American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

April 22, 2022

Douglas L. Parker
Assistant Secretary of Labor for
Occupational Safety and Health
Occupational Safety and Health Administration
200 Constitution Ave NW
Washington, DC 20210

Re: Docket No. OSHA–2020–0004, Occupational Exposure to COVID–19 in Health Care Settings; Occupational Safety and Health Administration Notice of Limited Reopening of Comment Period (Vol. 87, No. 56), March 23, 2022.

Dear Assistant Secretary Parker:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the Occupational Safety and Health Administration's (OSHA's) notice of a limited reopening of the comment period on the interim final rule establishing an Emergency Temporary Standard (ETS) on Occupational Exposure to COVID-19.

For more than two years, through multiple surges of infections in communities and several variants of the SARS-CoV2 virus, health care workers across the country have battled COVID-19 and worked tirelessly and courageously to care for patients with and without COVID-19. These health care workers' crucial life-saving roles have never been more evident than during the course of this pandemic. And our organizational leaders, engineers, supply chain managers and others have been there with them, supporting their efforts, seeking supplies of personal protective equipment (PPE), re-engineering ventilation systems as needed, sharing updates on the latest clinical care guidance, arranging for staff vaccinations as soon as they became available, and performing countless other tasks to support and protect staff. The safety and protection of all health care workers remains a top priority for the AHA and its members.

The AHA, together with hospitals and health systems, remains committed to following the science-based and sometimes quickly-evolving guidance issued by the Centers for

Disease Control and Prevention (CDC). Throughout the course of the pandemic, hospitals have followed these strict, evidence-based protocols to ensure the safety of front-line staff and patients. Since the authorization and approval of several COVID-19 vaccines, hospitals have been actively engaged in efforts to vaccinate their communities, starting with their employees and then expanding beyond their workforce into the local populace. These vaccination efforts remain the most promising route to ending the pandemic. The majority of hospital staff are now fully vaccinated[1], which is the strongest protection against illness, hospitalization and death.

Hospitals, through the diligent efforts of their organizational leadership, infection control officers, hospital engineers and material managers, and other front-line staff, have helped ensure that health care workers are protected and that the latest evidence-based practices and policies are followed. Maintaining front-line workers' health and safety is central to a successful response to the pandemic, and no one has a more vested interest in doing so than the nation's hospitals.

While we acknowledge and appreciate OSHA's consideration of additional flexibility for employers and other potential changes to the Occupational Exposure to COVID–19 in Health Care Settings interim final rule, we continue to oppose the establishment of new regulations that are not fully aligned with the CDC's evolving evidence-based guidance. As we have discussed, CDC guidance and recommendations have long been the national standard for safe operations and have been utilized by health care providers since the beginning of the COVID-19 public health emergency (PHE). Hospitals and health systems are held to those standards by Centers for Medicare & Medicaid Services (CMS) regulators.

Moreover, hospitals and most other health care settings also are now subject to a COVID-19 vaccination requirement, strictly enforced by CMS, which applies to all eligible staff working at a facility that participates in the Medicare and Medicaid programs, regardless of clinical responsibility or patient care, including staff who work in offsite locations in which they interact with patients or with staff who interact with patients. Finally, as OSHA itself has acknowledged[2], the agency has sufficient authority to help protect health care employees from the hazard of COVID-19. That is, OSHA maintains and vigorously enforces its general duty clause and other general standards, including the Personal Protective Equipment (PPE) and Respiratory Protection Standards.

---

[1] COVID-19 vaccination coverage among hospital-based healthcare personnel reported through the Department of Health and Human Services Unified Hospital Data Surveillance System, United States, January 20, 2021-September 15, 2021, American Journal of Infection Control, Vol. 49, Issue, Pages 1554-1557, Dec.1, 2021, https://www.ajicjournal.org/article/S0196-6553(21)00673-8/fulltext

[2] https://www.osha.gov/coronavirus/ETS

With the constantly evolving, science-based CDC guidance and recommendations, CMS' vaccination requirement and existing OSHA general standards, we strongly believe that an inconsistent and overly strict OSHA COVID-19 health care standard is not necessary, would cause confusion and will ultimately lower hospital employees' morale and worsen unprecedented personnel shortages in hospitals. It is essential to a well-functioning health care system that only one set of science-based standards be applied to health care providers, and that these standards be aligned across federal agencies.

