GREATER NEW YORK HOSPITAL ASSOCIATION
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James Frederick
Acting Assistant Secretary of Labor for
Occupational Safety and Health
Occupational Safety and Health Administration
200 Constitution Ave NW Washington, DC 20210

Submitted electronically

Dear Acting Assistant Secretary Frederick:

On behalf of the more than 160 voluntary and public hospitals and health systems in four states that make up Greater New York Hospital Association's (GNYHA) acute care membership, thank you for the opportunity to provide comments on the Occupational Safety and Health Administration's (OSHA) interim final rule establishing an Emergency Temporary Standard (ETS) for occupational exposure to COVID-19.

GNYHA members, like their counterparts across the country, were blindsided by the initial wave of the COVID-19 epidemic. In the early months of the emergency, public health officials and health providers grappled with logistics, supply shortages, an ever-increasing volume of patients, and the helplessness that came with a novel pathogen and devastating illness.

Hospitals responded quickly and bolstered their existing infection control infrastructure and policies despite enormous challenges and tremendous stress on our entire health care system. Hospitals worked with public health agencies to understand this novel virus, how it is transmitted, and how it could be prevented and treated. This expertise has them to design optimal infection control policies and procure appropriate personal protective equipment (PPE) as well as other protections for their employees. These same hospitals have also made substantial investments to stay abreast of and comply with the evolving recommendations from the Centers for Disease Control and Prevention (CDC). More recently, they worked to vaccinate their staff and communities.

While GNYHA and its members share OSHA's commitment to health care worker safety, the ETS, published on June 21, 2021 and fully effective by July 21, is concerning for several reasons. The timing of these requirements, their prescriptive nature, and their deviation from accepted scientific standards create inefficiencies and added costs to questionable benefits. Given the existing, evidence-based standards and policy controls in place to enforce them through the CDC and local public health agencies, *we recommend that OSHA allow the ETS to expire and not issue a final rule.*

In addition, we are providing comments on the following points and key concerns:

GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

- If OSHA finalizes the ETS, then its requirements should only be applicable to health care facilities in regions with a high prevalence of COVID-19 cases and hospitalizations (e.g., hospital in regions with >5% case positivity).
- OSHA should not develop and require its own set of infection control standards, and should instead incorporate by reference those currently in place from the CDC.
- OSHA should remove the mini respirator protection program from the requirements.
- OSHA should remove non-invasive ventilation from the definition of aerosol-generating procedures.
- The ETS should remove any prescriptive requirements for health screenings at points of entry; alternative strategies should be acceptable.
- The ETS should consider factors such as duration of exposure and the vaccine status of individuals when determining exposures, and not apply unproven exposure standards as employer requirements.
- The ETS should remove physical barrier requirements for employers.
- OSHA should streamline employer-required logging and reporting and remove any duplicative reporting of COVID-19 cases in health care workers.

Please contact Zeynep Sumer King (zsumer@gnyha.org) if you have any questions or would like further information on GNYHA's recommendations.

Thank you for the opportunity to comment and the extended timeframe in which to do it thoughtfully.

Sincerely,

Kenneth E. Raske
President, GNYHA

Overarching Concerns About the ETS

GNYHA members prioritize the safety of their patients and staff. In the absence of OSHA guidance last year, hospitals developed their own COVID-19 workplace safety plans based on facility assessments, evolving risks, CDC guidance, and state and local orders. To further protect their patients and staff, many hospitals, and some states like New York, are requiring vaccinations of their staff. The ETS does not require or even strongly recommend COVID-19 vaccination for employees, which we know to be the most effective way to protect employees and prevent transmission. The most important act OSHA could take to protect employees would be to mandate COVID-19 vaccination. Meanwhile, the ETS requirements would instead call for a new set of plans and protocols. This burdens the health system in a way that is not designed to keep up with evolving science or the changing landscape of the epidemic and requires additional investments with little to no benefit.

