

**Cal/OSHA Airborne Infectious Disease Advisory Meeting
Non-traditional and Community Based Services
March 16, 2005, 1515 Clay St. Oakland CA**

Chairs: Bob Nakamura and Deborah Gold

Participants

Jennifer Chau, EHC Life Builders, Sobrato Family Living Center

Purva Grover, SEIU UHW

Jon Rosenberg, California Department of Health Services, DCDC

Melvin Steward, IAEP

Phyllis Brown, RN, California Nurses Association

Rupali Das, California Department of Health Services, OHB

Kay McVay, RN, California Nurses Association

Nancy Lewis, CNA, SF Department of Public Health

Marc Pinkas, IAEP

Renee Haynes, Kaiser

John Mehring, SEIU

Linda Jones, EHC Life Builders

Linda Kincaid, UC Berkeley

Kathleen Moser, San Diego TB Control, California TB Controllers Association

Kathy Elliott, California Association of Health Facilities

Mitzi Golden, EHC Life Builders

Kevin White, California Professional Firefighters

Jonathan Sanagun, IAEP

Letia Tybor, IAEP/APIR

Diane Langford, Sutter VNA and Hospice

Melvin Steward, IAEP

Vickie Wells, San Francisco Department of Public Health

Summary of Major Topics

Communication and case identification

Participants identified communication as a key problem, particularly between institutions and agencies. Paramedics and emergency medical services said that they do not receive information about potentially infectious patients when receiving a call. Further, there is a need for better systems for transmitting information back to these agencies about patients they have treated and transported, when they are diagnosed with a significant infectious disease. Some of these communication difficulties are attributed to confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA), although the act may not actually prohibit these communications. Communications can also be a problem within institutions. There was discussion regarding the role of the county TB controllers. Home health providers, paramedics, emergency medical services, and other community-based services may encounter people with unidentified airborne infectious diseases in going into patient's homes or facilities, and there is little guidance regarding how they should protect themselves.

Training and resources

Some homeless shelters identified a lack of training on airborne infectious diseases, and a lack of resources, such as on-site medical personnel, for identifying, evaluating, and isolating people suspected of having TB or other infectious diseases.

Control measures

Some organizations have airborne infection exposure control plans and some do not. The organizations represented at this meeting typically did not have airborne infection isolation rooms or areas. Many participants did not think that five hours was a practical time frame for transferring people who needed airborne infection isolation to an appropriate facility. Many participants agreed that source control measures, such as asking people who are coughing to wear masks or use tissues to cover their cough, would be helpful, but participants expressed a need for public education on these measures. Homeless shelters expressed concerns that these measures might cause clients to leave. Some organizations do not have clear policies about the use of personal protective equipment, and some participants reported that there were problems getting equipment in the field.

Medical surveillance and exposure follow up

There is a lot of variability in testing for latent tuberculosis infection in non-traditional and community based environments, and there is not a shared understanding of who should be tested. Some organizations do not have clear procedures for follow-up for exposure incidents, and it is unclear how people who have been exposed to people with infectious diseases should be notified and treated, and how to deal with their work status.

Detailed Minutes

The meeting was called to order by Deborah Gold at 9:35. D. Gold introduced herself and Bob Nakamura of the Division and welcomed the attendees to the meeting. She discussed the background of events that initiated this advisory group. In summary, federal OSHA dropped their proposed Tuberculosis standard in December of 2003. This action had the net effect of requiring that all employers issuing tight-fitting respirators, such as the N95, would have to conduct annual fit testing. Since Cal/OSHA regulations must be at least as effective as the federal regulations, the California Occupational Safety and Health Standards Board adopted the same regulatory changes. In the public comment period the Board acknowledged the concerns of the health care industry, which requested that the Division convene an advisory committee to discuss this issue as well as the broader issue of a possible standard to deal with airborne infectious diseases. Consequently the Division convened two general advisory meetings in July and November of 2004, and focused meetings for laboratories and law enforcement and correctional facilities in 2005. The reason for the focus meetings has been to get greater representation from those sectors and to give specific attention to these groups, which may have different issues than hospitals and other large providers of health care. D. Gold then summarized the rulemaking process as presented in the Office of Administrative Law's chart. D. Gold explained that the advisory meetings are actually the preliminary

phases of the rulemaking process and are prior to formal rulemaking activities under the Administrative Procedures Act.

D. Gold then asked each participant to identify themselves by name and affiliation and to state their name when making a comment so that the minutes could be as accurate as possible.

