



April 20, 2022

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

***Re: Docket No. OSHA-2020-0004 Occupational Exposure to COVID-19 in Healthcare Settings; Emergency Temporary Standard; Occupational Safety and Health Administration Interim Final Rule and Partial Reopening; Request for Comments (Vol. 87, No. 56), March 23, 2022.***

Dear Assistant Secretary Parker:

I write to you on behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members. Thank you for the opportunity to provide additional comments on the Occupational Safety and Health Administration (OSHA's) COVID-19 Healthcare Emergency Temporary Standard (ETS)/Interim Final Rule as published in the Federal Register March 23, 2022.

For more than two years, frontline healthcare workers across our state have battled tirelessly and courageously to take care of patients with and without COVID-19. These clinical staff have been supported by a cadre of organizational leaders, infection control specialists and engineers working to better understand this novel virus and its variants, how it is transmitted, and how it can be prevented and treated. Starting in 2020, supply chain managers throughout the state have convened regularly with business and academic leaders to strategize on best practices for securing PPE and other critical supplies. These efforts continue today through a partnership between AzHHA, the Arizona Coalition for Healthcare Emergency Response (Arizona's ASPR-funded healthcare coalition) and Arizona State University. We know that maintaining front-line workers' health and safety is central to a successful response to the pandemic. And no one is more vested in doing so than our state and country's hospitals.

AzHHA hospital and healthcare system members have demonstrated their commitment to protecting the health and safety of their staff and patients by following scientifically grounded guidance issued by the Centers for Disease Control and Prevention (CDC). These evidence-based protocols, which have evolved (often quickly) over the course of the pandemic, are the cornerstone of most COVID-related infection control policies and procedures. In addition, when COVID-19 vaccines became available, hospitals throughout the state quickly ramped up vaccination sites for their staff and communities. We

know vaccinations work and are the most promising route to ending the pandemic. While many Arizona hospitals and health systems implemented vaccine mandates before the Centers for Medicare and Medicaid Services (CMS) mandate was finalized, all Arizona hospitals are now fully in compliance.

AzHHA and our members are wholeheartedly committed to protecting the healthcare workforce. But, as communicated in our August 19, 2021 letter to OSHA (Attachment A) and a subsequent letter to the Arizona Division of Occupational Safety and Health (Attachment B) we are concerned by several elements of the ETS published on June 21, 2021. We appreciate OSHA's willingness to reopen the comment period and will attempt to restrict our comments to the limited issues raised by the Administration in the March 23, 2022 *Federal Register*.

Before making detailed comments, we offer general comments below on the justification of the ETS and interim final rule.

#### Justification of the Interim Final Rule and ETS

First, while we truly appreciate OSHA's consideration of additional flexibility and potential changes to the interim final rule, we continue to oppose the establishment of new regulations that are not fully aligned with the CDC's evolving evidence-based guidance. CDC guidance and recommendations have long been the national standard for safe operations and infection control. Healthcare providers have relied on these protocols since the beginning of the COVID-19 public health emergency (PHE). Moreover, hospitals and health systems are held to these standards by CMS regulators.

Second, hospitals and other affiliates of healthcare systems are also now subject to CMS's strictly enforced COVID-19 vaccination requirement. This requirement—part of the Medicare and Medicaid Conditions of Participation—applies to staff regardless of clinical responsibility or patient care, including staff who work in offsite locations in which they interact with patients or with staff who interact with patients.

Third, OSHA already has sufficient enforcement authority to protect healthcare employees from the hazards of COVID-19. The Administration maintains and vigorously enforces its general duty clause and other general standards, including the Personal Protective Equipment (PPE) and Respiratory Protection Standards.

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

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

## Detailed Comments

### **A.1—Alignment with CDC Recommendations for Healthcare Infection Control Practices**

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

AzHHA is concerned that a final rule that adopts *specific versions* of CDC guidance will result in OSHA's standard becoming outdated as the scientific understanding of COVID-19 matures and recommended healthcare infection control practices evolve. Embedding any static version of CDC's guidance into the ETS or final rules will lead to different standards adopted by different federal agencies, which will confuse healthcare employers and their employees. The CDC is best positioned to determine how healthcare providers should evolve their practices to mitigate spread of the virus.

Moreover, OSHA's *de minimis* enforcement policy could result in inappropriate over-regulation of healthcare employers as more of the U.S. population is fully vaccinated and the pandemic begins to slow down and eventually enter its endemic stage. CDC's COVID-19 guidance and recommendations are likely to become less stringent over time when this occurs. OSHA's longstanding *de minimis* enforcement policy, which only allows employers to rely on documents that are **at least as protective** as a document incorporated by reference, would hold employers to a standard that CDC no longer recommends.