Therefore, the AHA does not believe that finalizing the OSHA interim final rule will provide any additional benefit beyond what hospitals have already been doing, and continue to do, to protect their workforce throughout the pandemic and afterwards, as the PHE ends and COVID-19 becomes endemic. As such, we urge OSHA not to finalize its interim final rule.

However, if OSHA decides to finalize the COVID-19 health care standard, our responses to the topics and questions raised in OSHA's notice follow.

A.1—Alignment with CDC Recommendations for Health Care Infection Control Practices

OSHA acknowledges that evolving CDC recommendations have resulted in inconsistencies between those recommendations and some of OSHA's health care ETS provisions. The agency is therefore seeking comment on whether it would be appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period.

AHA Comment. The AHA is concerned that a final rule that adopts by reference *specific versions* of CDC guidance will inevitably result in OSHA's standard becoming increasingly more outdated as the scientific understanding of COVID-19 grows and recommended health care infection control practices evolve. Embedding static versions of CDC's guidance into the ETS will lead to disparate standards that will confuse health care employers and their employees, and could result in excessive burden and, potentially, harm. The CDC is in the best position to determine how health care providers should evolve their practices to mitigate spread of the virus.

Moreover, in the ETS interim final rule, OSHA notes that it has a longstanding *de minimis* enforcement policy that allows employers to rely on documents that are at least as protective as a document incorporated by reference. However, as more of the U.S. population is fully vaccinated and up-to-date with booster shots, and the pandemic begins to slow down and eventually enter its endemic stage, CDC's COVID-19

guidance and recommendations are likely to become *less* stringent over time. But OSHA's *de minimis* enforcement policy will result in inappropriate over-regulation of health care employers because the ETS standards will no longer comport with CDC's evidence-based guidance.

The AHA believes that because the science surrounding COVID-19 is constantly evolving, OSHA should not embed static versions of CDC's guidance into the ETS. This will inevitably lead to disparate standards that will confuse health care employers and their employees, and could result in excessive burden and, potentially, harm. The CDC is in the best position to determine how health care providers should change their practices to mitigate spread of the virus.

Therefore, the AHA recommends that OSHA incorporate by reference relevant CDC guidance and other standards by linking directly to the live online CDC document. We further recommend that whenever CDC substantially updates its guidance, OSHA issue an announcement indicating when compliance with the changes will be required. For instance, if CDC makes minor changes to its guidance, such as identifying an additional aerosol-generating procedure for which a respirator is recommended, then a short timeframe to allow for compliance is reasonable. However, if CDC makes a major change to its guidance, for instance recommending significant changes to ventilation systems for COVID-19 units, that change would necessitate that hospitals are allowed a longer time to come into compliance.

A.2—Additional Flexibility for Employers

OSHA notes that some employers expressed concern that the provisions of the health care ETS were overly prescriptive. The ETS specified how employers were required to implement particular policies and procedures, such as the criteria for medical removal and return to work, cleaning, ventilation, barriers, and aerosol-generating procedures. OSHA is considering restating various provisions as broader requirements without the level of detail included in the ETS and providing a ''safe harbor'' enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue.

AHA Comment. **In general, the AHA supports OSHA's consideration to establish broader, less-detailed requirements in a final rule, with a "safe harbor" enforcement policy linked to the relevant CDC guidance.** The ETS included many requirements that were overly specific and complex, leading to confusion and wasted efforts. For example, the physical distancing standards and the related physical barrier requirements were overly specific, did not account for employee vaccination status or other controls in place and prevented individual health care facilities from using their

internal risk assessments for other approaches to ensure the safety of their employees, such as the use of higher-level PPE.

In fact, the AHA continues to recommend that OSHA remove the physical barrier requirements from the ETS altogether. As noted in our comments to the ETS, we believe the efficacy of the barrier requirement in reducing the transmission of COVID-19 in hospitals remains unproven, especially in hospitals where multiple other controls are already routinely used (e.g. high level of vaccination, masking, ventilation). Further, physical barriers may cause harm by interfering with the ventilation system airflow, fire and life safety protection systems, as well as increasing the risk of ergonomic and communication concerns.

The AHA also recommends that OSHA simplify the ventilation requirements contained in the ETS. As noted in our previous comments to the ETS, we remain concerned that the ventilation requirements may be misunderstood by hospital leadership because they partially duplicate, but are not as comprehensive as, the current ventilation consensus standards that are adopted by CMS and which health care facilities already follow: the American Society of Heating, Refrigerating and Air-Conditioning Engineers/American Society for Health Care Engineering (ASHRAE/ASHE) Standard 170, Ventilation of Health Care Facilities. Therefore, we recommend that OSHA allow facilities installing new or upgrading existing air handling systems to follow the latest edition of the CMS adopted standard for health care ventilation, ASHRAE/ASHE 170. Regarding existing systems, the AHA recommends that OSHA permit facilities to evaluate their existing air handling systems to determine if improvements can be made to the filtration.

