



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

August 4, 2009

Route to: Risk Manager  
Medical Staff Director  
Nursing Director  
Infection Control Director  
Human Resources Director  
Laboratory Director  
Engineering Director  
Employee Health Director

TO: CHA Members

FROM: Roger Richter, Senior Vice President, Professional Services

SUBJECT: Cal/OSHA Aerosol Transmissible Disease Standards

On August 5, new standards for aerosol transmissible diseases (ATDs) go into effect for hospitals. The California Occupational Safety and Health Administration (Cal/OSHA) adopted the new standards in late May to protect employees who may encounter ATDs. This memorandum summarizes information provided at a July 21 CHA web seminar on the new standards and addresses a number of issues that have developed since that event.

For your reference, the new regulations are available on the CHA website at [www.calhospital.org/Download/ATD.pdf](http://www.calhospital.org/Download/ATD.pdf) (250 kb pdf). Please note that although the document is titled "Proposed State Standard," the regulations listed are final.

### **Background**

The ATD regulations are based on existing TB standards and were developed over the past five years. As Cal/OSHA regulations, the standards only affect health care workers and not hospital patients or visitors.

The Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) Licensing and Certification Program (L&C) have issued guidelines that affect hospital patients relative to ATDs and the H1N1 flu. In some cases, local public health departments have issued guidelines that supersede those of the CDC and L&C. Any local public health department's guidance supersedes all other guidance except for the Cal/OSHA regulations.

Each hospital is required to have a written ATD exposure control plan, and the plan should reflect the guidance the hospital is following as well as the Cal/OSHA ATD standards. For a copy of the L&C guidance, please visit CHA's emergency preparedness website at [www.calhospitalprepare.org/category/11/315/372](http://www.calhospitalprepare.org/category/11/315/372) and open "AFL 09-19," as well as its attachment. Hospitals should check with their local public health officer regarding the appropriate guidance to follow outside the Cal/OSHA ATD standards.

---

The new standards are considered the most complex, and perhaps the most controversial, ever issued by Cal/OSHA, according to some California Occupational Safety and Health Standards Board members. In developing the regulations, Cal/OSHA consulted with the National Institute of Occupational Safety and Health, state and local health departments, and a number of advisory groups including hospitals. CHA established a taskforce that provided input and included representatives from the California Association of Practitioners of Infection Control and Epidemiology Coordinating Council, Association of Occupational Health Professionals in Healthcare, hospital engineers and research laboratory managers. Due to CHA's input, a number of changes were proposed to the standards.

The ATD standards address diseases requiring airborne infection isolation or droplet precautions (See Appendix A for a specific list of ATDs). While the standards were being developed, the focus was on traditional airborne infectious diseases such as Anthrax, Avian Flu, Smallpox, Tuberculosis and Novel, or unknown pathogens, etc. When the ATD standards were in the final draft stages, many public health and occupational health advocates felt the timing of the regulations could not have been better to minimize the potential effect of H1N1. The ATD standards were adopted on May 21, 2009, and on June 11, 2009, the World Health Organization declared the H1N1 flu a pandemic.

The major issue in implementing the standards is in Section (d)(2)(M), which requires an employer to ensure an adequate supply of personal protective equipment to minimize exposure to ATDs. This includes the storage of N95 respirators for all hospital workers who may come in contact with confirmed or suspected ATD cases (e.g., H1N1 virus). CHA testified during the public hearing period that "the supply of personal protective equipment (PPE) is under the control of the county public health officer for use in foreseeable emergencies and surge situations so the requirement in subsection (d)(2)(M) for employers to ensure this adequacy of PPE supply should be limited to normal operations and an explanation of how the hospital links to the county plan." In its response, Cal/OSHA concurred with CHA's assessment. H1N1 cases are projected to increase this year according to the CDC and could affect 40 percent of the U.S. workforce this fall.

Hospitals, health systems and local public health agencies are concerned because, at present, there is an inadequate supply of N95 respirators to meet the standards. Cal/OSHA's ATD standards could result in:

- All N95 stockpiles being depleted.
- Workers in high-risk exposure areas having inadequate protection when supplies are used up.

CHA is working with Cal/OSHA, CDPH and the Administration to resolve the N95 issue. This issue could be resolved if H1N1 was no longer classified as a novel virus and instead was addressed as seasonal flu. However, this will not occur prior to the ATD standards going into effect August 5.

