

August 20, 2021

James Frederick
Acting 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;
Emergency Temporary Standard; Occupational Safety and Health Administration
Interim Final Rule and Request for Comments (Vol. 86, No. 116), June 21, 2021.***

Dear Acting Assistant Secretary Frederick:

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) COVID-19 Health Care Emergency Temporary Standard (ETS) interim final rule.

For more than a year, health care workers have battled COVID-19 and worked tirelessly and courageously to care for patients across the country 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, 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 similarly 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 frontline staff and patients. More recently, 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 are the most promising route to ending the pandemic. As health care workers received top priority in these efforts, the majority are now fully vaccinated, which is the strongest protection against illness, hospitalization and death.

Hospitals, through the diligent efforts of their administrators, 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. We know that those measures have kept health care workers safe, as evidenced by a recent study¹ that found that health care workers were more likely to catch COVID-19 in the community than from the workplace. Maintaining frontline 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.

Nevertheless, in promulgating the ETS, OSHA now asserts that COVID-19 poses a grave danger for health care workers and that these regulations are necessary to address the danger. Considering hospitals' and health systems' long-standing commitment to adhering to the CDC's science-based guidance and recommendations and the strong movement towards vaccinating all health care workers, we do not believe that the ETS is necessary. OSHA's recent decision is particularly puzzling, especially considering that in the spring of 2020, when COVID-19 was still novel and its transmission less understood – when hospitals were overwhelmed with patients with suspect or confirmed COVID-19 infections and experiencing unprecedented shortages of essential supplies necessary to protect health care workers and patients – OSHA declined to deem COVID-19 a grave danger and expressly stated an ETS was not needed.

At this point in time, the AHA does not believe that the ETS provides any additional benefit beyond what hospitals have already been doing, and continue to do, to protect their workforce throughout the pandemic. **As such, we urge OSHA to withdraw the ETS interim final rule. If the agency declines to do so, we recommend that the ETS be allowed to expire at the end of the six months and not be published as a final rule.**

Below is a summary of our other overarching concerns and comments. Additional detail on each is included in our specific comments.

¹ Jacob JT, Baker JM, Fridkin SK, et al. Risk Factors Associated With SARS-CoV-2 Seropositivity Among US Health Care Personnel. *JAMA Netw Open*. 2021;4(3):e211283. doi:10.1001/jamanetworkopen.2021.1283

- **If OSHA declines to withdraw the ETS, the AHA strongly urges OSHA to reconsider our previous request to delay the ETS compliance dates for at least an additional six months.** Hospitals and health systems are struggling under the weight of the COVID-19 pandemic's fourth wave and have told us that although they remain committed to following the CDC's guidance, they need more time to fully implement the ETS' many new requirements.
- While we appreciate that OSHA incorporated into the ETS some of CDC's COVID-19 guidelines and recommendations, we are concerned about requirements that contradict, or in some cases go far beyond, what CDC recommends; in some instances, the ETS does so in ways that may put health care workers at greater risk. This is particularly a concern in the areas where outdated CDC guidelines have been incorporated into the ETS by reference, which OSHA will nevertheless continue to enforce. **Therefore, the AHA recommends that when OSHA incorporates by reference relevant CDC guidelines and other standards, it does so by linking directly to the live document.** The AHA also makes recommendations to address other discrepancies between the OSHA ETS requirements and CDC's evidence-based guidelines, including concerns around different definitions of "exposure" and related medical removal policies; more limited flexibilities for fully vaccinated health care professionals; different cleaning and disinfecting requirements following aerosol-generating procedures; and unproven and unnecessary physical barrier requirements.
- **The AHA urges OSHA to amend the physical distancing requirement to better account for health care worker and community vaccination status.** Furthermore, hospitals believe that the requirement hinders staff education, negatively impacts staff morale, and impedes hospital's exhausted workforce from doing their job efficiently – all when hospitals are already taking many other precautions for the benefit of employee safety.
- **The AHA recommends OSHA remove from the ETS its physical barrier requirement.** The efficacy of physical barriers in reducing the transmission of COVID-19 in hospitals remains unproven and may cause harm by interfering with ventilation system airflow and fire-and-life safety protection systems, while increasing the risk of ergonomic and communication issues. Furthermore, installing physical barriers presents a significant burden in this setting where multiple other controls are already in place and routinely used, such as universal masking, high levels of vaccination among employees, ventilation, screening and medical removal practices.

- The AHA appreciates OSHA’s decision not to require health care facilities to install new heating, ventilation and air-conditioning (HVAC) systems to augment or replace functioning systems, and to instead focus on ensuring that existing HVAC systems are operating in a manner consistent with manufacturers’ instructions and design specifications. However, we are concerned that the ETS ventilation requirements may be misunderstood because they partially duplicate, but are not as comprehensive as, current ventilation standards that are adopted by the Centers for Medicare & Medicaid Services (CMS), with which health care facilities already comply. **Therefore, the AHA recommends that OSHA require that facilities installing new, or upgrading existing, air handling systems follow the latest edition of the CMS adopted standard for health care ventilation, the American Society of Heating, Refrigerating and Air-Conditioning Engineers/American Society for Health Care Engineering Standard 170, Ventilation of Health Care Facilities. Regarding existing systems, the AHA recommends that OSHA require that facilities evaluate their existing air handling systems to determine if improvements can be made to the filtration.**
- Hospitals are concerned about the uniform application across all communities of the ETS’s screening requirements, regardless of rates of infection and community vaccination. **The AHA recommends that OSHA consider providing in the ETS deference to state and local health department guidelines to scale up or down requirements for patient monitoring and screening based on local epidemiology.**
- The AHA believes that the ETS standard fails to place enough emphasis on the most important protection currently available against COVID-19: vaccinations. **We urge OSHA to include more emphatic language regarding COVID-19 vaccination as well as additional flexibilities for fully vaccinated health care workers.**
- Hospitals are concerned with the infeasibility of the ETS requirement that employers notify employees of a COVID-19 exposure in the workplace within 24 hours. **The AHA recommends that OSHA revise this requirement so that notification in these circumstances is promptly provided, but instead must be done within a more feasible 72 hours of the employer becoming aware of the employee’s COVID-19 illness or symptoms.**
- **The AHA recommends that OSHA revise the requirements for facemasks to allow health care employers, in contingency and crisis capacity situations,**

to impose extended use and limited re-use of facemasks in order to continue to protect health care employees when shortages occur.