The AHA agrees that the other provisions of the ETS mentioned in this section of the notice, such as the criteria for medical removal and return to work, cleaning and aerosol-generating procedures also should be less specific, and instead refer directly to the applicable CDC guidance. Please see our previously submitted comment letter for additional recommendations on ways to simplify the OSHA health care rule.

Further, if a safe harbor enforcement policy is instituted, it is critical that OSHA's area offices and the compliance safety and health officers (CSHOs) conducting inspections and initiating enforcement actions are thoroughly trained on the evolution of CDC's guidance and recommendations over time so that they can apply the safe harbor policy appropriately.

A.4—Tailoring Controls to Address Interactions with People with Suspected or Confirmed COVID–19

OSHA is considering the need for COVID-19-specific infection control measures in areas where health care employees are not reasonably expected to encounter people

with suspected or confirmed COVID-19. This could include eliminating certain requirements that were included in the health care ETS and that applied to all areas of covered health care settings. For example, OSHA notes it could consider imposing cleaning requirements or medical removal provisions only with respect to staff exposed to COVID-19 patients or eliminating facemask requirements for staff not exposed to COVID-19 patients. If OSHA did restrict infection control requirements to particular areas of a facility or particular staff, it could consider balancing that narrower scope with a new ''outbreak provision'' to ensure that health care employers would still have a duty to address an outbreak quickly if an outbreak occurs among staff in the areas normally subject to fewer requirements.

AHA Comment. The AHA notes that CDC already addresses such considerations in its various COVID-19 and more general guidance documents, including which infection prevention and control measures should be taken if health care personnel are exposed to individuals with suspected or confirmed COVID-19. If OSHA were to incorporate relevant CDC COVID-19 health care personnel guidance by directly referencing the live documents – for example the infection prevention and control guidance, the isolation and work restriction guidance, and the interim guidance for managing health care personnel with SARS-CoV-2 infection or exposure to SARS-COV-2 – then such "tailoring of controls" as envisioned in this section of the notice would be unnecessary.

However, in the absence of such specific reference to CDC live guidance, the AHA would not support this approach as it would further drive a wedge between OSHA's rule and CDC's evidence-based guidance.

A.5.1—BOOSTER DOSES

In the ETS, certain requirements take account of whether individuals are ''fully vaccinated,'' which is defined in paragraph (b) of the ETS as meaning ''2 weeks or more following the final dose of a COVID–19 vaccine.'' Subsequent to the publication of the ETS, the Advisory Committee on Immunization Practices (ACIP) has recommended additional doses and booster doses. CDC has also adopted the concept of ''up to date'' to describe vaccination recommendations beyond the primary vaccination series. OSHA is seeking comment on how these ACIP and CDC recommendations might impact the requirements in the ETS that take account of individuals' vaccination status (e.g., fully vaccinated, up to date).

AHA Comment. Currently, according to CMS' interim final rule requiring COVID-19 vaccinations, staff at health care facilities must be fully vaccinated, which is defined by CMS as two weeks or more since the individual completed a primary vaccination series for COVID-19. Since the CMS rule takes preeminence in settings participating in the Medicare or Medicaid program, it would be confusing and counterproductive if OSHA, in a rule that is not intended to mandate employee vaccination, were to define "fully

vaccinated" differently. However, CDC's guidance for health care workers does call out the additional protections afforded those who are "up to date" with their vaccinations, meaning that they have completed their primary vaccine course and have had any booster shots that are recommended for those in their age or risk group. CDC's guidance provides some additional flexibilities for those who are up to date with their vaccines. **The AHA recommends that OSHA's definition of "fully vaccinated" be consistent with CMS' definition, and that it align additional flexibilities with those granted to health care workers who are "up to date" on their vaccines as CDC does.**

A.5.2—EMPLOYER SUPPORT OF EMPLOYEE VACCINATION

The Healthcare ETS included a provision requiring employers to inform employees about the safety, efficacy, and benefits of vaccination and provide reasonable time and paid leave to each employee for vaccination and side effects experienced following vaccination. The agency seeks comments on several possible changes.