General discussion of issues of community based and non-traditional settings

B. Nakamura then began the discussion by noting the content of an article (distributed with the meeting announcement) by Grady that discusses the current trends in health care delivery. The article states that health care services are now provided to a greater extent outside of the acute care facility by home health care, long-term care, and related services. One outcome of this trend is that it is more difficult to provide adequate infection control assessments by professionals at facilities and for the personnel conducting home health care. This would also extend to outreach service centers and shelters. B. Nakamura asked if that problem was observed by participants.

Phyllis Brown agreed with that statement. In one facility, she found that 15% of the patients were infected with MRSA [methicillin resistant Staphylococcus aureus], and specific appropriate actions were not being taken. She has only been fit tested once for a respirator over a number of years, despite having significant weight fluctuations. She has observed that in some home health organizations, nurses are only fit-tested immediately before they are scheduled to go to an appointment where it is known that the patient has an infectious disease.

Nancy Lewis added that although she felt her educational and training background was very good, there was not much content on TB hazards. P. Brown said that she had 15 minutes on TB in college. Mark Pinkas said that his organization represents private sector emergency medical services (EMS). EMS staff confront the issue of possible exposure all the time, and there are numerous other agencies involved in responding to incidents as well, including fire, sheriffs and hospitals. Each group should have an infectious disease officer, but there is one only at the county level. There is also no coordination between agencies in communicating that responders were exposed to a communicable disease. There is no point person for contact and TB exposures are not tracked. Kathy Moser said that it is often very difficult to track who has been involved in responding to an incident. M. Pinkas noted that training standards are different regionally, and there may be several different agencies responding to an incident.

M. Golden asked who does the training. D. Gold asked if EMSA does some training and M. Pinkas said no, it is done by each employer. Under state law, emergency medical services are delegated to each county, and each county has a local EMS agency. Kevin White said that paramedics and firefighters are often the first contact with people who have infectious diseases, and they have no knowledge of the person's status. There is a lot of concern expressed about the confidentiality of the injured, he said, but there is no one model for coordinating communications and no oversight for OSHA-related issues. Each agency or region tends to want to handle the situation their own way. There needs to be central regional coordination for infection control. M. Golden noted that there have

been many training programs marketed for HIPAA [Health Insurance Portability and Accountability Act of 1996] but there have not been any for TB. M. Pinkas responded that the employer is required to provide in-house training programs. He said that there is a lag of several days at least in communication between agencies because each agency has different procedures for transmitting and handling the information. Also, each agency deals with exposures differently. M. Moser said there needs to be something like a “chain of custody” for individuals with infectious disease. The TB controller may not get involved for a month or more. San Francisco is one of three model centers for TB training.

John Mehring noted that many participants in this process had been involved with the concerted effort to adopt the bloodborne pathogens (BBP) regulation over a decade ago. The effort led to development of a full-blown OSHA standard to address the issues, and every agency now uses it as its guide. With infectious diseases, there is not as much consensus as to how things should be done or even which diseases to include. There is a Cal/OSHA P&P [Policy and Procedure], but it’s not a regulation, and the lack of regulation leads to laxity. We’ve done a good job on bloodborne diseases, workers are much better protected now than 20 years ago. If controlling respiratory infectious diseases is a priority, there needs to be a regulation. With this process, there should be more focus. Even the proposed TB standard was not successful, and now there are a number of emerging diseases and other exposure issues.

Vickie Wells agreed that it is difficult to notify the right people when you find an infectious patient, and that agencies deal with it in different ways.

Jonathan Sanagun said that it seems that the training is being done about the disease, but everyone does it their own way. There needs to be an infrastructure based on a regulation to establish parity among all organizations in the state. It seems that within a hospital, the information about a patient is passed along fairly well. But it doesn’t work as well outside the hospital. They may not know who to notify. For example, at the gas pipe explosion in Walnut Creek, many agencies responded, and patients were quickly dispersed across the county. There is no infrastructure regarding how each health officer communicates with other organizations about an infectious patient. M. Pinkas noted an incident where personnel from different organizations were exposed to pertussis. Each agency responded differently, some took people off work, while some were not immediately notified, and employees were sent off on emergency runs. It was all left up to the employer.

M. Moser said the county health officer should be the person to ensure that there is coordinated notification and response. K. White noted that the health officer is often not available during off hours. M. Pinkas said that the exposure occurred on a Saturday, and they were not notified until Monday morning.