- **The AHA has serious concerns about the mini respiratory protection standard and urges OSHA not to finalize this short-sighted and dangerous policy.** The standard removes the hospital's ability to oversee the safe use of PPE by employees in its facility; degrades trust in the long-standing evidence-based PPE framework; unnecessarily depletes the supply of respirators; and causes increased burden and liability risk for the hospital while at the same time making employees less safe.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Roslyne Schulman, AHA's director for policy, at rschulman@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy

**American Hospital Association (AHA)
Detailed Comments on OSHA COVID-19 Health Care
Emergency Temporary Standard Interim Final Rule**

TABLE OF CONTENTS

TABLE OF CONTENTS

JUSTIFICATION FOR THE ETS.....	7
COMPLIANCE DEADLINE.....	9
OSHA ETS IS INCONSISTENT WITH CDC GUIDELINES AND SCIENCE.....	10
PHYSICAL DISTANCING AND PHYSICAL BARRIER REQUIREMENTS	14
VENTILATION	17
PATIENT SCREENING AND MANAGEMENT	18
INADEQUATE EMPHASIS ON THE IMPORTANCE AND BENEFIT OF VACCINATION..	19
EMPLOYER NOTIFICATION TO EMPLOYEES OF COVID-19 EXPOSURE	19
TRAINING	20
PPE REQUIREMENTS FOR ALL EMPLOYEES	20
COVID-19 PLAN: EFFECTIVELY COMMUNICATE AND COORDINATE WITH OTHER EMPLOYERS.....	21
MINI RESPIRATORY PROTECTION STANDARD	22

JUSTIFICATION FOR THE ETS

While the AHA shares OSHA's commitment to health care worker safety, we question the agency's justification for issuing the ETS on June 21, 2021, particularly when OSHA earlier in the pandemic had declared an ETS unnecessary when community transmission rates were higher and PPE was in short supply.

The AHA, together with hospitals and health systems, remains committed to following the CDC's science-based and sometimes quickly-evolving guidance. Indeed, since the beginning of the COVID-19 pandemic, with the help of the CDC and other scientific bodies, hospitals and health systems have invested enormous energy and expertise in efforts to understand this novel coronavirus, how it is transmitted, and how it can be prevented and treated. This expertise has enabled our members to develop appropriate policies and procedures, procure appropriate personal protective equipment (PPE) and ensure staff know how to use it, and put into place other protective measures to ensure the health and safety of staff and patients.

More recently, 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 are the most promising route to ending the pandemic, as each of the authorized vaccines have been demonstrated to be safe and remarkably effective in preventing illness; these vaccines also are substantially effective in preventing SARS-CoV-2's transmission to others.

Much has been written in the press about the heroic efforts of doctors, nurses, pharmacists and others who provide direct care to patients during the pandemic; they deserve all of the praise and gratitude that has been bestowed to them. However, front-line caregivers are not alone in their efforts. Administrators, infection control officers, hospital engineers, supply managers and others who work alongside those front-line caregivers each help ensure that health care workers are protected. They work tirelessly to provide support, secure needed PPE, build and execute on programs to ensure proper use and care of PPE, reengineer ventilation and make other adjustments to the physical plant, and stay abreast of the latest scientific information and guidance.

All across the country, hospitals have done an outstanding job protecting their staff and the patients in their care, even as they learned more about this novel coronavirus. The effectiveness of those efforts is emerging in several scholarly articles. For instance, a recent study of nearly 25,000 health care workers concluded that the community prevalence of COVID-19 and known exposure to someone with COVID-19 outside work were more common predictors of health care workers contracting COVID-19 than anything about their work environment.²

² Jacob JT, Baker JM, Fridkin SK, et al. Risk Factors Associated With SARS-CoV-2 Seropositivity Among US Health Care Personnel. *JAMA Netw Open*. 2021;4(3):e211283. doi:10.1001/jamanetworkopen.2021.1283

Nevertheless, the preamble to the ETS begins with a discussion asserting COVID-19’s “grave danger” to health care workers and concludes that an ETS is necessary to address this grave danger. However, in the spring of 2020, when many communities experienced widespread outbreaks of COVID-19 and a growing number of hospitals were experiencing surges of suspected or confirmed COVID-19 patients, when PPE was in short supply, and when hospitals were still learning how this disease is spread and effectively treated, the situation was most assuredly serious. Yet, on May 29, 2020, OSHA stated that there was a lack of evidence suggesting that infectious diseases, including COVID-19, to which employees may be exposed, constituted a “grave danger” requiring an ETS as an appropriate remedy.

On that day, the CDC’s data reflect that there were 44,581 hospitalizations and 1,190 deaths in the U.S. By contrast, on June 21, 2021, when the ETS was published in the Federal Register, the New York Times reported that there were 16,945 people hospitalized with COVID-19 in the U.S. and just 311 deaths – still a tragic loss, but only a quarter of the number of deaths on May 29 of the previous year.

Moreover, as of Aug. 3, 2021, nearly 58% of Americans over the age of 12 have been fully vaccinated, and more are getting vaccinated every day. Meanwhile, the vast majority of those who are sick enough to require hospitalization are unvaccinated. Vaccines are readily available to all who want to be vaccinated, including all health care personnel; as such, it is baffling to understand why, at this point, OSHA is asserting there is a grave danger.

