

Nassau-Suffolk Hospital Council, Inc.

Representing the not-for-profit hospitals serving the residents of Long Island

888 Veterans Memorial Highway, Suite 310, Hauppauge, New York 11788-2940
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- Long Beach Memorial Hospital
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- Rockville Centre
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- North Shore
- University Hospital
- Manhasset
- North Shore University Hospital
- at Glen Cove
- Glen Cove
- St. Charles Hospital and
- Rehabilitation Center
- Port Jefferson
- St. Francis Hospital
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- University Hospital
- Stony Brook
- Veterans Administration
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- Northport
- Winthrop University Hospital
- Mineola

June 19, 1995

John Steelnack
Project Officer
Respiratory Protection Standards Division
Occupational Safety and Health Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

re: **Docket No. H-049 (Proposed Rule for Respiratory Protection)**

Dear Mr. Steelnack:

We have recently been apprised that OSHA intends to incorporate all aspects relating to the use of respirators for occupational exposure to tuberculosis (TB) under the rubric of its forthcoming TB standard and that hospitals and health care providers will still be held to the current standards for hazards other than TB, i.e. asbestos, formaldehyde. While many of our comments in our proposed testimony stem from the application of the respiratory protection standard for protection against TB, we believe that they are still relevant to respiratory protection for hazards other than TB.

While we are declining our testimony scheduled for June 20, 1995, we still believe that the issues we raise in our comments (see attached) regarding the selection of respirators (section d, page 58939), medical evaluation (section e, page 58940), fit testing (section f, pages 28940-58941) and use of respirators (section g, page 585940) are still relevant to other applications of respiratory protection in the health care setting and should be taken into consideration as part of the rulemaking process for 29 CFR Parts 1910, 1915, and 1926.

If you desire further assistance, please do not hesitate to contact me at (516) 435-3000. Thank you for your cooperation.

Sincerely,

Kevin M. Lachy
for Rochelle Battino

Assistant Director, Public Policy and Planning

cc: Mr. Tom Hall
Ms. Susan Harwood, Ph.D.



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April 13, 1995

Docket Office
[Docket No. H049]
U.S. Department of Labor
Occupational Safety and Health Administration
Room N2525
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Re: Proposed Rule for Respiratory Protection

Dear Sirs,

The Nassau-Suffolk Hospital Council, which represents twenty-two voluntary acute care hospitals on Long Island, appreciates the opportunity to submit comments on OSHA's proposed rule concerning respiratory protection as published in the November 15, 1994 edition of the Federal Register. In reviewing the notice of proposed rulemaking, it is apparent that many of the requirements put forth in this proposal exceed current scientifically developed standards and practice for protecting employees against Mycobacterium Tuberculosis in health care facilities in a manner that could add considerable costs without any corresponding increase in safety.

As a general observation, we are concerned that since many of these standards are based primarily on experience in operations in the manufacturing industry, they are not necessarily applicable or appropriate for the implementation in the health care setting. To the extent possible, OSHA should take these comments and suggestions into consideration when developing their new TB standards and, as done with the construction and maritime industries, consider providing health care facilities with their own separate industry standard for respiratory protection. Thus, we offer the following specific comments and recommendations:

Section (c) Respiratory Protection Program, page 58939

Section (c)(2) of the proposed rule states that the employer shall designate a person qualified by training and/or experience to oversee the program. It is our belief that this performance criteria should be based upon the nature of the work setting and allow the employer to choose the best qualified person(s). This section should be clarified to read that the employer shall "...designate a person qualified by appropriate training and/or experience, *as determined by the employer*, to be responsible...". This would be consistent with the CDC's recommendation that the supervisory responsibility for the personal respiratory protection program should be assigned to designated persons with expertise in issues relevant to the program.¹

Section (d) Selection of Respirators, page 58939

Section (d)(2) of the proposed rule calls for employers to provide a selection of respirators in at least three sizes from at least two different manufacturers when using elastomeric facepiece respirators. We question the rationale of OSHA's proposed requirement of employers to stock additional equipment. The proposed standard implies that employers will be required to have available at all times respirators from at least two manufacturers in at least three different sizes. This requirement will impose an unnecessary burden on hospitals, particularly those institutions with several thousand employees. We believe that asking employers to purchase and stock such a selection is cost prohibitive and minimizes hospitals' abilities to hold costs down through utilizing individual vendors.

In addition, it has not been demonstrated that providing such a selection will decrease an employee's exposure to TB or other biohazards. Studies have shown that in cases of TB outbreak in health care facilities, noncompliance with the administrative and engineering measures for control recommended by the CDC were the primary reason for these outbreaks.^{2,3} The outbreaks ceased when these measures were implemented. This standard should be revised to state that "...the employer shall provide *the minimum number of respirator sizes to adequately assure fit, comfort, and availability for all employees.*"

Section (e) Medical Evaluation, page 58940

The requirement for employers to obtain a written medical opinion from a licensed physician for each employee required to wear a respirator for more than five hours per week is unnecessary. It is our understanding from reviewing the Preamble that this is only one of three alternatives put forth by OSHA regarding the medical evaluation provision of this proposed rule. Also, it is unclear from the specific proposed standard (e)(1) on page 58940 whether or not these requirements are only one of three suggested alternatives or are to be part of any type of medical evaluation. The proposal as presented implies that each and every employee obtain a medical evaluation from his/her own personal physician. Furthermore, the employer will be responsible for detailing specific criteria such as the type of respiratory protection to be used, substances to which the employee will be exposed, and special environmental conditions. In the health care setting, particularly in hospitals where employees are required to have annual health assessments and have access to employee health personnel, we believe that the goals of this mandate can be accomplished by giving employers the option to conduct such an assessment via a medical health

questionnaire. Therefore, we support the third alternative put forth by OSHA, which would require a health questionnaire to be administered to all respirator wearers, as a mechanism that is both effective and appropriate. This is a much more logical approach and will minimize the potential subjectivity which may be engendered in proposed section (e)(1) where the individual conducting the evaluation may not have the proper training and experience in judging the potential risks, if any, associated with respirator use. This questionnaire can be administered in conjunction with the mandated annual health assessment given to all hospital employees and will allow employers to identify those workers who require further evaluation.

