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August 4, 2010

David Michaels, PhD, MPH
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

SUBJ: Public Docket No. OSHA-2010-0003

Dear Dr. Michaels:

I write on behalf of the Infectious Diseases Society of America (IDSA), a national medical society comprised of more than 9,000 infectious diseases physicians and scientists devoted to patient care, education, research, prevention and public health. IDSA appreciates the opportunity to comment on the Occupational Safety and Health Administration's (OSHA) Request for Information (RFI) on occupational exposure to infectious agents in settings where health care is provided and health care-related settings.

Patient and health care worker (HCW) safety is of utmost importance to IDSA. As such, we wish to lend OSHA our expertise during every step of your investigation into methods that will ensure greater protections in health care and health care-related settings. While we understand OSHA's interest in creating a standard that maximally protects HCWs from infectious agents, we have concerns about the potential scope and breadth of this potential undertaking. The advantages of establishing a new standard for HCWs can be easily outweighed by the unforeseen consequences caused by such a standard, particularly if the standard is not supported by scientific evidence. For this reason, we implore OSHA to directly involve expert stakeholder groups, such as IDSA, while investigating the need to create such a standard.

With this RFI, OSHA appears to be moving in a direction similar to its blood-borne pathogen standard in terms of focusing on regulating exposure to infectious agents, rather than the prevention of the infections themselves. OSHA's blood-borne pathogen standard was valuable, in that it encouraged facilities to be proactive in the preparation for and the prevention of exposures to blood and body fluids. Taking a parallel approach for other occupational exposures may prove problematic. For example, a facility cannot prevent exposures to methicillin-resistant *Staphylococcus aureus* (MRSA) without universal screening for MRSA colonization or infection. A facility also cannot regulate a HCW's exposure to a patient with a respiratory infection without first instituting Centers for Disease Control and Prevention (CDC) guidelines. Of

importance, compliance with existing CDC guidelines already is monitored by the Joint Commission, the Centers for Medicare and Medicaid Services, and at the local level by state health departments (with some having stricter standards than those at the federal level).

From a patient and HCW safety perspective, IDSA strongly believes that setting a standard to regulate exposure, without addressing infection prevention and control, may create a host of unintended consequences. IDSA sees a need for greater infection prevention and control practices in hospitals as well as in non-traditional health care settings, such as in-home health care or same day surgery centers. Infection prevention and control through standard precautions and vaccination is evidence-based, whereas a standard focused solely on exposure, is not. Exposures occur in a variety of settings, and it is often difficult to determine where the exposure first occurred. Data presented by the CDC has shown that in the case of H1N1, many HCWs were exposed to the virus at home or in the community. As such, a standard focused on limiting exposures in health care and health care-related settings would have had less impact than a standard supporting mandatory vaccination of HCWs against H1N1 or seasonal influenza.

An additional source of concern for IDSA is that a potential rule expansion of this magnitude—one that covers all infectious diseases—has the potential to be extremely impactful on facilities and facility resources, without necessarily achieving greater patient or HCW protections. A regulatory standard focused on exposures places an inherent burden on facilities to track and document the large number of potential exposures—the vast majority of which are trivial in nature—and are unlikely to lead to transmission (an example being a patient with a cold). The burden on smaller health care facilities—be they hospitals, clinics or other settings where health care is delivered—could be enormous. Considering most U.S. hospitals have fewer than one hundred beds, the burden on the facility to provide this level of documentation would be grave, not only impacting facility resources, but human resources as well.

In conclusion, IDSA recommends OSHA take a measured approach by first evaluating the data on HCW exposure to determine where deficiencies exist, rather than applying a regulatory standard to any and all modes of exposure in any and all potential healthcare or healthcare-related settings. Research funding to measure the best approaches is greatly needed. We caution OSHA to first focus on basic personnel and infection prevention and control policies before attempting to regulate infectious diseases exposure in the universe of health care settings. Finally, it is imperative that OSHA directly reach out to professional societies and other stakeholders during each step of this potential rulemaking, as it has the potential to radically impact health care in the United States. Such inclusion and a fully transparent process will help to ensure there are as few unintended consequences as possible, not only ones borne by facilities, but by patients and HCWs as well. IDSA stands ready to help.

Thank you for the opportunity to comment.

Sincerely,



Richard Whitley, MD, FIDSA
President, IDSA

cc: Thomas Frieden, MD, MPH, Director, CDC