The federal government’s own data – the same data OSHA cites in its ETS when noting that 1,600 health care workers across America have died during this pandemic – documents that, since Feb. 13, 2021, very few deaths of health care workers have been recorded. There were 24 weeks between February and the last week of July with fewer than *five* reported deaths of health care workers; in the period between July 7 and July 31, there were *zero* recorded deaths of health care workers.³

If OSHA saw no grave danger warranting an ETS last May or in any of the intervening months during which COVID-19 surged across the U.S., how can it perceive a grave danger now, with many health care workers fully vaccinated, and those vaccines and other protective measures – to which hospitals remain committed – are working?

The AHA does not see any additional benefit that the ETS provides beyond that which hospitals have already been doing – and continue to do – to protect their workforce throughout the pandemic. As such, we urge OSHA to withdraw this ETS. If, however, the agency declines to do so, we recommend that the ETS be allowed to expire at the end of the six months and not be published as a final rule.

³ https://covid.cdc.gov/covid-data-tracker/#health-care-personnel_healthcare-deaths

Protecting our workforce and our community requires that we are able to follow the evolving science and maintain the necessary flexibility, particularly in areas with high vaccination rates and low community transmission of COVID-19.

COMPLIANCE DEADLINE

If OSHA declines to withdraw the ETS or allow it to expire after six months without being finalized, the AHA strongly urges OSHA to reconsider our request to delay the ETS compliance dates for at least an additional six months in our [June 29 letter](#). Hospitals and health systems are struggling under the weight of the COVID-19 pandemic's fourth wave; they have told us that they remain committed to following the science-based and quickly-evolving guidance issued by the CDC, but require more time to fully implement the many new requirements contained in the ETS. **In addition, we again reiterate our request that the agency's initial enforcement efforts take into account hospitals' good faith efforts to comply and address enforcement in an educational, non-punitive manner.**

The ETS requirements are extensive and complex, and require changes in hospitals' policies, procedures and structures. As we noted in our June 29 letter, changes in hospital policies and procedures are not simply a matter of changing words on paper; rather, they require careful analysis and planning, the acquisition of needed materials and tools, and the retraining of personnel. For organizations rendered by the latest surges busier than ever caring for their communities' ill and injured, and with employees who are burned out from 18 months of dealing with the pandemic, it will take time to accomplish all of these required changes, particularly those that are inconsistent with, or unrelated to, CDC guidance.

Further, our rural hospitals, with limited resources and staff, are seriously concerned about the compliance timeframe, particularly as it relates to the extensive array of new policies and practices that were required to be put into place within 30 days. They are especially concerned about the timing and costs of provisions such as the written COVID-19 plan based on a detailed hazard assessment, the requirements to monitor points of entry and screen all those who enter, physical barriers, ventilation, and the medical removal protection benefits.

Moreover, we believe OSHA would agree that the standardization of protocols is a good measure to take for the sake of patient and employee safety. Adequate time is needed for hospital committees and working groups to approve and implement all the details in the ETS requirements related to employee screening, contact tracing, work clearance and data reporting. We believe that allowing time to review of these protocols through a regular workflow will result in more successful implementation. Additional time is also needed to educate and communicate to hospital employees so that changes are done with purpose and confidence. Chaotic and rushed implementation will negatively impact safety, is unnecessary and detracts from our members' missions in health care. To

ensure that they can do so in a thoughtful and effective manner, we request that OSHA extend the compliance period.

OSHA ETS IS INCONSISTENT WITH CDC GUIDELINES AND SCIENCE

While we appreciate that OSHA incorporated into the ETS some of CDC's COVID-19 guidelines and recommendations, we are concerned about requirements that contradict or go far beyond what CDC recommends – in some instances, in ways that may put health care workers at greater risk.

It is uncertain how hospitals will be able to resolve the discrepancies between CDC guidance and the ETS. As described in more detail below, this is particularly a concern in the areas of outdated CDC guidance that the ETS incorporates by reference and will continue to enforce, including different definitions of exposure and related medical removal policies, the more limited benefits for vaccinated health care workers under OSHA compared to CDC, and the divergent cleaning and disinfecting requirements following aerosol-generating procedures.

The establishment of new standards that differ from the CDC's evidence-based guidance is counter-productive. The CDC's guidance and recommendations have been the standard for safe operations utilized by health care since the beginning of the COVID-19 public health crisis, and health care systems are held to those standards by the CMS regulators. **Creating new standards, separate and different from CDC's, and applicable only to health care providers, is contradictory and will sow doubt about the guidance provided by CDC.** Imposing standards that diverge from CDC's recommendations will also result in unnecessary investments of time and resources, without providing meaningful additional protections for health care personnel.

The lack of alignment with evidence-based guidance from CDC and the chilling message these regulations will send while requiring changes in protocols and practices is concerning. Hospitals have been working for over a year to adjust and refine protocols in coordination with CDC guidance; they have done so primarily to ensure worker and patient safety in numerous care settings. The changes demanded in the ETS sends the message that the measures that health care providers previously pursued to create a safe environment of care were not actually safe. We fear that these inconsistent and overly strict requirements will ultimately lower hospital employees' morale and worsen persisting personnel shortage in hospitals.

Incorporation of CDC Guidance and Other Materials by Reference. In the ETS, OSHA incorporates by reference a number of CDC and the Environmental Protection Agency (EPA) evidence-based guidance documents as well as certain consensus standards. OSHA acknowledges that although CDC, EPA and the other organizations may update their guidelines based on the most current available scientific evidence, OSHA is only requiring compliance with the standards or guidelines incorporated by reference, which

are *fixed in time at the point of publication*. If the documents incorporated by reference become outdated when newer versions of those documents are published, OSHA claims that it will quickly update the ETS through a new rulemaking or issue enforcement guidance, as appropriate.