Additionally, the rule should also allow for an appropriately trained healthcare professional acting under the supervision of a licensed physician to conduct the medical screening evaluation program, as determined by the employer's policies and procedures governing the respiratory protection program.

The employer should have the right to direct those workers in need of further medical evaluations/exams to a designated physician or a licensed practitioner, e.g., an occupational health nurse, acting under the direction of the physician. It is important that the specific procedures to be included in the medical evaluation be left to the professional judgment of the physician or health care professional performing the medical exam, as is allowed under existing OSHA guidelines for respiratory protection.

These recommendations regarding medical evaluation provisions are consistent with the CDC's guidelines for TB control which advocate the use of a questionnaire to screen employees for pertinent medical conditions, the results of which can be used to identify workers who need further examination. The CDC states that the screening could occur as infrequently as every five years. The CDC guidelines also point out that routine physical examinations are not necessary or required.

We are also concerned about the recommended elements of a medical evaluation as described in Appendix C on pages 58947-58948. Although they do not appear to be a mandate on the part of OSHA, we believe that they may be perceived by employees to be required tests which must be performed by their physician. We recommend deleting Appendix C and support leaving the elements of any medical evaluation to the professional judgment of the health care professional performing the exam.

Section (f) Fit Testing, pages 58940-58941

Section (f)(2) proposes that each employee undergo an annual fit test. Due to the fact that there is no documented evidence that performing an annual fit test reduces an employee's exposure to biohazards, this requirement is unnecessary. The annual health assessment questionnaire would be able to detect any changes in a person's visual appearance, such as facial scarring, cosmetic surgery, or an obvious change in body weight, which would trigger another fit test. During the initial fit test, employees receive instructions regarding fit checks each time (s)he dons the respirator. If OSHA's rationale is to assure proper fits, the employee should be delegated the responsibility of notifying employee health when significant physical changes occur for a potential re-fit. Each employee has a vested interest in assuring a proper fit.

Based upon a previously published analysis⁴, the Council has calculated that it will cost our twenty-two member hospitals approximately \$498,338 to fit test all employees on an annual basis (excluding physicians who are not employees of the hospitals) or an average of \$22,651 per hospital. We estimate that the fit testing of each employee will require 40 minutes of time: 20 minutes transit time and 20 minutes to fit test. For all 29,000 FTEs at our hospitals, this translates into 19,333 hours of lost time. This would be the equivalent of the annual time worked by 9.5 FTEs (assuming that each FTE works 2040 hours per year). Given an annual average salary of \$35,000, the annual cost would be \$332,500. The cost attributable to person(s) who will perform the fit testing for employees would be equal to 4.7 FTEs at a cost of \$165,838. Thus the average annual cost would be \$498,338.

We recommend deleting the proposed requirement in (f)(2) for annual fit testing and concerning refitting, we suggest that OSHA defer to (f)(7) which states that "employees shall be refitted as necessary, such as when visual observations are noted regarding an employee's condition which could affect respirator fit."

Section (g) Use of Respirators, page 58940

Section (g)(9) proposes that disposable respirators which cannot be cleaned and sanitized at the end of a task or work shift be discarded. OSHA's October 1993 Enforcement Policy and Procedures for Occupational Exposure to Tuberculosis states that:

If a facility chooses to use disposable respirators as part of their respiratory protection program, their reuse is permitted as long as the respirator maintains its structural and functional integrity. The facility shall address the circumstances in which a disposable respirator will be considered to be contaminated and not available for reuse.⁵

We are questioning OSHA's rationale and basis for this proposed change, as we are unaware of any new evidence to contradict this practice.

In closing, we thank OSHA for the opportunity to provide comments on this significant policy and look forward to elaborating on our comments at the June 1995 testimony.

Sincerely,

Handwritten signature of Rochelle Battino in cursive script.

Rochelle Battino

Assistant Vice President, Public Policy and Planning

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- ¹ Centers for Disease Control and Prevention. Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994. Federal Register, Vol. 59, No. 208; Friday October 28, 1994: 54293.
- ^{2,3} Garner JS, Simmons BP. Guideline for Isolation Precautions in Hospitals. Infection Control 1983; 4: Suppl.: 245-325.
- Dooley SW, Castro KG, Hutton MD, Mullan RJ, Polder JA, Snider DE. Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Settings, with Special Focus on HIV-Related Issues. MMWR Morbidity and Mortality Weekly Report 1990; 39: (RR-17): 1-29.
- ⁴ Adal KM, Anglim AM, Palumbo CL, Titus MG, Coyner BJ, Farr BM. The Use of High-Efficiency Particulate Air-Filter Respirators to Protect Hospital Workers from Tuberculosis -- A Cost-Effective Analysis. New England Journal of Medicine 1994; 331:169-173.
- ⁵ Occupational Safety and Health Administration. Enforcement Policy and Procedures for Occupational Exposure to Tuberculosis. October 8, 1993:1-9.