OSHA is considering an adjustment to the requirement that would include paid time up to four hours for employees to receive a vaccine (including travel time) and paid sick leave to recover from side effects. The agency also is considering requiring employer support for employees who wish to stay up to date on vaccination and boosters in accordance with the Advisory Committee on Immunization Practices and CDC recommendations. OSHA seeks comment on these approaches.

AHA Comment. **If OSHA is intent on promulgating this rule based on its legislative mandate to protect the health and safety of employees, it should focus its requirements on those processes or equipment that are essential for employee health and safety and refrain from addressing issues of employee time off.** These issues are more appropriately dealt with in discussions between employers and employees or their union representatives. Other required vaccines are dealt with in this way, and while it might have been appropriate to call for a different approach as we were still learning about the impact of the COVID-19 vaccines, that is no longer necessary.

However, if OSHA intends to continue to pursue these changes to its provisions, we note that in most cases, employee vaccination would not typically include travel time, as hospitals and health systems usually vaccinate their employees within their health care facility. Moreover, hospitals typically provide benefits to employees, including paid sick time or paid time off for employee illness, which we assume would include employer coverage for vaccine side effects. Further, it would be useful for OSHA to clarify that if paid sick time or paid time off is a part of the employee's employment package, this requirement has been met.

OSHA is considering whether to limit the provisions that provide support for vaccination to employees not covered by the CMS vaccination rule.

AHA Comment. **The AHA does not support this proposal.** Hospitals and health systems want uniform policies to apply to staff unless there is a substantive and clear reason for a distinction to be made. CMS' vaccine mandate does not apply to certain employees only in limited circumstances, including if they are working in off-site offices, providing telehealth services, or working exclusively from home such that their risk of exposure to COVID-19 is no different than that of anyone else in the community and their chance of transmitting it to a person while that person is being treated by the hospital or health system is negligible. It is unclear why OSHA would establish a provision in this rule that calls out those individuals for specific support to get vaccinated. In addition, it inadvertently could be a source of discontent for those on the staff whose jobs include more direct contact with COVID-19-positive-patients but who are not offered the same support.

A.5.3—Requirements for Vaccinated Workers

During the initial comment period, stakeholders raised questions about whether the Healthcare ETS requirements should be relaxed or eliminated based on the vaccination status of the individual worker involved, the general vaccination rate of the entire staff, and/or the general vaccination rate of the community. OSHA is considering suggestions that requirements be relaxed:

- for masking, barriers, or physical distancing for vaccinated workers in all areas of health care settings, not just where there is no reasonable expectation that someone with suspected or confirmed COVID-19 will be present;
- in health care settings where a high percentage of staff is vaccinated; and/or
- for exposure notification for vaccinated employees.

AHA Comment. **The AHA urges OSHA to adopt the CDC's evidence-based guidance and recommended routine infection prevention and control practices during the COVID-19 pandemic.** In certain instances, CDC factors into its recommendations the vaccination status of health care personnel based on scientific evidence of a lower risk of illness for those individuals. In addition, several of the CDC's recommended infection prevention and control measures, such as use of source control and screening testing, are influenced by levels of SARS-CoV-2 transmission in the community. For instance, CDC's infection control guidance states that in health care facilities located in counties with low to moderate community transmission, health care personnel who are up to date with all recommended COVID-19 vaccine doses could choose not to wear source control (i.e. respirators or well-fitting facemasks or cloth masks) or physically distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen). OSHA regulations that are

inconsistent with CDC's recommendations would be confusing and counterproductive in health care settings.

A.6—Coverage of Construction Activities in Health care Settings

OSHA notes that it did not expressly include employers that engage in construction work in hospitals, long term care facilities and other settings that are covered by the ETS. The construction industry was not included in its industrial profile for the rule. OSHA is considering clarifying this coverage and seeks comment on this approach. For example, it is considering the same coverage for workers engaged in construction work inside a hospital as for workers engaged in maintenance work or custodial tasks in the same facility. OSHA could consider exceptions for construction work in isolated wings or other spaces where construction employees would not be exposed to patients or other staff.

AHA Comment. While OSHA's full intention here is unclear, the agency seems to be referring to the inclusion of contracted construction crews under the health care ETS requirements in the same way that other health care support services[3] are included. It is our understanding that this would include, for instance, consideration of contracted construction employees in the development of the host health care employer's COVID-19 plan, communication and coordination between host employers and contractors about the specifics of the plan and sharing of additional information as necessary on an ongoing basis and notification of other employers whose employees have been in close contact with the COVID-19-positive-person in the host employer's workplace.

