AMERICA'S ESSENTIAL HOSPITALS

August 20, 2021

James Frederick
Acting Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Ave. NW
Room N3626
Washington, DC 20201

OSHA-2020-0004: Occupational Exposure to COVID-19; Emergency Temporary Standard

Dear Acting Assistant Secretary Frederick:

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned interim final rule related to occupational exposure to COVID-19. Keeping America's health care workforce healthy and safe is of utmost importance to America's Essential Hospitals. Our members understand the critical role their staff and health care providers play in our nation's response to the COVID-19 public health emergency (PHE). The Occupational Safety and Health Administration's (OSHA's) emergency treatment standard (ETS) is complex and will require resources to implement, all within a short compliance period (for most provisions, 14 days from publication of the rule). Further, the ETS comes at a time when hospitals are working determinedly to urge staff and the broader community to get vaccinated, while also addressing another surge in cases due to the rise of the COVID-19 delta variant. We are concerned the timeline for implementation and scope of the ETS will unduly burden essential hospitals, and we offer the below comments as OSHA implements this new standard.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.9 percent on average compared with 8.8 percent for all hospitals nationwide.[1] These narrow operating margins result in minimal reserves and low cash on hand, circumstances which have been exacerbated by the financial pressures of COVID-19. Throughout the pandemic, essential hospitals and their employees have been on the front lines screening, testing, and treating COVID-19 patients. Essential hospitals continue to make substantial investments to maintain capacity for treatment of COVID-19 patients and to lead vaccination efforts in their communities. They were some of the first providers involved in vaccinating health care workers and the general public. Many of these necessary steps come with disruptions to daily operations and a significant price tag. They include constructing temporary spaces for diagnosing and treating COVID-19 patients, ensuring adequate stock of

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. https://essentialdata.info. Accessed July 1, 2021.

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necessary equipment for patient care, and securing personal protective equipment (PPE) for front-line staff. Essential hospitals also face workforce issues, such as increased staffing costs and shortages, related to the rise of the delta variant and low rates of vaccination in some areas.

As the pandemic continues and hospitals dedicate additional resources to vaccination efforts, essential hospitals face an uncertain financial future. We strongly urge the agency to provide more time for hospitals to comply with the ETS and clarify the differences between the ETS and guidance from other agencies, including the Centers for Disease Control and Prevention (CDC). Further, we urge OSHA to refrain from instituting requirements that add burden and could have unintended consequences for essential hospitals that developed processes over the course of the pandemic to effectively provide safe, quality care to all, included marginalized and underrepresented people.

1. OSHA should delay the ETS at least six months, use nonpunitive means of initial enforcement, and take a flexible approach to surveying.

The COVID-19 PHE has had, and continues to have, significant and ongoing effects on care delivery nationwide. Challenges over the course of the pandemic include shortages of PPE; issues with hospitalizations and transfers; staffing and supply shortages; and funding scarcity. Further, because COVID-19 prevalence is not consistent across the country, and vaccination rates also vary, hospitals in different areas have been affected differently at various times throughout the pandemic. Some members, like those in Missouri, California and Florida, are experiencing a surge in cases in younger, unvaccinated people—and this is compounded by the increase in prevalence of coronavirus variants.

The ETS—which is more than 250 pages—was published to the *Federal Register* and became effective June 21. Employers must comply with all but a few requirements by July 6, and they must meet the remaining requirements by July 21. It is unreasonable to believe hospitals are in the position to read, interpret, and implement the new ETS in this short amount of time. Hospitals must carefully review existing protocols and procedures, developed over the course of the COVID-19 pandemic, to determine necessary changes. In some cases, these changes could be onerous and difficult to implement. For example, the distancing and barrier requirements at nursing stations could require significant cost and disruption. Further, a hospital might need to contract with outside vendors to effectuate these changes (e.g., HVAC updates).

Before implementing a mandatory ETS, OSHA should speak with stakeholders to better understand processes developed and used effectively during the pandemic. At minimum, these discussions should review ways in which existing protocols, such as an emergency management plan, could satisfy the various components of the ETS—particularly those components with the potential to add administrative burden, such as the requirements to maintain a COVID-19 log of employee cases without a work-relatedness determination and to report all work-related COVID-19 inpatient hospitalizations and fatalities. **We strongly urge OSHA to delay the compliance date for all requirements at least six months from the effective date of the rule.**

The rule references remarks from the Department of Labor that "[n]ever in the last century have the American people been as mindful, wary, and cautious about a health risk … protective measures are being implemented voluntarily, as reflected in a plethora of industry guidelines, company-specific plans, and other sources." Indeed, throughout the COVID-19 pandemic, essential hospitals have served as valued partners working with the federal government to respond to our nation's needs through swift action to protect patients and staff. Our members are committed to these efforts and will continue to provide a safe environment for all employees. However, given the ongoing stress to our health care system, with essential

hospitals in many parts of the country responding once again to surges related to the delta variant, **we encourage OSHA initially to use nonpunitive, educational means of enforcing the ETS.**