Jon Rosenberg commented that a lot of these issues had actually been discussed in previous advisory meetings, going back more than 20 years. When BBP was first discussed, the group considered making it an infectious disease standard, but decided to restrict it to BBP because of the differences in the exposure routes. For BBP, it makes

sense to require universal precautions. With airborne disease, you only take precautions if you suspect or identify disease. The airborne disease precautions would start with isolation. However, for homeless shelters, there is little or no isolation available. You need different approaches, for high-risk situations and for situations where there can be airborne isolation. What about non-diagnosed patients in situations where there is little exposure? You can't put everyone in a respirator. It would be good to know how BBP is working in home health care. Who can do the training that would be necessary? For example, with the BBP standard, training was induced by the requirements and it is not that hard to get training on BBP done. You also need to see where BBP approaches will not work well, for example, for post-exposure follow-up; it would be difficult for OSHA to require one employer to notify everyone. The basic problem is that the communication system and privacy requirements are a patchwork of laws and regulations. The Ryan White Act requires employers of EMS staff to have a designated officer to follow up on exposures. State law requires local health officers to inform EMS regarding infectious disease exposures, but doesn't say how that person is supposed to get the information. Many links of the chain are in state law, and he wouldn't expect OSHA to fix that. The need is for systems at the local level, and a regulation along that line would be helpful. Now EMSA is the only state agency with that type of authority.

D. Gold noted that at every meeting, some aspect of communication is reported to be a problem. Some issues are attributed to HIPAA, but it is not necessarily true that HIPAA prohibits certain communications. She said that she and Bob would look at putting more about communication into the draft standard.

M. Pinkas said that one good aspect of the BBP standard is the requirement for engineering controls. For instance, newer ambulance designs have less ventilation of the patient area, when they could open the front and back windows to get airflow. Now they are in an enclosed compartment, and the exhaust fan may not work. K. Moser asked why the ventilation has been reduced, and M. Pinkas answered that it is cheaper. The ventilation in helicopters and other aircraft is worse than vehicles. J. Mehring noted that a similar issue about vehicle ventilation had been brought up at the law enforcement meeting.

Linda Jones said that she works with homeless shelters, and they are considered to be at high risk for TB. But the health department has only contacted her once about a possible case. D. Gold noted that TB is an established concern in those settings, but there are other diseases that are of possible future concern such as avian flu and SARS. J. Rosenberg said that the biggest concern for shelters is TB but an emerging concern is MRSA. A person can be infectious for a long time, before they are detected and exposures are traced. Another issue is chickenpox. Although the person is infectious for only a short period, the primary concern is exposures to pregnant women. M. Golden added that scabies is also a major concern.

J. Sanagun asked the shelter staff if they had been given very much training. L. Jones said they had some training regarding protection from bodily fluids. M. Golden said that HIPAA concerns prevent them from collecting certain information. J. Sanagun said that

they needed to protect themselves, their co-workers, and their families. J. Rosenberg noted that shelters are somewhat unique as institutions, as they are not licensed, so they are not required to take the same actions that licensed facilities are. He asked if there was any move to require licensing by the Department of Social Services, and M. Golden said she was not aware of any. J. Rosenberg said that it is left to the local health departments to deal with homeless shelters, which are often in dire straights for money. M. Golden said that she would be pursuing ways to provide additional training. K. Moser asked if OSHA applies to homeless shelters. J. Rosenberg said that Cal/OSHA can conduct inspections for health and safety issues, and that the shelters should have an IIPP (Injury and Illness Prevention Program). Cal/OSHA would investigate if there were complaints. V. Wells noted that shelters also have unique problems such as using loaned facilities and staffing by many volunteers. D. Gold explained that Cal/OSHA has done inspections of shelters. TB is still a problem in shelters, and when it does emerge, it is a serious concern. There are also other impacts. For example, sometimes if employees perceive that adequate precautions are not taken, they will decide it is too risky to work there, and will quit. There are other work places that, similar to homeless shelters, include volunteers, such as hospitals, and there are also a lot of temporary staff in hospitals.

M. Golden said that they do training on conflict management, sexual harassment and other risks encountered on a daily basis. J. Sanagun said that employees receive training on perceived risks, but EMS responds to homeless shelters on a daily basis. He asked whether homeless shelters are notified about infectious cases. M. Golden said that in her cases, the health care facilities did realize where the patients had stayed. They also have staff from Valley Medical who come on site daily at the large sites.

Jennifer Chau that she had a recent scabies incident to deal with in an independent living facility, and she had to do research how to handle it. They didn't know the client had scabies. She had concerns about notifying clients because of HIPAA. M. Golden said that there are some shelter collaboratives, and that in their group a person had started a safety and security committee. V. Wells said that there's a big range of establishments that are called shelters. Some are emergency shelters that are set up on a temporary basis, and some are transitional living situations.