The AHA has serious concerns about this approach to incorporating and enforcing possibly outdated CDC guidance and recommendations in the ETS. First, we are not confident that OSHA will be able to update the ETS in a timely manner if significant changes in the evidence-based guidance occur. In the best of times, it takes OSHA one to three years to issue a proposed rule and longer still to finalize that rule. While enforcement guidance can be issued more quickly than regulations, it is inevitable that, as CDC updates its COVID-19 guidance in concert with the evolving pandemic and the rapid pace of scientific discovery, many of the ETS provisions incorporated by reference will become obsolete before OSHA can issue rulemaking or revised enforcement guidance.

Even in the short period of time since OSHA published its ETS in the Federal Register, the following CDC guidance documents have been updated in response to new scientific learning about COVID-19:

- CDC's April 5-released Cleaning and Disinfecting Your Facility Every Day and When Someone is Sick has already been updated to a version released on June 15, 2021;
- CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID–19) Pandemic, has been updated from the Feb. 23 to a June 3, 2021 version;
- CDC's If You Are Sick; Separate yourself from others if you have COVID–19, which OSHA reports as being updated Feb. 18, 2021, no longer exists on CDC's website. However, a similar guidance, CDC's COVID-19 Quarantine and Isolation Guidance, was most recently updated on July 29, 2021; and
- CDC's Return to Work Criteria for Healthcare Personnel with SARS–CoV–2 Infection (Interim Guidance), has been updated from the Feb. 16 to a June 2, 2021 version.

Moreover, while OSHA notes that it has a longstanding *de minimis* enforcement policy to allow employers to rely on documents that are at least as protective, once more of the U.S. population is vaccinated, and the pandemic begins to slow down, 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 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. **Therefore, the AHA recommends that OSHA incorporate by reference relevant CDC guidance and other standards by linking directly to the live document. We further recommend that when CDC updates its guidelines, 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 would require that hospitals allowed a longer time to come into compliance.

Employer Notifications to Employees of COVID-19 Exposure in the Workplace. The way in which the ETS deems employees to be “exposed” to COVID-19 in the workplace is inconsistent with CDC’s guidance on exposure. That is, the ETS notification requirement considers any employee who has been in close contact with a COVID-19 positive individual to be “exposed” if the employee is not wearing a respirator. This means any employee wearing a facemask, instead of an N95 respirator, in these circumstances is considered to be exposed. In these cases, the ETS requires the employer to notify the employee within 24 hours and immediately remove them from the workplace. This directly contradicts CDC’s risk assessment guidance for health care personnel⁴. CDC’s risk assessment guidance includes both respirators and facemasks as sufficiently protective PPE for avoiding removal from the workplace.

Thus, OSHA’s definition of exposure and its related requirements are not only inconsistent with CDC’s recommendations, but will also impose a much heavier financial burden on health care facilities because of the required removal of more employees than necessary, along with the subsequent pay for these employees’ medical removal protection benefits. It will also unnecessarily worsen the serious workforce shortages currently being experienced by hospitals and health systems. Some hospitals are already experiencing challenges in finding sufficient staff to cover all of their open beds, and this rule could cause some to reduce the number of beds that are opened and staffed at a time, all at a time in which most communities are experiencing significant needs for beds for COVID and non-COVID patients, many of whom have already delayed care due to the pandemic.

OSHA’s notification requirements also consider an employee “exposed” regardless of whether they have been in close contact with the COVID-19 positive individual. That is, employers must notify employees wearing facemasks, instead of respirators, even if

⁴ Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2, updated Mar. 11, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

they merely worked in the same floor (or other well-defined portions of a workplace) on which an infected person was present, without an assessment of whether or not there was in fact close contact. This is inappropriate and will impose further unnecessary burden on the employer, while needlessly frightening employees. Furthermore, this is not how contact tracing is done; notification should be made to those in close contact, which CDC defines as being within six feet of an infected person, for a cumulative total of at least 15 minutes. It should not apply to everyone who happens to be working on the same floor as the infected person.

The AHA urges OSHA to revise the ETS to comport with CDC’s exposure guidelines, including recognizing facemasks’ protective value and removing the requirement to notify every employee working in the same well-defined area of the workplace as the infected person, unless an assessment is made that they had close contact with the infected person.

Vaccinated Staff Benefits Lacking. Another example of an ETS provision that is inconsistent with CDC guidance relates to the flexibilities that fully vaccinated health care personnel can enjoy. CDC guidance⁵ allow fully vaccinated personnel to dine and socialize together in break rooms and conduct in-person meetings without masking or physical distancing. By contrast, OSHA’s exception for fully vaccinated personnel in “well-defined areas” only applies if there is “no reasonable expectation that any person with suspected or confirmed COVID-19 will be present.”

AHA members tell us that this standard is much too strict, as there is always a chance a person with suspected or confirmed COVID-19 will roam into these “well defined areas,” such as a hospital cafeteria or a room where staff meetings take place. In other words, there are very few places in hospitals where this “no reasonable expectation” standard could be met. So while OSHA believes that the relaxation of masking, physical distancing and physical barrier requirements in non-patient care areas will incentivize staff vaccination, the agency is in fact threatening to undermine its own intent through this overly stringent rule.

The AHA is concerned that this overly strict standard could actually discourage staff vaccination. There is concern the rule in essence eliminates the “carrot” of vaccinated hospital employees being able to work and socialize without masks in certain areas. Many hospitals that adopted additional flexibility for fully vaccinated staff to encourage vaccination are now forced to retrench to OSHA’s far more onerous standard. **The AHA urges OSHA to remove the “no reasonable expectation” language from this provision in the ETS.** In addition, OSHA may consider amending its “well defined areas” exception to include employees who have had COVID-19 and fully recovered, as there is evidence of substantial immunity conferred by prior infection (although not as strong as that conveyed through vaccination).