The new ETS likely will lead to more OSHA surveys and surveyors deployed to hospitals nationwide. This is in addition to the return of regular surveys from the Centers for Medicare & Medicaid Services (CMS), after those surveys were suspended for a period of time during the PHE. Further, given the focus of the ETS on workplaces where employees have a high frequency of close contact exposures, it is safe to assume essential hospitals are a targeted employer. **We urge OSHA to take a flexible approach to its survey process if a hospital is experiencing a COVID-19 surge.**

2. **OSHA should issue clarifying guidance and offer educational content and resources as soon as possible to improve hospitals' ability to comply with the ETS.**

OSHA has issued numerous nonmandatory guidance products over the course of the pandemic to advise employers on how to protect workers from SARS-CoV-2 infection. While these guidance products do not impose a legal obligation, we believe hospitals earnestly used the guidance from OSHA, as well as materials issued by CDC and CMS, when crafting policies and procedures to protect their employees. Hospitals need immediate compliance assistance in interpreting what is a lengthy and complex set of standards.

For example, under the ETS, when an employer is notified that a person in the workplace is COVID-19 positive, the employer must notify all other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace. OSHA's example of a well-defined portion of a workplace is "a particular floor." This is both confusing and concerning when compared with contract tracing principles and CDC guidance (i.e., close contact exposure defined as being within six feet for at least 15 minutes). This is very different than a floor of a facility, as indicated by OSHA, and could lead to significant disruption in hospital operations if not clarified.

Additionally, the ETS includes a provision to require that employers separate each employee from all other people by at least six feet unless "the employer can demonstrate that such physical distancing is not feasible for a specific activity." It is unclear what would be the demonstration criteria for lack of feasibility to comply; this seems too subjective and open to interpretation. **OSHA should issue clarifying guidance and provide resources, including educational webinars and FAQs, to help hospital employers comply with the ETS and to express concerns about their ability to comply.**

3. **OSHA should resolve any differences between CDC guidance and the ETS, to reduce complexity and burden for hospitals, and account for local factors and future changes in guidance as our understanding of the virus and the virus itself evolves.**

Certain provisions in the ETS are in direct conflict with existing CDC guidance, which leads to confusion and a need to spend resources to closely review these differences to ensure compliance. For example, OSHA found it necessary to develop its own list of symptoms requiring notification and removal from the workplace. The OSHA guidance defines fever at greater than or equal to 100.4 F. Whereas, CDC defines fever as either subjective fever (i.e., feeling feverish) or a measured temperature of 100.0 F or higher. Further, the ETS states that if test results are negative, the employee may return to work after seven days following exposure.

However, CDC recommends not returning to work for 14 days after last exposure if not fully vaccinated or having recovered from SARS-CoV-2 infection in the prior three months.[2] **We urge OSHA to resolve any inconsistency in language that will add to the overall burden of employers in complying with the ETS**.

CDC recently took action to update its public health recommendations for vaccinated people, given new evidence on the delta variant in the United States.[3] The agency's rationale for updating guidance throughout the COVID-19 pandemic was based on the availability of new evidence. CDC also updated guidance on mask wearing for the public using local factors (i.e., community transmission, by county) to determine the recommended mitigation strategy. **We urge OSHA to provide flexibility for future changes in guidance, based on our evolving knowledge of the virus and its variants, as well as local factors, such as vaccination rates of staff, local infection rates, and job types.**

For example, the requirements for patient screening and management require the employer to screen and triage "all clients, patients, residents, delivery people and other visitors, and other non-employees entering the setting." Not every community has the same infection rates and these requirements could affect patient visits and create bottlenecks in normal operations, such as supply logistics at already strained loading docks. **We urge OSHA to ensure essential hospitals are not unduly burdened by a mandated ETS that does not consider local factors.**

4. OSHA should monitor the ETS; modify it based on future conditions, including hospitalwide policies; and seek further stakeholder input before creating a permanent standard.

Essential hospitals continue to educate staff and their communities about the importance of vaccination in the fight against COVID-19, particularly given the rise of cases tied to the delta variant. Vaccine acceptance has varied, with higher rates in some facilities and the use of mandates by health care employers. Most recently, America's Essential Hospitals, along with other hospital associations, called for its member hospitals to require their employees be vaccinated.[4] We are concerned hospitals will divert resources, which are critical to our nation's response to the delta variant and case surges, to comply with this ETS. Local conditions, often changing daily, place additional strain on hospitals to comply with an ETS that does not account for these changes. **We encourage OSHA to revisit the ETS in the coming months to evaluate its overall appropriateness and to modify the scope of the standard in response to future conditions.**

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[2] Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2. Centers for Disease Control and Prevention. Updated March 11, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. Accessed July 1, 2021.

[3] Interim Public Health Recommendations for Fully Vaccinated People. Centers for Disease Control and Prevention. Updated July 28, 2021. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html. Accessed July 28, 2021.

[4] America's Essential Hospitals Urges Members to Require Employee Vaccination. America's Essential Hospitals. July 21, 2021. https://essentialhospitals.org/general/americas-essential-hospitals-urges-members-require-employee-vaccination/. Accessed July 28, 2021.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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