J. Rosenberg asked if the county TB control officers take an active interest in homeless shelters. K. Moser said that they don't have homeless shelter guidelines. Each TB control officer takes their own approach. Federal funding requires that the TB controller has a TB education plan, which can include homeless shelters. She said that they think that they are getting out into this community, but the example today from Santa Clara shows there's more to be done. V. Wells said that the San Francisco controllers are very active. Kay McVay said there seems to be a serious lack of communication. BBP succeeded because of the media coverage of the problem, but there is no coverage for homeless issues. There are also many fewer public health nurses, and they are the ones who used to actually do the contacts. Now, in LA there are only 3. Public Health should have been the cornerstone for dealing with these issues. There should be a central point for health care facilities to provide information to EMS. There shouldn't be such a long delay. She

asked whether there is some way to notify EMS about an infectious patient when they go to pick that person up.

K. Moser said that there is no mention of employer's reporting cases to the health department in the draft standard. She said that she would rather hear from eight different people about a suspect TB case, then to not get a report. J. Mehring said that employers would probably contact their workers' compensation carriers regarding an exposure incident. J. Rosenberg said that communicable disease controllers are required for every county as part of the bioterrorism grants. This controller should be available 24-7. Emergency disaster response plans are being developed, and one key is trying the plan. The system won't work if it's not triggered. V. Wells said that this program is geared towards big events, not for a single patient. It might deal with SARS, but would omit less serious diseases like chicken pox. J. Sanagun asked if the implementation is audited, and J. Rosenberg said the auditing started a year ago, and there is supposed to be testing. Nancy Lewis said that she felt fortunate to work for the SF department of public health, which has a largely intact structure, with clinics and TB surveillance. But it's a continuing battle for funding. TB is basic, and has been with us forever.

B. Nakamura summarized that it appears that the group has identified communications as a big issue, for EMS, and between agencies. We need to look at addressing this issue through the exposure control plan – with specific or suggested language. The homeless shelter issue is complicated, as only some control measures, such as awareness training, are practical. He asked if there were further comments on this agenda item.

J. Mehring said that another type of workplace that should be considered for inclusion in this standard are some social services offices, such as intake offices. An SEIU representative for many employees in this type of establishment was unable to make this meeting. J. Sanagun said that outreach officers are concerned about TB exposures, and they are not getting annual testing. There was a case where a coworker got active TB. There is also a lack of communication causing significant lag time. Intake workers are at high risk; their testing, education, and communication issues need to be addressed. He had some concern regarding attempting to test too large a population, but felt there should be some provision for intake workers at high risk.

V. Wells said they offered TB testing to SF social services staff. Despite a massive education effort only 15 people in a group of 1000 elected to participate. She thought it might be because people didn't want to be stuck with a needle for the test. She also asked about the status of Quantiferon. K. Moser said that the new generation of Quantiferon had just received FDA approval, and that San Francisco appeared to be leading the charge. She asked where you would draw the line about coverage, for example do you cover a clothing store on the border, or the DMV, where people are on line for long periods of time? J. Sanagun said that the issue goes back to social economic status, but it's not only SES. A case can be made for some scenarios in which there is higher risk, such as some social services facilities that require a long interview process. V. Wells added that she is specifically concerned about a higher risk in medical social services offices, because people who come in are often applying because they are ill. J. Sanagun asked why the

employer didn't require the employees to be tested. V. Wells said that these are not employees designated for testing by any agency, and testing hadn't been made a condition of employment. Education was done, and done well, and they worked with the unions to advocate for the program. The first year the response was low, and in subsequent years it was dismal.

There was a general discussion about individual rights applying to testing. J. Mehring noted that there is wide variability on who gets tested for TB. Kaiser, for example, tests very broadly. V. Wells said that the SF health department tests. K. Moser said there is supposed to be annual testing in San Diego in jails, but the union is against forcing employees to be screened. J. Mehring said that the only group of workers required to be screened is health care workers at high risk, under Title 22. V. Wells noted that Title 22 used to require more people to be screened.

There was a lunch break and the meeting resumed at 12:40.

Control Measures

D. Gold introduced the discussion of control measures such as isolation rooms and ventilation. She said that the Division does not expect the non-traditional settings to have negative pressure rooms and noted that the language in subsection (d) largely came from the proposed federal TB standard. The idea is to isolate the source with a room, with a mask, by distance, etc. Then, be able to move the patient to an airborne infection isolation room within 5 hours. She asked whether this provision would work in the settings being discussed. The general response was that the time frame was not practical. D. Gold noted that at the corrections meeting, people asked if there were some way to get help from the TB controller to arrange a transfer. She asked what happened in homeless shelters.