In addition, CHA is working with Cal/OSHA to resolve several other major issues. The first relates to the requirement that hospitals pay employees their full wages and benefits when an em-

ployee is subject to precautionary removal from his/her assignment during the incubation period of a reportable ATD (see 8 CCR 5199(h) (8)). CHA is seeking clarification on the use of PTO/sick leave or other paid leave, and exploring the legal justification and authority for this requirement.

The standards also impose more rigid requirements on a hospital's ability to share medical information than what is imposed by current law under the Confidentiality of Medical Information Act. (see 8 CCR 5199 (j)). CHA is communicating these concerns to Cal/OSHA as well.

Following are additional ATD provisions that affect hospitals:

### **ATD Standards**

The official designations of the standards are:

- Title 8. Industrial Relations
- Division 1. Department of Industrial Relations
- Chapter 4. Division of Industrial Safety
- Subchapter 7. General Industry Safety Orders
- Group 16. Control of Hazardous Substances
- Article 109. Hazardous Substances and Processes
- Section 5199. Aerosol Transmissible Diseases

### **Scope and Application of Those Affected by the Standards**

This information is contained in Section 5199(a), pages 1-4, which includes all health care settings except for dental clinics/offices.

### **Definitions of Terms Used in the Standards**

The definition of terms is in Section 5199(b), pages 4-12.

### **Referring Employers**

Section 5199(a)(3)(A), page 4, defines referring employers, which are facilities, services or operations in which there is occupational exposure. Section 5199(C), pages 12-15, lists requirements for referring employers. To avoid confusion, Cal/OSHA accepted CHA's recommendation that a hospital never be considered a referring employer since hospitals are covered under other sections of the standards.

### **ATD Exposure Control Plan**

The Aerosol Transmissible Diseases Exposure Control Plan (ATD Plan) can be coordinated with the disaster plan component of SB 739 (Chapter 526, Statutes of 2006), which requires the disaster plan to include a pandemic influenza component. The elements that must be in the ATD Plan include elements defined in Section 5199(d)(2), pages 15-17.

### **Engineering and Work Practice Controls, and Personal Protective Equipment**

Section 5199(e)(1), pages 17 and 18, requires that employers use feasible engineering and work practice controls to minimize employee exposure to ATDs.

According to the standards, work practices must be implemented to prevent or minimize employee exposure to airborne droplets, and contact transmission of ATDs in accordance with Appendix A. Work practices not addressed in the appendix should be implemented in accordance with the *Guidelines for Isolation Precautions*. ATD exposure and contact should be minimized in accordance with *Guidelines for Preventing the Transmission of Mycobacterium TB in Health Care Settings*. Written source-control procedures need to be developed and should incorporate recommendations from *Respiratory Hygiene/Cough Etiquette in Health Care Settings* for everyone entering the facility. Employers must document the engineering and work practice controls they choose and document the results of their consideration process.

Other requirements for engineering and work practice controls are found in Section 5199(e)(2), (3), (4) and (5) on page 18.

Transfers within a facility, or to another facility, are addressed in Section 5199(e)(5)(B)(1) and (e)(5)(B)(2) on pages 18 and 19. Requirements for Airborne Infection Isolation (API) rooms and negative pressure requirements are detailed in Section 5199(e)(D) on pages 19 and 20.

### **Laboratories**

Section 5199(f)(1) through (5), pages 20-22, addresses aerosole transmissible pathogens (ATPs) in laboratories. Health care facilities involved with zoonotics should also be familiar with the separate ATD standards for zoonotics (see Title 8, Division I, Chapter 4, Section 5199.1).

### **Respiratory Protection**

CDC has issued guidelines that recommend airborne infection isolation for hospitalized cases and the use of respirators, such as an N95 filtering face piece respirator, by employees who must enter areas in which people who are suspected, probable or confirmed cases are located. The federal OSHA has stated that it will enforce those recommendations for the protection of employees, and has further recommended the use of respirators such as the N95 to protect health care employees against this disease. California operates a “state plan” under the authority of the federal Occupational Safety and Health Act, and is required to be as effective as federal OSHA. Cal/OSHA has been addressing employee protection against H1N1 through guidance documents and enforcement of existing standards such as the Injury and Illness Prevention Plan (see Title 8, California Code of Regulations (CCR), Section 3203) and the Respiratory Protection standards (see Title 8, California Code of Regulations, Section 5144). This is consistent with current CDPH recommendations.