⁵ Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination, updated Apr. 27, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html>.

Cleaning and Disinfecting After an Aerosol-generating Procedure (AGP). The ETS requires that after each AGP performed on a person with suspected or confirmed COVID-19 is completed, the employer must clean and disinfect the services. This is another provision that is inconsistent with CDC guidelines. Typically, when hospital clinical staff conduct AGPs, such as bronchoscopies, all staff are wearing the required PPE for high-risk procedures, including respirators. The rooms in which such procedures are performed are generally cleaned and disinfected one or more times a day, but not after each AGP, because with all the staff donning appropriate high-level PPE, this is unnecessary. It is also not efficient or practical to completely clean the rooms in which these procedures are performed 15 or more times a day.

The CDC’s Environmental Infection Control guidelines⁶ referenced by OSHA for this provision is not COVID-19 specific; it addresses only the original SARS-CoV-1 outbreak. While these guidelines do recommend cleaning and disinfecting more frequently than daily after AGPs, it also does not require this to occur after every procedure. It states: “In-patient rooms housing SARS patients should be cleaned and disinfected at least daily and at the time of patient transfer or discharge. *More frequent cleaning and disinfection may be indicated for high-touch surfaces and following aerosol producing procedures (e.g., intubation, bronchoscopy, and sputum production).*” Also, CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic⁷ states, with regard to AGPs, “Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.” However, the section to which this refers has no information on the frequency of cleaning.

PHYSICAL DISTANCING AND PHYSICAL BARRIER REQUIREMENTS

Physical Distancing Requirement. Hospitals are concerned that the ETS physical distancing and barrier requirements do not account for employees’ vaccination status or adherence to rigorous PPE protocols. With more than half the country and at least 75% of hospital health care workers fully vaccinated, and with the growing number of hospitals and health systems mandating the vaccination of their workforce, the physical distancing requirements are becoming more difficult to manage for health care employers. Many are concerned that they will be cited for violation of this requirement despite their best efforts.

Furthermore, hospitals believe that the requirement to keep employees at least six feet away from all other persons hinders staff education, negatively impacts staff morale, and impedes hospital’s exhausted workforce from doing their job efficiently – all when hospitals are already taking many other precautions for the benefit of employee safety.

⁶ CDC’s Guidelines for Environmental Infection Control in Health Care Facilities. Updated July 2019.
<https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf>.

⁷ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

The AHA urges OSHA to amend the ETS physical distancing requirements to better account for health care worker and community vaccination status.

Physical Barrier Requirements. The AHA recommends OSHA remove the physical barrier requirement from the ETS. We believe the efficacy of the ETS physical barrier requirement in reducing the transmission of COVID-19 in hospitals remains unproven and installing physical barriers presents a significant burden in this setting. In hospitals, where multiple other controls are already in place and routinely used, such as universal masking, high levels of vaccination among employees, ventilation, screening and medical removal practices, we do not believe physical barriers meaningfully contribute to risk reduction. 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.

Nevertheless, in OSHA's response to concerns AHA raised in its June 29 letter, the agency noted that "[i]n addition to scientific studies cited in the preamble supporting the use of barriers to reduce droplet transmission, CDC guidance supports the use of barriers to mitigate the spread of COVID-19 in workplaces where social distancing is not possible. See Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (March 8, 2021); COVID-19 Employer Information for Office Buildings (April 7, 2021)." Upon investigation, both of the references to CDC guidance documents are revealed to be archived documents, with CDC noting, "This webpage is for historical purposes and is no longer being updated."

Moreover, in the ETS preamble, OSHA acknowledges that COVID-19-related research on barriers is fairly limited due to the recent emergence and ongoing nature of the pandemic. Although OSHA does go on to cite some studies that it claims address the effectiveness of physical barriers in health care settings during the COVID-19 pandemic, these studies, upon review, either are based on experiments evaluating unrelated outcomes and using surrogates for SARS-CoV-2, or did not actually demonstrate that physical barriers independently reduced transmission.

For instance, the Mousavi study cited by OSHA as evidence that physical barriers can reduce transmission is not relevant to demonstrating the need for the ETS requirement that hospitals use physical barriers in fixed work location outside of direct patient care areas where each employee is not separated from all other people by at least six feet of distance. Instead, the Mousavi study was a highly structured experiment intended only to demonstrate the efficacy of health care facilities turning general patient rooms into isolation rooms using HEPA filtration and plastic barriers with zipper doors. By contrast, the types of barriers described in the ETS for fixed work locations are entirely different in both size and purpose and therefore the conclusions of the Mousavi study do not apply here. Moreover, the several simulation studies described by OSHA as justification similarly do not convincingly demonstrate the need for the physical barrier requirement in the ETS due to their vastly different contexts in which the studies were done; e.g.

barrier around a patient’s head, neck and chest in dental procedures and acrylic boxes around a patient’s head in endoscopies.

In the Hale and Dayot (Aug. 13, 2020) study cited in the ETS preamble, the agency alleges that, “Researchers found that a COVID-19 outbreak among hospital food service employees was effectively contained with the prompt implementation of physical barriers in the workplace where physical distancing was not implemented.” However, upon a review of this study, it is clear that the authors do not demonstrate that physical barriers alone were responsible for reduced transmission, but rather that reduced transmission was the result of the implementation of a wide variety of infection control measures and practices. The authors state, “The outbreak was halted when infection control measures and safe practices were reinforced with staff, symptom monitoring including temperature checks were implemented prior to start of each shift, asymptomatic testing was performed for enhanced case finding, all positive staff were isolated at home, physical barriers were installed, and physical distancing and universal masking were observed.”