M. Golden said that most people seeking shelter come in between 3:30 and 5:00 p.m. so the idea of getting them moved within five hours is not practical. V. Wells said that they often come late, once it gets cold, and that can be after midnight. D. Gold asked what happens when they are admitted. M. Golden said that if they knew about an illness, they would notify Valley Medical for guidance. L. Jones said that just because a person is coughing it doesn't mean they need isolation. V. Wells said that a lot of people come in coughing especially in the winter. K. Moser noted that the staff needs to know how to determine whether a person is suspected of having TB. She asked about the origin of the five hour timeframe. D. Gold said she was not sure of the exact reason for five hours, but she thought they were generally trying to place a time limit on exposures to employees, so that they were not left in under-controlled conditions for indefinite periods of time. [In the documentation for the proposed federal standard, OSHA cites a study by Moran et al that "shows that emergency departments that made a presumptive diagnosis of TB were able to initiate isolation in an average of 5 hours from the time of patient registration (Ex. 7-251)."]

K. McVay said that with the homeless, if you start isolation and other procedures, you may lose the person from the shelter. Many homeless people have psychological issues

that would prevent them from either accepting using a mask, or accepting being separated or confined. So they are often inclined to just leave. M. Golden said that the county hospital is a 24-hour facility. V. Wells said that was true, if there were a way to get them there. You could only refer them to the emergency room, and they might not stay, as compared to waiting until the morning, and referring them to the TB clinic. They have had some success in getting people to wear a mask. There is no room in most shelters for an isolation area. K. Moser said that there is no one solution for all situations. The best thing is for the standard to require a plan. If there has to be a time frame, twelve hours would be more reasonable. D. Gold asked what action a TB controller would take if a shelter notified them of a homeless case. K. Moser said that it varied by county, but if she were notified about a potential case, they would send someone out to evaluate the person. V. Wells said that their on-site nursing staff evaluates the patient, and their suspect cases go directly to the TB clinic. D. Gold asked if they call for a van, and V. Wells said they do.

M. Pinkas asked, why we are focusing only on TB. D. Gold said that the CDC (Centers for Disease Control and Prevention) only requires airborne isolation for a few diseases, including tuberculosis, chicken pox, measles, small pox, and recently SARS and monkey pox. Cal/OSHA would have problems going beyond the CDC guidelines in requiring airborne infection isolation for other diseases. K. Moser concurred. D. Gold noted that as a control for EMS, this particular section doesn't apply. V. Wells said that they have a system for transporting cases requiring isolation to a hospital. K. McVay said that the facility should notify the EMS regarding the infectious status of a patient. P. Brown said that in home health they have a form the patient signs giving them permission to provide information to paramedics. M. Sanagun said that there shouldn't need to be a form to tell EMS about infection risks. He said that EMS are not told about infection risks all of the time, and that HIPAA and other excuses are used for not providing the information. L. Jones said that they are not permitted to share info without a sign-off, unless the person is a danger to themselves or others. M. Golden said that there is a need to train employees in facilities regarding legal responsibilities in sharing info with EMS. L. Jones repeated that they could not share information on a person's disease status without a sign-off. J. Sanagun said that they can provide information if they are calling paramedics because they suspect an infectious disease, and they can tell the paramedics if they are calling because of TB symptoms. K. Moser agreed that HIPAA is a pervasive problem. D. Gold said that there are some exceptions in HIPAA permitting information to be given if the information is legally required to be provided. She said that she and B. Nakamura would try to get some clarifications about the HIPAA issues from our legal unit. Mr. Sanagun noted that there are many situations where HIPAA is used as an excuse not to do something. Kathy Elliot said that when HIPAA came out, everyone was scared of getting sued, and felt it was better to be careful when not sure.

J. Sanagun asked how long it takes to transfer a case in long-term care facilities (LTCF). K. Elliot answered that most facilities do not take active TB cases, and when it is discovered, they immediately transfer them, unless they have an isolation room. V. Wells said that typically they don't have isolation rooms. K. Moser said that they do have to wait for a bed to open up, and they keep the patient at the site to keep them from going to

the emergency room while waiting. J. Mehring asked how long a transfer time is needed in LTCFs. K. Elliot said that sometimes 5 hours is more than enough, but some places can't do it within 5 hours. Ms. Gold said that there could be ways to provide additional time, such as intermediate care plans, or contingency plans. K. Elliot said that she could poll some of their sites to see what actually exists. D. Gold said that would be great, and also to see if there are plans already being used by facilities. One of our goals is to encourage pre-planning.

