conference. The workshop is also offered "on the road" throughout the year in all parts of the country. "Getting Started" provides the basic information for the novice OHP in healthcare and a foundation for the professional to develop competence. In addition, the association's annual conference provides the latest information for the multi-faceted job of the OHP in healthcare.

The "Getting Started" manual addresses the components of pre-placement health examinations. These components include general health history, occupational history, immunization history, tuberculin skin testing (TST) status and current health status. It is recommended that CDC guidelines for two-step TST and blood work to check immunity (protection) to measles, mumps, rubella and varicella be followed. Respirator fit testing may also be performed during the pre-employment health assessment depending on the facility's process. Individual state departments of health may also have pre-placement health requirements (Example: two-step TST and health clearance). A physical exam may or may not be performed based on the facility or state requirement. The most important information about the candidate's health status is gained from the history, TST and lab work. This baseline information can be referred to in the event of an "exposure".

Other functions of the OHP are also discussed in the workshop and manual. Some examples of other functions addressed include:

- TB surveillance program based on risk assessment of the organization (IPC works with local health department to determine risk level)



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- Return to work visits after illness to determine fitness for duty, especially level of infectivity
- Workers' compensation information
- Networking and resources are also discussed. The "Getting Started" Manual contains over 200 Web links, many to the OSHA website, that provide quick and up-to-date information on the current requirements.

AOHP recommends that OHPs collaborate with IPC specialists within their respective organizations to provide early identification of patients with infectious diseases and any exposure risk for the healthcare workers. In some instances EHS professionals have a dual role that includes EHS and IPC responsibilities. Documented occupational exposures are considered work-related illnesses and are covered by each state's workers' compensation statute regarding wages, lost time, medical and legal costs. The illness must be clearly linked to occupational exposure and investigated by both EHS and IPC. One example is methicillin resistant staphylococcus aureus (MRSA). This organism can be acquired both in the community and in the workplace. An employee should report the illness in order for an evaluation and investigation to be conducted. Only after a thorough investigation should a determination as to the origin of the infection be made.

AOHP networks with national organizations such as OSHA, NIOSH and CDC to discuss issues of mutual interest that will ultimately protect the HCW. We value the ability to participate in this dialogue.

Note: Requirements for Hepatitis B are not included as they are covered in OSHA's Bloodborne Pathogen Standard and have not been considered in these comments.

Question #33 – Recordkeeping

If, after investigation, it is determined that the HCW had an occupational exposure that resulted in an infectious disease that met the current OSHA recordability requirements (lost time, medical treatment beyond first aide, etc.) it would be documented on the OSHA 300 log. Therefore, it is not necessary to add additional requirements for recording these illnesses on the OSHA 300 log.

AOHP is a national organization with approximately 1000 occupational health professionals who work in healthcare settings, primarily hospitals. AOHP's vision is to be the defining resource and leading advocate for occupational health and safety in healthcare. Our mission is dedicated to promoting health and safety of workers in healthcare. This is accomplished through:

- A**dvocating for employee health and safety
- O**ccupational health education and networking opportunities
- H**ealth and safety advancement through best practice and research
- P**artnering with employers, regulatory agencies and related associations

Again, thank you for the opportunity to provide comments on this document. Please contact MaryAnn Gruden, our Association Community Liaison, if additional information or questions arise. She can be reached at 412/578-6792 or by email at magaohp@yahoo.com.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Sandra Domeracki', is written over a light blue horizontal line.

Sandra Domeracki, RN, FNP, COHN-S
AOHP Executive President