Putting up physical barriers in health care settings can also be dangerous. For example, a study cited by OSHA, Abuhegazy et al. (Oct. 20, 2020), warns that, “if not designed or installed properly for the specific work environment, barriers may obstruct or interfere with the ventilation system airflow, and fire and life safety protection systems (e.g., fire alarm notification devices, fire sprinklers, fire pull stations).” For instance, often the barriers that are installed by hospitals are acrylic (i.e. Plexiglas). The problem with that, according to the American Society for Health Care Engineering (ASHE), AHA’s health care engineering society, is that once the COVID-19 public health emergency ends, state and local fire marshals will cite facilities for having these kinds of barriers in place. This is because Plexiglas is flammable and not permitted in a health care occupancy by the Fire Code or Life Safety Code⁸ in the quantities currently being installed. In addition, as noted above, many of the installations create obstructions with other life safety systems, such as fire suppression.

The Abuhegazy et al. study also notes that physical barriers may result in ergonomic and communication concerns. That is, “[t]he installation of Plexiglas barriers has the potential for increasing the risk of musculoskeletal injuries in certain settings where the Plexiglas barrier diverts normal body motion.” The study’s authors further state, “The Plexiglas barrier may interfere with voice communication causing individuals to lean forward from the natural sitting or standing position to project their voice. The combination of the barrier with facemasks or cloth face coverings may also cause communication issues.”

⁸ NFPA 101 Life Safety Code, Chapter 10 (Interior Finish, Contents, and Furnishings) and Chapter 18 and 19 (Health Care New and Existing).

For these reasons, as noted above, the AHA recommends OSHA remove the physical barrier requirement. In the event that OSHA declines to do so, we recommend that a sentence be added to the physical barriers section stating, “The installation of barriers shall be coordinated with other environmental controls and shall not conflict with life safety features of the building.”

VENTILATION

The AHA appreciates OSHA’s decision not to require health care facilities to install new heating, ventilation and air-conditioning (HVAC) systems or airborne infection isolation rooms to augment or replace functioning systems, as well as its focus on ensuring that existing HVAC systems are operating consistent with the manufacturer’s instructions and design specifications. These considerations will allow hospitals to decrease the risk of transmission of COVID-19 without requiring costly large-scale changes.

However we are concerned that the ventilation requirements may be misunderstood by hospital leadership because they partially duplicate, but are not as comprehensive as, the current ventilation 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, the AHA recommends that OSHA require that facilities installing new or upgrading existing air handling systems follow the latest edition of the CMS adopted standard for health care ventilation, ASHRAE/ASHE 170. Regarding existing systems, the AHA recommends that OSHA require that facilities evaluate existing air handling systems to determine if improvements can be made to the filtration. This evaluation should include the verification of the system design, verification of the system current operational capability and if filtration can be upgraded to a minimum of a MERV-13 rated filter without affecting the system’s other performance requirements.

We understand that both OSHA and CDC have reviewed ASHRAE’s recommendations, but the article⁹ cited as the basis for OSHA’s decision regarding ventilation requirements was written about “buildings” in general, not specifically about health care facilities, which are much more complex than a standard office building. By contrast, the committee responsible for the development of the ASHRAE/ASHE standard is multidisciplinary and includes professional engineers, epidemiologists, facility managers and other experts in the area of ventilation and filtration for health care facilities. They

⁹ Guidance for building operations during the COVID-19 pandemic. ASHRAE Journal 72-72. https://www.ashrae.org/file%20library/technical%20resources/ashrae%20journal/2020journaldocuments/72-74_ieq_schoen.pdf. (Schoen, May 2020).

utilize the latest research to make decisions on filtration and ventilation requirements specifically for the health care environment through a consensus-based process. In fact, the standard was recently revised to include discussions about ventilation during the COVID-19 pandemic, which were either incorporated into the standard or into additional guidance provided by the committee.

As noted above, the ASHRAE/ASHE standard is also far more comprehensive than the ETS's ventilation requirements. The ETS requirements, by simply requiring hospitals to increase the filtration requirements without a system-by-system analysis and an understanding of potential performance of that filtration, could be harmful. This is because increasing filtration could have downstream impacts to the system that could alter the designed pressure relationships, causing the system to be out of balance, and potentially exposing immunocompromised individuals and others to harmful conditions. As noted in the ETS preamble, filters with MERV ratings of 13 or greater are much more efficient at capturing particles of a size relevant to COVID-19 than a MERV-8 filter. However, what OSHA does not capture in its requirements is that MERV-13 filters are less efficient at moving air and ventilating the space. By contrast, the ASHRAE/ASHE 170 guidance includes these kinds of important provisions that need to be considered with any change in filtration, such as air changes per hour, pressure relationships, temperature and humidity.

In conclusion, while OSHA based its ventilation requirements on the guidance provided by ASHRAE, this is not enough. The ETS requirements should be considered in the specific context of a health care environment where there are potentially many risks that must be controlled by the ventilation and filtration systems. With CMS on the 2008 edition of ASHRAE/ASHE 170 and many states soon to be on the 2021 edition, OSHA should not confuse matters by requiring compliance with additional requirements that are already more comprehensively addressed by other health care standards. **To avoid confusion between multiple standards and potentially creating dangerous situations that could infect many patients, AHA recommends that health care facilities follow one public consensus standard that takes all of the evidence into consideration, the ASHRAE/ASHE 170 Standard.**

PATIENT SCREENING AND MANAGEMENT

The ETS requires that health care employers limit and monitor each setting's points of entry and screen and triage all clients, patients, residents, delivery people and other visitors, along with other non-employees entering the facility.