V. Wells suggested putting a requirement for pre-planning into the regulation. Times should also be based on the specific disease. While staying a few hours might not be a big risk for TB that might not be true for other diseases, such as SARS. Rather than putting in a fixed time limit, the regulation should allow for a decision to be made by a medical provider. J. Mehring asked whether a LTCF with double-occupant rooms would implement respiratory precautions if they can't immediately transfer a patient. K. Elliot answered that there should be a plan for that, and the facility would relocate one of the occupants. K. Moser said that the LTCF were easier, because there are medical providers present. She asked what kind of resources were available to homeless shelters, and whether they could move someone in 5 hours. M. Golden said it depends on the time of day, and said it is better to have it planned out in advance. D. Gold said that sometimes you need a time frame, because otherwise, as happened recently in a correctional facility, you could have an infectious patient stay in a facility with inadequate isolation for two weeks. But it sounds like people are saying that five hours is too short in many cases. V. Wells said that five hours is very difficult for the shelters she is involved with.

J. Mehring said he was concerned about home health, and asked where the TB patients are staying, at home or a hospital? K. Moser said that most TB patients start at a hospital, which will discharge them based on certain criteria. P. Brown said that SNIFs won't take patients without PPD, so they test them in the morning, and then transfer them to the facility, where they are read in the following days. V. Wells said that the LTCFs would probably be able to comply much more easily than with the home health situation. The health care worker going to the home may know what the patient has, but may not know what other residents have. K. Moser added that there are others who come into the home, including home health nurses or relatives, which makes it hard to track contacts. She asked if it was possible to put a sign on the door indicating the presence of an infectious case. There was discussion regarding placing signs indicating an infection control risk on the door or inside a residence to warn home health providers and EMS, but many people thought there would be a number of problems with that, including discrimination and civil rights issues. R. Harris noted that DNR orders are placed on the refrigerator in her home health agency. D. Gold said that this discussion again emphasized the problem of communication between agencies and providers, but it was unlikely that Cal/OSHA could or would require signs on people's homes. M. Sanagun noted that other signs are placed, such as those informing emergency personnel that there is a disabled person in residence. D. Gold said that those signs are voluntarily placed by the resident.

D. Gold said that one of the problems in home health is that besides the patient, there may be other residents with TB or other diseases. So, do you mask everyone entering a

home? Currently, that would be unacceptable. Some home health agencies only do an initial phone intake, and a home health aide may be the first person to actually enter the home. That person doesn't have sufficient training to assess infectious disease risks. Employers need a plan for what to do if there is an infectious disease risk in the home, and they need someone to evaluate whether there is a problem at a given home. M. Pinkas asked whether the home health aides are provided with training. V. Wells said that home health aides aren't doing medical procedures. R. Haynes said that her organization specifies that the first person visiting a home must be licensed.

K. Moser said that there are some circumstances in which it is allowed to post a sign saying that a person has infectious TB. V. Wells said that the health department can do it, but there might be some opposition. The county public health officers have that authority, but wouldn't do it under normal circumstances. K. McVay said sometimes patients have no idea what diseases relatives or other people in the home have, and the nurses going into that home have no idea either. Shelters also don't have information, and the people coming to shelters, particularly for the first time, don't have any idea either. She said that she remembers quarantine signs, and what it meant to have them posted, and to put labels on people. That is not a workable system now. V. Wells said that for their home health workers the problem often isn't the patient, and that's the same for EMS. You don't know what's going on in the home, you're lucky to get information on the patient.

M. Pinkas asked what to look for in identifying the disease requiring airborne infection isolation. D. Gold said that initial disease recognition is difficult. Many diseases look the same on initial presentation. That's why the advisory group has been recommending some initial precautions for general symptoms such as cough hygiene, and also pre-planning. She asked people to continue to provide ideas and feedback on this portion of the proposal.

K. Elliot asked what the timeframe is for developing this new regulation. Would there be a new regulation this fiscal year? D. Gold said that was not likely to happen. She said that the plan is to have another general advisory meeting in southern California. After that, the Law Enforcement group wants to have another separate meeting. She said that it is possible to have another meeting specifically for home health, paramedics, long term care, etc., but in the end, a lot of what people are saying here is that there needs to be more communication with hospitals and other facilities. So probably it would be better to bring these issues into the general meeting. Another part of the process is the laboratory section, which has had one subcommittee meeting. She said that optimistically, the earliest Cal/OSHA would have a proposal to the Standards Board is the end of this calendar year.