OSHA rationalizes the need for the ETS because it states health care workers are in "grave danger" from COVID-19. But the current state of epidemic, particularly in parts of the country with significantly lower case-positivity and hospitalizations, as well as low-to-no health care worker infections, do not constitute a "grave danger." This is particularly true when contrasted with the critical situation in the spring of 2020, when New York and surrounding communities had widespread COVID-19 outbreaks, exploding hospitalizations, and insufficient amounts of PPE. Yet OSHA did not deem the situation early in the epidemic as posing grave danger to health care workers and did not issue an ETS to address the situation. Hospitalizations in New York City and New York State both peaked on April 12, 2020 at 12,184 and 18,825, respectively. Current hospitalizations for New York City are 839 and 1,934 for New York State. Both State and New York City hospitalizations are slightly above 20% of what they were during last winter's peak. The ETS is therefore too much and certainly too late.

Finally, the ETS requirements are not consistent with the newest CDC guidelines and the policies states have adopted to support them. The CDC has provided current scientific information and recommendations based on data gathered throughout the pandemic, and its guidance continues to evolve. This is especially true as we learn more about special circumstances required for those who are immunocompromised and the durability of the protective measures, such as vaccines, that have been put in place. While it has been challenging for hospitals and other health care organizations to follow this evolving evidence, they have kept pace and regularly amended their practices throughout the pandemic to ensure the safety of both staff and patients. The ETS is at odds with CDC guidance in critical areas and will complicate those efforts. The OSHA ETS as written locks in place compliance with some CDC guidance that may soon be out of date, placing the ETS even further out of alignment with the latest science.

For all these reasons, OSHA should allow the ETS to expire at the end of six months and not introduce a final rule. If OSHA finalizes the ETS, then its requirements should only be applicable to health care facilities in regions with a high prevalence of COVID-19 cases and hospitalizations (e.g., hospitals in regions with >5% case positivity.) In addition, OSHA should not develop and require its own set of infection control standards but should instead incorporate by reference those that are currently in place from the CDC.

ETS Mini Respirator Protection Program

The ETS establishes the mini respiratory protection program that applies to specific circumstances specified under the ETS, generally when workers are not exposed to suspected or confirmed sources of COVID-19 but where respirator use could offer enhanced worker protection. The ETS states the program is designed to improve worker protections with limited provisions for the safe use of respirators that can

be implemented more quickly and easily than the more comprehensive respiratory protection program required by the OSHA Respiratory Protection standard. In short, the ETS requires hospitals to allow staff to wear a respirator when one is not necessary for the job being performed. The underlying assumption in the program requirement is that having a higher-level form of PPE is always better, but this is not true.

In fact, hospitals create policies based on thoughtful assessments of the associated risk in a setting or activity and couple that with the appropriate equipment to ensure safety. They have extensive plans and policies in place to ensure the right fit and equip staff with the training to properly don, doff, and care for the equipment. Unit managers maintain awareness of activities and supplies and support their staff with fit-testing and training. The mini respirator protection program undermines this planning and poses additional risk to staff. During this pandemic, we have seen many examples of items being sold as if they met the requirements to be N95s when they do not, and people wearing face coverings that are improperly fitted and improperly donned or doffed in a manner that could transmit disease. Hospitals will be additionally burdened with determining the quality of respirators that employees bring to work and ensuring that they are appropriately maintained, fitted, and safely worn. We are concerned that these standards, which contradict OSHA's existing PPE and respiratory protection standards, may expose employers to liability and put employees at additional risk. *The ETS mini respirator protection program should therefore be eliminated from any final version of the ETS.*

Definition of Aerosol-Generating Procedures

The ETS defines aerosol-generating procedures (AGPs) as medical procedures that generate aerosols that can be infectious and of respirable size, and therefore require higher levels of infection control including appropriate PPE, a limited number of staff involved in the procedure, an existing airborne infection isolation room (AIIR), and cleaning and disinfection after the procedure. The ETS lists procedures that would be considered AGPs and includes non-invasive ventilation (e.g., BIPAP, CPAP) among these procedures.

