

OSHA's proposed standard has already largely been solved. APIC testified, "Clearly, the TB crisis that OSHA is attempting to address has passed." (DC TR, p. 722). This sentiment was echoed by other commenters, such as the American Medical Association, Infectious Disease Society of America, Home Health Service Staffing Association, American Health Care Association, Society of Healthcare Epidemiologists of America, American Association of Homes and Services for the Aging, who also questioned the need for an OSHA standard in an era of declining TB cases. (Exs. 17-719; 183-1; 17-673; 18-61; 17-666; 17-673). The American Lung Association's American Thoracic Society, stated:

The [proposed] OSHA \* \* \* TB standard, is based heavily on the CDC's 1994 guidelines. \* \* \* The CDC guidelines were an appropriate response at the time they were formulated but the proposed OSHA standard will be far out of proportion to the risk by the time it is implemented and increasingly inappropriate and burdensome with each passing year if the current epidemiologic trends continue. (DC TR, pp. 1035-36)

In contrast, other commenters, such as the United Food and Commercial Workers Union and the Service Employees International Union (SEIU), argued that, because CDC's TB guidelines are not directly enforceable, there remain employers who have placed their workers at risk by failing to implement them fully. (DC TR, p. 676; Ex. 17-1089, p. 1-2; DC TR, pp. 635-636). Some of these commenters, such as SEIU, pointed to the geographic variation in TB rates to support the argument that a standard is needed because not all employers are taking appropriate protective action. (Tr LA, pp. 245-246)

In response to these arguments, OSHA acknowledges that a standard is often the most efficient way of assuring that employers reduce their employees' exposure to specific hazards. TB is primarily a public health hazard, however, and occupational exposure at this time is in large part a function of the prevalence of active TB in the population at large. There has been a decade-long decline in TB prevalence, resulting in large part from the Federal resources devoted to public health and infection control measures that were implemented without an OSHA standard in effect.

OSHA believes this shows that, in the unique case of TB, there are powerful incentives for employers to continue to provide appropriate protection even without an OSHA TB standard. The ongoing Federal commitment to TB control provides them with a wealth of

information and expert resources to assist in TB control efforts. Among other incentives, hospitals and nursing homes must have infection control plans to qualify for Medicaid and Medicare reimbursement, and are subject to annual reviews to verify their continuing compliance. (Ex. 17-756, 42 CFR 482.42; 42 CFR 483.65) Facilities participating in CMS's PACE program must comply with "at least" the CDC guidelines. (42 CFR 460.74) The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), which many hospitals and nursing homes use to demonstrate qualification for Medicare and Medicaid reimbursement, also requires an infection control plan as a condition of accreditation. (Exs. 17-756; 187, p. 58; Chicago TR, p. 931) The record also shows, as does CDC's new TB elimination plan, that the sobering memory of the 1985-1992 TB resurgence is not likely to fade anytime soon, and that the complacency that led to that resurgence is unlikely to recur. (Ex. 187, p. 21; NY TR, p. 212)

Nor does OSHA believe that the facts that there are pockets of TB prevalence and a few states where TB rates have increased require it to promulgate a standard. First, the states with the highest levels of TB during the resurgence are also states that have been aggressive in implementing control measures, and are among the states where the most significant recent declines have occurred. From 1992 to 2002, only three states reported an increase in their TB rates, and these increases represent only an additional 106 TB cases (which is less than 1% of the total TB cases in the U.S.). (Centers for Disease Control and Prevention, Trends in Tuberculosis Morbidity—United States, 1992-2002, MMWR 2003; 52: 217-222) These increases do not detract from the fact that, nationally, there are fewer TB cases and lower TB rates being reported each year. CDC's new plan for TB elimination, CDC's Response to *Ending Neglect*, directs resources specifically at localized areas and population groups who remain at higher risk for TB. (Centers for Disease Control and Prevention. *CDC's Response to Ending Neglect: The Elimination of Tuberculosis in the United States*. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2002) Even without a standard, OSHA can take appropriate enforcement action to address those situations where employers are not taking adequate steps to reduce their workers' TB exposure.

OSHA has additionally concluded that, as a practical matter, early identification of infectious TB patients

will not occur enough more often than it already does to justify adoption of a standard. The fact that TB symptoms are neither universal nor unique to TB could also make OSHA enforcement of an early identification provision highly problematic. As the proposal recognized, identification of suspect cases requires the exercise of judgment. (62 FR 54247) Unless an employer simply fails to implement any identification criteria at all, it would be very difficult to establish when a violation occurs. As noted above, however, the record shows that most affected workplaces with the expertise and other resources to do so have already adopted programs to control exposure, including early identification of infectious TB patients, and OSHA will continue to use its general duty clause to require others to follow suit.

For employers without these resources, OSHA believes that providing assistance in exercising the judgment necessary for an effective early identification program can best be accomplished through outreach, consultation, and education efforts, and OSHA intends to provide this type of assistance. CDC's targeted guidelines already provide some guidance, and OSHA believes that the most effective approaches are likely to be the integrated ones that build on the CDC guidelines and target occupational TB transmission as part of a broader TB control program.

As noted above, workers are exposed to TB when they serve patients or clients who have infectious disease, and one of the most straightforward ways to reduce that exposure is to reduce the number of such contacts that occur by reducing the rate of infectious TB in the patient or client population. As CDC's most recent prevalence data show, ongoing TB reduction efforts have been remarkably effective in achieving this goal.

Nor is there any indication that this success is leading to the type of complacency and inattention that contributed to the last TB resurgence. CDC's new TB control plan takes full account of the "scientific, programmatic, and health-sector developments of the last decade." This plan is focused strongly on the current demographic and epidemiological profile of TB, with one of its major goals being to reduce the global burden of TB. In *CDC's Response to Ending Neglect*, CDC explained that "the heavy impact of TB in foreign-born persons living in this country" is a major factor tempering its recent success in TB control." (CDC; 2002, p. 13) Now that foreign-born residents account for more than half the