Scope

V. Wells asked about employees exposed to animal sources? There is monkey pox, hantavirus, bovine TB, etc. J. Mehring said that there needs to be further discussion regarding including at least some social services operations in the standard. D. Gold said that in this draft, the pre-planning document is the exposure control plan and it pretty much tracks the bloodborne pathogens program. She asked if paramedics had ECPs to

address airborne infection risks. M. Pinkas said the bigger ones do, but due to money, the smaller ones don't. A lot of companies have don't have masks on their ambulances, and noted that Cal/OSHA doesn't inspect employers without a complaint. V. Wells said that there are infection control plans and policies are already in place in her organizations, but they don't all meet the requirements in the draft. K. Moser noted there is a template to produce a TB control plan available from the Curry Center [<http://www.nationaltbcenter.edu/index.cfm>]. J. Mehring said that all major health care systems had infection control plans. J. Sanagun said employees often are not aware of what the employer should be doing. J. Mehring said the plan for airborne infectious diseases should be with the BBP exposure control plan. V. Wells said it would be good to combine them into one. M. Pinkas noted that ambulance services cannot be accredited without a BBP program, but K. White said that depended on the county.

Personal Protective Equipment (PPE)

J. Sanagun asked K. White if in his experience masks and other PPE were readily available. K. White responded that in fire departments each person has a fanny pack with isolation equipment. He noted that fit-tests and respiratory protection are a part of fire department procedures, but a lot of departments don't realize that they should fit-test N95s. D. Gold said that in one county, the fire chief had told firefighters to wear turnouts as PPE, and that had been brought to Cal/OSHA's attention. V. Wells said that some fire departments are using the same mask for the SCBA and for air purifying full facepiece respirators, so there's only one fit test required. K. White said the biggest problem is going into the unknown, and when to use PPE. There are a lot of questions about application. When is a post-exposure evaluation necessary, how often should they do TB screening? No one says, this shall be done, and there are too many opinions.

There was a general discussion about TB screening tests and that the recommendations are changed in the new CDC guidelines. K. Moser said that annual screening is generally okay. Only people who do higher risk procedures, like sputum tests, are screened more frequently.

Source Control

Bob Nakamura introduced the discussion of source control measures, such as cough etiquette. M. Golden said that this would be totally new for shelters. Some people would participate, and some people would leave if asked to wear a mask. Many people are coughing in shelters. L. Jones said that it would deter people from coming in. People would see masks, and be afraid. Melvin Steward asked if that would be true even if the cough etiquette was explained to them. K. Moser said that one problem is in a shelter, there is no end point for the precautions. How long is the person to use the mask? That's unlike health care, where the initial precautions are used until the patient is evaluated, at which point they may be discontinued. M. Pinkas asked how Cal/OSHA could regulate the clients in a shelter, and B. Nakamura said that, for example, a regulation would require the shelter to explain things to the client and give them a mask. K. White said there's a learning curve for the message, and as the message gets out, it will be easier. M. Pinkas said that already you see people in airports using masks.

M. Golden said that there is no funding for shelters to do this, and suggested that Cal/OSHA fund it through grants. K. McVay said that there is a general need for funding to implement these programs in shelters, and one source might be the California Wellness foundation. M. Golden said she saw some up-front challenges in implementing a program and suggested that maybe hospitals could partner with shelters. J. Mehring said that implementation of source control measures is a challenge for everyone. Education is needed. Health care workers and other front-line workers are already under stress, and asking them to do something that people may be offended by exacerbates that. There's a need for general education for the public. There should be a handout for the public. But it can be done. Other protective measures like condoms and clean needles have been introduced and are now practiced and accepted. Public health departments should help homeless shelters. We need to problem solve as a group. V. Wells said that surgical masks are available in San Francisco's public health clinics and shelters, but they have mixed success with getting people to use them. Sometimes the staff won't even approach a client to use them because there are concerns about combative behavior.

D. Gold asked her what is the endpoint is for masking, is it medical evaluation? V. Wells said that there is a question about how people get medically evaluated. Most shelters do not have medical staff. M. Golden said that they have 12 sites. Only the largest site has medical staff, some others have mobile vans that come on certain days. K. McVay said there is a big lack of public education over the use of masks, tissues, hand washing, etc. When they first instituted universal precautions, they had to change from the existing mindset that you shouldn't put on gloves or a mask because it offends the patient. We need to think about how to educate people. In a shelter, they want to get people in. They don't want to cause them to leave. M. Golden agreed that they were concerned about driving them away. K. McVay said that controlling infectious diseases earlier would ultimately lower costs. M. Golden said that is the reason they contract with Valley Medical.