Many hospitals have voiced concerns about the uniform application of these requirements across all communities, regardless of their rate of infection and the vaccination status in localities across the nation. But in communities where infection rates are dropping and the majority of people are vaccinated, the benefits of limited

entry and screening are reduced. Limited entry and screening also create bottlenecks at entry points; they require excess resources that can discourage visitation and ultimately affect the patient experience negatively. Local health departments already manage these rules using CDC guidance and so can more easily adapt these policies based on local epidemiology. **The AHA recommends that OSHA consider showing deference in the ETS to state and local health department guidelines to scale up or down requirements for visitor or employee monitoring and screening based on local epidemiology.**

INADEQUATE EMPHASIS ON THE IMPORTANCE AND BENEFIT OF VACCINATION

The AHA believes that the OSHA standard fails to place enough emphasis on the most important protection against COVID-19 currently available: vaccination. Indeed, as of Aug. 4, nearly 1,400 hospitals and 100 health systems have established mandatory vaccination policies for their employees. Many other types of health care facilities, including nursing homes, clinics, and physician and dental offices have mandated that their employees be vaccinated against COVID-19 as a condition of employment. No other infection prevention and control policy currently in use are as effective in stopping the transmission of the COVID-19 virus as vaccination. **The AHA and its members urge OSHA to include more emphatic language regarding COVID-19 vaccination as well as additional flexibilities for fully vaccinated health care workers.**

The ETS does include some limited benefits for fully vaccinated employees, including the exemptions in certain well-defined hospital ambulatory settings, in certain home health settings, as well as the narrow exemption from certain requirements for well-defined areas within a health care facility where suspected or confirmed COVID-19-positive individuals are not reasonably expected to be present. **However, as more health care workers become fully vaccinated against COVID-19, we encourage OSHA to find additional ways to encourage vaccination by loosening or eliminating as many of the ETS requirements as possible to reflect the reduced risk in hospitals and other health care settings.** For instance, OSHA should consider eliminating or reducing the frequency of required employee health screening for fully vaccinated employees.

EMPLOYER NOTIFICATION TO EMPLOYEES OF COVID-19 EXPOSURE

The ETS requires that employers notify employees of a COVID-19 exposure in the workplace within 24 hours of becoming aware of the infected employee. Hospitals are concerned that notification within 24 hours is not feasible. For instance, small hospitals that rely on physicians for their occupational health are not equipped to do 24-hour notification. Large hospitals will have many more employees who will need to be notified (particularly given OSHA's overly broad definition of "exposed", as discussed above) and doing so within 24 hours may not be possible. **The AHA recommends that OSHA revise this requirement so that notification in these circumstances must be done**

“promptly,” but within 72 hours after the employer becomes aware of the employee’s COVID-19 illness or symptoms.

TRAINING

Hospitals are seeking clarification on many aspects of the ETS training requirements. The AHA would appreciate OSHA addressing several of these topics in the ETS or in the supporting materials on OSHA’s website, such as the “Frequently Asked Questions.” Such areas that require clarification include:

- The ETS notes that an employer may rely on training completed prior to the rule’s effective date to the extent that it meets the relevant training requirement. While hospitals conducted a great deal of training of their employees throughout the pandemic, they are concerned that their prior training may not exactly match the detailed training requirements in the ETS. Hospitals would like to be able to comply by demonstrating that their past training was substantially equivalent to what OSHA is requiring.
- The ETS requires that training allows for interactive questions and answers. Hospitals would like clarification about what OSHA means by “interactive” and requests that OSHA clarify that online learning management system software is sufficient.
- The ETS requires that additional training is required when there is an indication that the employee has not retained the necessary understanding or skill. Hospitals seek guidance on how employers could measure in real time these deficits.
- The ETS requires additional training when an employee’s risk of contracting COVID-19 at work changes. As the evidence-base and understanding of COVID-19 continually increases and improves, risk levels may fluctuate up or down regularly even without changes in an employee’s job task. Hospitals seek examples of the types of changes that could require such additional training. We ask that, if changes are not substantially different, OSHA afford providers the ability to conduct such additional training of employees through non-interactive means, such as a memorandum notifying them of new policies and practices.

PPE REQUIREMENTS FOR ALL EMPLOYEES

The ETS requires health care employers to provide facemasks to those employees who are not required to wear respirators, with a sufficient number of facemasks provided so that each employee is able to change it at least once per day, whenever it is soiled or damaged, and more frequently, as necessary. The AHA is concerned that this requirement, imposed uniformly across all health care systems, will result in an

unanticipated shock to the supply chain, potentially causing facemask shortages. This is especially important in light of the surging numbers of COVID-19 cases across the nation and the well-known fragility of the PPE supply chain.

CDC, in its “Strategies for Optimizing the Supply of Facemasks”¹⁰ indicates that when supplies are constrained, CDC’s contingency and crisis capacity strategies allow for “extended use of facemasks as PPE” and “limited re-use paired with extended use”, respectively. However, the OSHA ETS does not allow for such flexibility for facemasks. Instead, OSHA only references CDC strategies to optimize the supply of N-95 respirators, by noting that employers may follow the CDC’s “Strategies for Optimizing the Supply of N95 Respirators” when supplies are limited. However, as respirators are not the same as facemasks, this flexibility OSHA permits for reuse (and other strategies) of respirators would not be permitted for facemasks. **Therefore, the AHA recommends that OSHA revise the requirements for facemasks to allow health care employers, in contingency and crisis capacity situations, to mandate facemasks’ extended use and limited re-use in order to continue to protect health care employees when shortages occur.**

COVID-19 PLAN: EFFECTIVELY COMMUNICATE AND COORDINATE WITH OTHER EMPLOYERS

The ETS requires that when employees of different employers share the same physical location, each employer must effectively communicate its COVID-19 plan to all other employers, and coordinate to ensure that each of its employees is protected as required by the rule. Further, the rule requires that, in this circumstance, the employer must adjust its plan to address any particular COVID-19 hazards presented by the other employees.