Hospitals, particularly large hospitals, have hundreds of different kinds of contracts for a wide variety of services, making it hard to respond thoughtfully to the notion of including contract employees, as if their jobs, their risk exposure and the opportunity for the hospital or health system to prevent infection were similar. They are not. Contract nursing or physician staff may have similar risk profiles to other nurses and doctors who are employed by the hospital. Contractors providing periodic elevator maintenance services, picking up expired drugs for disposal, or re-constructing areas of the facility that have been repurposed to accommodate different needs have very different risk profiles.

All hospitals have run into barriers in trying to track the vaccination status of contract staff. There are particular struggles for those located in rural areas, who have encountered resistance from contractors in obtaining information on the vaccine status of contract employees. CMS has recently clarified its guidance to be clear that hospitals are not expected to maintain information on the vaccine status of contract employees;

[3] Health care support services are defined in the ETS as including patient intake/admission, patient food services, equipment and facility maintenance, housekeeping, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.

however, they are expected to have policies in place to ensure those organizations with whom they contract have clarity about the need for the workers in patient care and other related areas of the hospital to be vaccinated or exempted. **The AHA encourages OSHA to address any policies related to contractors in the final rule with a clear understanding of the differences in risks and a realistic view of what such a requirement would mean for the contractors, many of which are national or regional in scope and serve a wide variety of hospitals.**

Hospitals assess different kinds of risks for different contract activities and apply appropriate safeguards. For example, when there is construction done in the health care environment, there are existing guidelines commonly used to conduct risk assessments in the planning phase of projects and mitigation efforts based on the risk assessments for infectious diseases and other environmental risks. Specifically, the Facilities Guidelines Institute, an independent, not-for-profit organization dedicated to developing guidance for the planning, design, and construction of hospitals and other health care facilities, provides support for the development of safe, effective health care built environments. We believe that duplicative or inconsistent rules applied to contracted construction work in hospitals may prove confusing and burdensome. **The AHA encourages OSHA to address these concerns in the final rule if the construction industry is included.**

A.8—Triggering Requirements Based on the Level of Community Transmission

When employees are treating people with suspected or confirmed COVID-19, the ETS requires certain control strategies (e.g., PPE) regardless of community transmission levels. Under the CDC's current guidance for health care workers, many recommendations are triggered based on the level of community transmission of COVID-19 (e.g., controls needed in areas of substantial or high transmission, controls not needed in areas of low or moderate transmission). **OSHA is considering linking regulatory requirements to measures of local risk, such as either what the CDC uses in its guidance for health care settings (i.e. community transmission) or what the CDC uses in its guidance for prevention measures in community settings (i.e. COVID-19 Community Levels)**. OSHA is seeking comment on that approach, including impacts of such an approach on compliance and enforcement.

AHA Comment. CDC's COVID-19 Community Levels recommendations do not apply in health care settings and should not be used by OSHA. **Instead, the AHA would support OSHA's deferring to CDC guidance for health care settings, which already incorporates community transmission levels in its recommendations.** That said, some of our larger health systems with hospitals and other health care facilities located in many different communities are concerned about the complexity involved in tracking the level of community transmission across all their facilities and as

the levels change over time. In rural communities, there may be areas of sparse population where this calculation of community transmission becomes a "small numbers" problem. That is, a very small number of individuals contracting COVID-19 can result in a shift of the community from one level to another. **If OSHA finalizes policies that link to community transmission levels, we urge the agency to develop tools and resources to help hospitals and health systems comply in a way that would not be overly burdensome and take into consideration this complexity for health systems in its enforcement of the regulation.**

A.9—Evolution of SARS–CoV–2 into a Second Novel Strain

It is possible that a future variant of SARS–CoV–2 will have sufficient genetic drift to be designated another novel coronavirus strain but still result in a disease that is similar to the current illness. OSHA is considering specifying that this final standard would apply not only to COVID-19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects. OSHA seeks comment on this approach and alternatives to addressing the potential for new strains related to SARS–CoV–2.

AHA Comment. **The AHA opposes applying OSHA's COVID-19 health care standard to subsequent related strains of the SARS-CoV-2 virus.** It would be inappropriate for OSHA to make assumptions about how an unknown strain of the virus would spread in health care settings and the steps needed to mitigate its spread.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Roslyne Schulman, AHA's director of policy, at rschulman@aha.org or (202) 626-2273.

Sincerely,

/s/

Stacey Hughes
Executive Vice President