V. Wells said that they put out masks and signs, and some people do use them. J. Mehring said that when people see others wearing masks, it makes them think. K. Elliot agreed said there is a need for public education. You need to start with the public being concerned, with people not wanting someone around coughing. You can educate people in shelters and other venues. There could be commercials. J. Mehring suggested lobbying CDC to promote source control with the public, since it's their recommendation. K. Elliott said that at her facility they have staff whose job it is to do education on hand washing.

Medical Surveillance

B. Nakamura introduced the discussion of medical surveillance. He said that there seemed to be agreement at previous meetings that having the employer offer immunizations is a cost-effective measure that protects employees and patients. There has been some concern about requiring declinations for annual flu shots.

V. Wells said that most health care facilities provide immunizations, it's not a big financial burden. J. Mehring said that he had heard that many LTCFs often don't provide

them for cost reasons. J. Sanagun said that many smaller EMS providers and volunteer fire departments don't provide vaccinations. V. Wells said that San Francisco provides vaccinations in LTCFs. Rupali Das said that there is not a good rate of flu vaccinations under current programs. V. Wells said that a lot of people don't take them, and she can try to get the numbers from the Department of Public Health. J. Sanagun said that the flu vaccination participation is different, because a lot of people don't get the vaccine because they don't usually get the flu. P. Brown said that there is pretty high vaccine compliance in home health. J. Mehring asked if that's because they saw themselves at greater risk. R. Haynes said they bring the vaccine to staff meetings, and their own staff does the vaccination. V. Wells said she had mixed feelings regarding obtaining declinations for flu shots, because it would increase vaccinations, but it is a huge record-keeping burden.

K. Elliott said she had concerns regarding the 10 day time frame for providing vaccines. V. Wells asked about obtaining a titer for measles and varicella, and whether the time frame was sufficient for that. M. Golden asked if administrative people were exempt from vaccination requirements, and B. Nakamura said they were. M. Golden asked J. Mehring if Kaiser did everyone, and he said they did, but that is Kaiser's policy. V. Wells said that SF Department of Public Health also provides flu vaccine to all employees. M. Golden asked if the employee can decline vaccine. R. Haynes said employees can decline hepatitis B vaccination and flu vaccine, but can not decline PPD.

Exposure incidents

K. McVay noted that in hospitals TB cases are often initially diagnosed as pneumonia. The patient may be discharged by the time they find out it is TB. She isn't sure that everyone who has treated the patient is informed. In the ICU they have more control over exposures, there is less on general medical-surgical units. R. Haynes said that various providers enter patient rooms. V. Wells said that we should talk to TB controllers regarding contact tracing, and not duplicate what they do. D. Gold noted that this draft refers to covering the exposures within the facility, and that the employer is required to the best they can. J. Sanagun asked if the TB controller is a 24 hour operation, and V. Wells said they do not need to be. K. White said that again the concern is communication. K. McVay said there needs to be a single communications point for ambulances, nurses, etc. to notify. We don't have that. M. Pinkas agreed that there should be a central person for the employer to report to. He said that the only person who knows what's going on for them is the local EMS agency. V. Wells asked what constitutes an exposure incident, how broadly is it defined? Is it only the diseases requiring airborne infection isolation? M. Pinkas said that EMS personnel get sick more than others because they are in the back of the ambulance. They have had to push to make it a workers compensation incident if they get the flu, or chicken pox.

Medical removal

V. Wells said it is good to have medical removal protection, particularly when an employee is not sick but may be infectious after an exposure incident. Otherwise, what do you do with them? Infection control says to keep them away from patient contact, but what about other employee in non-patient areas. For example, some people were exposed

to chicken pox, and were sent home and required to use their own leave. Medical removal protection would deal with this problem. M. Pinkas agreed. He said that workers' compensation doesn't cover it, if you're removed because of the possibility of being infected. V. Wells said that this provision would be do-able, if it were limited to the few diseases requiring airborne infection isolation.

Next Steps

D. Gold thanked everyone for their participation, and said that the next step would be for Cal/OSHA to produce another draft, and then hold another meeting, possibly in southern California. People can call D. Gold or B. Nakamura, or send e-mails with any further specific suggestions or comments.