Our members have expressed concern about the burden involved in carrying out this requirement. Hospitals are complex institutions, with many different arrangements in place to provide care and support services. This ETS requirement would mean that a hospital would have to request and review the COVID-19 plan for any medical staff members who are not hospital employees, allied health companies that provide clinical staffing, food service vendors, grounds maintenance firms and many other vendors that provide clinical or other necessary services. While sharing the hospital’s plan with these other employers is not difficult, it is the requirement to collect and coordinate multiple employer plans that poses the larger burden, particularly given the timeframe for compliance required by the ETS.

As such, we suggest that OSHA consider changing its rule to allow providers to use an organized health care arrangement, similar to that permitted under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under

¹⁰<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

HIPAA, health care providers and other covered entities that participate in an organized health care arrangement may use a single, joint notice that covers all of the participating covered entities. **Another option OSHA could consider would be to permit the hospital's COVID-19 plan to take precedence over any other employer's plan with regard to activities taking place in the hospital.**

MINI RESPIRATORY PROTECTION STANDARD

The mini respiratory protection standard requires employers to allow employees, who are otherwise not required to wear respirators in the course of their work, to bring their own respirators from home to use at their discretion in the health care setting, rather than a facemask. Further, it permits employers to provide respirators to employees not otherwise required to wear respirators in the absence of medical evaluation, fit testing and a written respiratory protection program – safety protocols normally required for respirator use.

The AHA has serious concerns about the mini respiratory protection standard and urges OSHA not to finalize this short-sighted and dangerous policy. Our concerns are described below.

Loss of Employer Oversight Regarding PPE Used by Employees. This standard removes from health care organizations control over whether the PPE worn by an employee is authorized or approved by the Food and Drug Administration (FDA) or is approved by the National Institute for Occupational Safety and Health (NIOSH). The respirators that employees bring into the hospital could be unfamiliar to the organization and the organization may not be able to perform proper training on its use. It is also possible that the respirators are counterfeit or defective, but the hospital would not know because it is not managing the product's vetting and acquisition to ensure it conforms to federal standards, something hospitals have been doing throughout the pandemic. Our members strongly believe in giving the correct PPE to every employee based on their risk of exposure and then training each employee on this PPE's proper use, while then providing oversight to ensure the appropriate practices are followed. The rule's implication that employees are free to choose their own PPE would defeat this carefully constructed system of acquisition, distribution and training on PPE's safe use. The mini respiratory protection standard is inconsistent with what safety experts know about improving safety by standardizing tools and processes.

Loss of Trust in the Long-standing Science-based PPE Framework. Health care providers know how critical it is to preserve trust in the effective, science-driven PPE framework that currently exists. The mini respiratory protection program will cause confusion and undermine that trust. Hospitals have worked tirelessly through the pandemic to ensure that there is equity and confidence in the PPE framework across their workforce. That is the reason that many hospitals have not permitted employees to choose their PPE or to wear their own PPE from home. Wearing an N95 or a powered

air-purifying respirator (PAPR), if that is not right for the employee's work setting, undermines confidence among other employees, who may believe that they are less safe. A hospital's focus is on science and their infection control and safety officers know that deviating from what is known to be safe undermines their training program and trust. This kind of heterogeneity in PPE can undermine trust and equity among the workforce.

Increased Risk for Employees and Increased Burden and Liability on Hospitals. Both provisions in the mini respiratory protection standard impose increased burden and liability risk on employers. For instance, if the employer provides a respirator to an employee, despite the lack of a hazard that would justify its use, OSHA does not require medical evaluation, fit testing or a written respiratory protection program, each of which are part of the normal safety protocols OSHA's existing Respiratory Protection Standard require for a respirator's mandatory use. Instead, the mini respiratory protection standard establishes different and less comprehensive requirements, including certain training, user seal checks, reuse conditions and discontinuation requirements; each of these increase burdens on the employer while placing them at risk for increased liability if something goes wrong and an employee is harmed – all for a situation that does not require this higher level protection. Larger health systems have told us that the number of employees who would choose to wear a respirator in place of a facemask would put a great deal of burden on the system to implement and ensure these non-required respirators' proper use. The AHA believes that the time and effort spent implementing this provision could be better used to protect employees and patients who have actual COVID-19 exposure risks.

The mini respiratory protection standard provision that allows employees to use their own respirator, despite not having a job that requires its use, also poses greatly increased burden and liability risks for the employer, even if the employer shares the notice set out in the standard. For instance, the employee's respirator could be counterfeit or otherwise not NIOSH-approved. This means the employer must ensure that any employee who chooses to change out their facemask for a respirator must actually ensure national standards are met. Our members tell us that in large health care systems, it would be very difficult to review and validate each employee's individual respirator that was purchased elsewhere. Also, an employee who wears a respirator with an exhalation valve, which are not permitted in hospitals, could put their coworkers and patients at risk of infection. It would also be difficult to ensure that all employees who choose to wear their own respirator have had it validated by the health system and received the required information before they start wearing it. With potentially many different types and brands of respirators being used, it would be very difficult to control who has been cleared by the hospital and received the required information.

Throughout the pandemic many hospitals relied on employees to report any mask/respirator that other employees were wearing that were not those vetted and approved by the hospital. This will no longer be feasible given the new requirement.

Further, employers face increased liability risk if they have to rely on the employee for the individual's own respirator's proper use, cleaning, maintenance and storage. While the required OSHA notice states that the employee is in charge of cleaning and maintaining their respirator, it is likely that some will not be used or maintained correctly, thus putting the employee, coworkers and patients at risk of infection and imposing additional liability risk upon on the employer.

Impact on Supply of Respirators. The mini respiratory protection standard also depletes the respirator supply for other employees who are engaged in activities that requires the use of a respirator. This is especially important in light of the surging numbers of COVID-19 cases across the nation and the well-known fragility of the PPE supply chain. It is foolhardy to adopt policies that result in respirators' unnecessary use, lest we return to the extreme shortages health care experienced earlier in the pandemic.