

TABLE 2.—COMPARISON OF TUBERCULOSIS CONTROL MEASURES FOR 103 HOSPITALS THAT REPORTED MORE THAN SIX ADMISSIONS OF PATIENTS WITH TUBERCULOSIS IN 1992 CDC SURVEY AND THAT ALSO RESPONDED TO 1996 CDC SURVEY (EX. 187, P. 111)—Continued

	1992 number (%)	1996 number (%)
• Attending physicians	43/86 (69)	65/94 (69)
• Students	55/95 (58)	74/97 (76)
<i>Testing Elements:</i>		
• After exposure incident	98/101 (97)	102/103 (99)
• Two-step testing	NA	77/98 (79)
• Maintain yearly reports	64/98 (65)	93/98 (95)

¹ Numbers add to more than one hundred because facilities may use more than one type of mask.

The record also shows increased compliance with TB control procedures in prisons and other correctional facilities. CDC published TB control guidelines for these facilities in June 1996, and surveys it conducted with National Institute of Justice between 1992 and 1997 showed an increasing implementation of TB control measures in correctional facilities. The surveys examined the implementation of recommended control provisions in the Federal Bureau of Prisons facilities, all 50 state systems, and a number of large local jail systems. Results showed that 90% of facilities screened new employees for TB, and 75% of those included periodic tuberculin skin testing. The use of negative pressure isolation rooms increased from 30% in 1993 to nearly 98% in 1997 (for Federal and State systems) and 85% (for local jail systems). The use of directly observed therapy for inmates with active TB disease increased from 77% to 98% for Federal and State systems and 84% to 95% for local jail systems (Ex. 187, p. 113–114). Although an AFSCME report of a 1997 survey of correctional facilities where its members were employed showed “a wide variation of adherence to CDC guidelines from departments that had instituted rigorous programs throughout prison systems to those that had done very little,” the survey covered a “very small, nonrandom set” of facilities, and does not contradict the conclusion that compliance in correctional facilities is increasing. (Ex. 189–23, p. 4; 187 p. 116) The evidence in the record indicates that both hospitals and correctional facilities improved their TB control practices significantly over the 1990s.

Taken together, survey results suggest, at a minimum, two conclusions. First, institutional departures from recommended tuberculosis control policies and procedures were common, if not the norm, in the late 1980s and early 1990s. Second, institutions—at least hospitals and correctional facilities—were taking tuberculosis

control measures more seriously and reporting substantially higher rates of implementation of recommended measures in later years. (Ex. 187, p. 116).

Evidence about the use of infection control procedures in other types of settings also showed increasing levels of compliance, although generally not as high a level of compliance with CDC guidelines as was occurring in hospitals. (Ex. 187, pp. 114–117; DC TR, p. 676) AFSCME reported that, “in non-hospital healthcare settings, [its] survey revealed inadequate to virtually non-existent TB control programs.” (Ex. 189–23, p. 4) As noted above, however, IOM pointed out that this survey was of a “very small, nonrandom set of respondents,” only 23 long-term care facilities, 28 mental health facilities, and 28 social service agencies, and that its results “must be viewed with considerable caution.” (Ex. 187, p. 116) In contrast to the AFSCME survey, a number of participants provided evidence that voluntary implementation of the CDC TB guidelines had increased dramatically since 1994, even outside of hospitals. For example, Barbara Hood, testifying on behalf of the California Association of Homes and Services for the Aging stated:

* * * many health care employers have implemented key control measures as recommended in CDC’s 1994 TB guidelines and have incorporated these recommendations in their policies and procedures. This has improved screening and surveillance protocols for both residents and staff. As a result, nursing facility providers have significantly reduced the level of TB in long-term care organizations. (LA TR, pp. 124–125)

AHCA also asserted that many nursing and long-term care facilities have protected their workers effectively by implementing many of the CDC recommendations, even though these facilities are not necessarily complying with all the provisions in OSHA’s proposal. (Ex. 17–756)

Particularly in nursing homes and other long-term care facilities, this trend has probably been accelerated by the need to comply with requirements for Medicare and Medicaid eligibility. A regulation that took effect in October 1992 requires each of these facilities “to establish and maintain an infection control program * * * to help prevent the development and transmission of disease and infection.” (42 CFR 483.65) IOM reports that, at least as of 2000, the guidelines used by state inspectors to determine compliance in nursing homes “specifically require that facilities demonstrate procedures for early detection and management of residents with signs and symptoms of infectious tuberculosis, screening of residents and workers for tuberculosis infection and disease, and evaluation of workers exposed to tuberculosis in the workplace.” (Exs. 187, p. 58, n. 3; 17–756) Moreover, the Centers for Medicare and Medicaid Services (CMS) recently inaugurated a new Program of All-inclusive Care for the Elderly (PACE), which requires participants to “follow accepted policies and standard procedures with respect to infection control, including at least the standard precautions developed by the Centers for Disease Control and Prevention.” (42 CFR 460.74)

The national efforts to reduce the incidence of TB in the general population have also protected workers by reducing the likelihood that they will encounter infectious TB at work. As the IOM points out, “Overall, fewer cases of tuberculosis and less multidrug-resistant disease means less risk for nurses, doctors, correctional officers, and others who work for organizations that serve people who have tuberculosis or who are at increased risk for the disease.” (Ex. 187, p. 104) The Society of Healthcare Epidemiologists of America (SHEA) also credits the efforts of public health officials, government agencies, professional organizations and clinicians for “clearly put[ting] the United States back on the road to TB