As mentioned earlier, the standards establish certain requirements for “novel and unknown aerosol transmissible pathogens (ATPs).” Novel and unknown ATPs are defined in the standards as follows:

A novel or unknown ATP exists when a pathogen capable of causing serious human disease meets the following criteria:

- 1) There is credible evidence that the pathogen is transmissible to humans by aerosols;  
and

- 2) The disease agent is:
  - (a) A newly recognized pathogen; or
  - (b) A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility; or
  - (c) A recognized pathogen that has been recently introduced into the human population; or
  - (d) A not yet identified pathogen.

Novel H1N1 flu has been identified as a pandemic influenza strain. Neither CDC nor CDPH has determined that this strain is “fully characterized.” In fact, CDC has established a process for review of the status of H1N1 that includes awaiting the results of a panel convened by the Institute of Medicine that will meet in August, and CDC will reconsider H1N1 as a novel virus by October 1. Meanwhile, CDC continues to recommend respirators for employees who must come into contact with suspected, probable or confirmed cases. CDPH has not changed its recommendation that hospitalized H1N1 patients be placed in airborne infection isolation rooms, if available, and to provide health care workers with respirators.

In addition to airborne infection isolation (AII) requirements for novel pathogens, the ATD standards also require AII when either CDPH or the local health officer recommends AII for a pathogen. As noted above, CDPH currently recommends AII and the use of respirators for hospitalized H1N1 suspected, probable and confirmed cases.

CHA hospitals and health systems have all informed Cal/OSHA and CDPH that hospitals are already reporting shortages of respirators and the difficulty of getting orders filled. There is concern that respirators will be in short supply, placing employees who conduct high-risk procedures at extreme risk.

In the next few days, Cal/OSHA and CDPH officials will discuss this issue and establish policies. Items that will be discussed include:

- Can alternative respirators to the N95 be used and under what circumstances?
- Can N95 respirators be re-donned and under what circumstances?
- Can hospitals access state and local N95 stockpiles and, if so, what is the process for doing so.
- Can exceptions be made to the Cal/OSHA standards if there is an extreme shortage of masks as defined by Cal/OSHA?
- Can CDPH declare that the H1N1 is not a novel virus?

Section g of the ATD standards, pages 22-25, contains the specifics for respiratory protection and fit testing.

In the meantime, prior to any further policies being issued by Cal/OSHA or CDPH, hospitals should try to comply with the Cal/OSHA standards. However, those that cannot comply — due to shortages of respiratory protection supplies that will place employees at greater risk — should document in their ATD Exposure Control Plan that they cannot purchase adequate supplies from

vendors, and their local public health officer cannot provide them with supplies from stockpiles. The ATD Exposure Plan should then address alternative means of attaining worker protection and priority setting for those who should have access to N95s.

### **Medical Services**

Section 5199(h)(1)-(9), pages 25-31, of the ATD standards addresses medical services that an employer must make available to employees who have been exposed to a reportable aerosol transmissible disease (RATD) or a suspected case of an RATD, as well as reporting requirements. The regulations include various timelines for reporting and action. In addition, an employer is required to review records to determine if any employees of any other employer may have been exposed and to notify that employer. An employer must also seek a determination from a physician or other licensed health care professional as to whether precautionary removal is recommended. If recommended, the employer is required to maintain the employee's earnings, seniority, and all other employee rights and benefits.

### **Training**

Section 5199(i)(1) – (5) addresses employer training obligations, including timing and content. Training must be provided at the time of initial assignment to a task where occupational exposure may take place annually thereafter, as well as when any changes affect the employee's occupational exposure or control methods. The training must be interactive and, if not provided in person, must provide for any interactive questions to be answered within 24 hours by a knowledgeable person.

### **Record Maintenance**

Section 5199(j), pages 33-35, defines medical records that need to be maintained on employees and the confidentiality requirements surrounding these records.

### **Contacts**

If you have questions, please contact me at (916) 552-7570 or [rrichter@calhospital.org](mailto:rrichter@calhospital.org), or Cheri Hummel, CHA vice president, hospital preparedness, at (916) 552-7681 or [chummel@calhospital.org](mailto:chummel@calhospital.org). If you have questions regarding human resources issues, please contact Gail Blanchard-Saiger, CHA vice president, labor and employment, at (916) 552-7620 or [gblanchard@calhospital.org](mailto:gblanchard@calhospital.org).

RR:kb