Non-invasive ventilation has low associated aerosolization, but because of the growing evidence most medical teams would likely take enhanced infection control precautions anyway while actively working on the patient. However, by including it on the AGP list, the ETS limits the clinical autonomy of an ordering physician simply because of the AIIR requirement. Hospitals have a limited number of existing AIIRs. Patients that do not need invasive ventilation, which has increased risk of associated complication, may be subject to unnecessary procedures simply because of the requirement for BIPAPs or CPAPs to be performed in an AIIR. *The ETS should therefore not include non-invasive ventilation as part of the AGP definition. Alternatively, OSHA should consider a tiered approach to identifying AGPs, with certain, less risky procedures not requiring AIIRs.*

Physical Distancing and Physical Barriers

The ETS contradicts the widely accepted definition used by CDC and infectious disease experts of what constitutes an exposure. Instead, the ETS asserts a broad definition that does not acknowledge that health care personnel caring for COVID-19-positive patients in hospitals are wearing highly effective forms of PPE. It also does not consider employee vaccine status and does not encourage staff vaccinations, one of the most effective infection control measures. The ETS definition also does not consider the length of time, in addition to proximity, during which the infected person and the staff member were together, which is how CDC and other public health experts define whether someone has been exposed. Failing to consider these factors could lead to many employees being furloughed when there is minimal risk of exposure, which would worsen existing staffing shortages.

The ETS also relies heavily on physical barriers, which are well-intentioned but have been shown across numerous studies to be ineffective. In fact, much of the recent evidence shows that physical barriers in workplaces and schools could actually *impede* airflow and funnel air in a room toward others. Physical barriers are also a significant additional cost to organizations that have found more innovative and science-based methods for infection control in their work environments.

The ETS should remove the requirement for ubiquitous physical distancing and take into account other important factors such as duration of exposure and the vaccine status of individuals. Additionally, the ETS should eschew requirements based on inaccurate or outdated evidence and, specifically, remove physical barrier requirements for employers.

Health Screening and Medical Management

The ETS requires entrance screenings for employees, visitors, and patients with some flexibility given to employees to self-monitor. Hospitals have had these controls in place throughout the pandemic, certainly as part of Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, which incorporate by reference CDC's guidance on screening staff, patients, and visitors. The CDC and enforcing agencies are beginning to reconsider these requirements. Entry point screening is extremely time consuming and ineffective in identifying individuals who should be denied entrance to the hospital. These screenings create bottlenecks in which patients, visitors, and others are forced into close contact with each other and, as a result, become perfunctory. Hospitals and health systems are unique, complex ecosystems. They should be permitted the flexibility to design screening processes that work best for their facilities and the patients they serve. *The ETS should remove any prescriptive requirements for health screenings at points of entry; alternative strategies should be acceptable.*

The COVID-19 Log

The ETS requires employers to establish and maintain a COVID-19 log to record COVID-19 cases in their workforce in addition to the existing requirement for logging work-related infections.

Hospitals continue to expend significant time and resources, including outside counsel fees, to respond to and manage unreasonable OSHA investigations related to the existing reporting requirements. Last year, OSHA issued guidance to its investigators that detailed how to determine work-relatedness, which included considering alternative explanations and exposure to confirmed cases. Despite this guidance, hospitals report that some investigators are taking the contrary position that health care worker COVID-19 infections are presumed to be work-related unless proven otherwise. In some of these cases, OSHA investigators are failing to consider the underlying facts, such as the infection rate in the community at the time, whether the employee was exposed to a confirmed case at home, and if the employee took public transportation. At the height of the pandemic in 2020, infections were spreading throughout the community at rates far exceeding those within hospitals.

The ETS requirement for additionally logging COVID-19 infections among the workforce, including those not acquired at work, is unnecessary and burdensome. Hospitals already have policies and procedures for screening and reporting, regardless of where the infection was acquired. Hospitals have also operationalized ways to ensure the infection does not spread among the workforce, such as notification to other employees, paid time off, and testing. This activity requires substantial administrative effort and the ETS log requirement will only further burden already strained hospitals. *OSHA should streamline employer-required logging and reporting and remove any duplicative reporting of COVID-19 cases in health care workers.*