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

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

### **A.2—Additional Flexibility for Employers**

OSHA states some employers have expressed concern that the provisions of the healthcare ETS were overly prescriptive. The ETS, while rooted in a programmatic approach, specified how employers were required to implement certain policies and procedures, such as the criteria for medical removal and return to work, cleaning, ventilation, barriers, and aerosol-generating procedures. OSHA is considering

restating various provisions as broader requirements without the level of detail included in the ETS and providing a “safe harbor” enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue.

**AzHHA is in support of OSHA’s consideration to establish broader, less-detailed requirements in a final rule, with a “safe harbor” enforcement policy linked to the relevant CDC guidance.** The ETS included various requirements that were overly specific and complex, and which did not align with evolving scientific knowledge, on-going risk assessment and use of alternative safety control mechanisms. For example, the physical standard and the related physical barrier requirements did not account for employee vaccination status or other controls in place such as the use of higher-level PPE.

AzHHA continues to recommend that the physical barrier requirements be removed from the ETS. As pointed out in previous comment letters, we believe the effectiveness of these requirements in reducing transmission of COVID-19 in hospitals remains unfounded, especially in facilities where other controls are routinely used (e.g. high vaccination rates, higher-level PPE, and ventilation). Physical barriers may actually cause harm by interfering with ventilation airflow, fire and life safety protection systems, as well as increasing the risk of communication errors.

AzHHA also supports recommendations by the American Hospital Association to simplify the ventilation requirements contained in the ETS. As noted in their comments, these requirements may be misunderstood by hospital leadership because they partially duplicate, but are not as comprehensive as, the current ventilation consensus standards that are adopted by CMS and which health care facilities already follow.

In summary, AzHHA recommends OSHA align standards with the most current guidance or requirements adopted by other federal agencies, such as the CDC and CMS, as well as standards adopted by professional societies, such as the ASHRAE/ASHE. The criteria for medical removal and return to work, cleaning and aerosol-generating procedures also should be less specific and refer directly to the most current applicable CDC guidance.

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

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

The CDC already addresses such considerations in its various COVID-19 and more general guidance documents, including which infection prevention and control measures should be taken if healthcare personnel are exposed to individuals with suspected or confirmed COVID-19. If OSHA were to incorporate relevant CDC COVID-19 healthcare personnel guidance by directly referencing the live

documents – for example the infection prevention and control guidance, the isolation and work restriction guidance, and the interim guidance for managing health care personnel with SARS-CoV-2 infection or exposure to SARS-COV-2 – then such “tailoring of controls” as envisioned in this section of the notice would be unnecessary.

**In the absence of incorporating by reference up-to-date “live” CDC guidance, AzHHA would not support this approach as it would exacerbate misalignment between OSHA’s standards and CDC’s evidence-based guidance.**

#### **A.5.1—Booster Doses**

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

**AzHHA recommends that OSHA’s definition of “fully vaccinated” be consistent with CMS’ definition, and that it align additional flexibilities with those granted to healthcare workers who are “up to date” on their vaccines as CDC does.**

#### **A.5.2—Employer Support of Employee Vaccination**

The ETS included a provision requiring employers to inform employees about the safety, efficacy, and benefits of vaccination and provide reasonable time and paid leave to each employee for vaccination and side effects experienced following vaccination. The agency seeks comments on several possible changes. For example, OSHA is considering an adjustment to the requirement that would include paid time up to four hours for employees to receive a vaccine (including travel time) and paid sick leave to recover from side effects and seeks comment on the approach. The agency also is considering requiring employer support for employees who wish to stay up to date on vaccination and boosters in accordance with the ACIP and CDC recommendations. OSHA seeks comment on these approaches.

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

Moreover, some states like Arizona have established state laws governing earned paid sick time (see *Fair Wages and Healthy Families Act*; A.R.S § 23-371 et seq.). Arizona employers have been applying these statutory requirements during the pandemic, and we believe they should continue to govern paid time off related to employee vaccination moving forward. Establishing a separate federal requirement would

cause confusion, especially since Arizona’s law is “voter-protected” and cannot be overridden by state legislative action.

### **A.5.3—Requirements for Vaccinated Workers**

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

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

**As stated previously, AzHHA urges OSHA to adopt the CDC’s evidence-based guidance and recommended routine infection prevention and control practices during the COVID-19 pandemic.** In some instances, the CDC factors into its recommendations vaccination status of healthcare personnel based on scientific evidence of a lower risk of illness for those individuals. In addition, several of the CDC’s recommended infection prevention and control measures, such as use of source control and screening testing, are influenced by levels of SARS-CoV-2 transmission in the community. OSHA standards that are inconsistent with CDC’s recommendations would be confusing and counterproductive in healthcare settings.

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

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

**The CDC’s COVID-19 Community Levels recommendations do not apply in healthcare settings and should not be used by OSHA. Instead, AzHHA would support OSHA’s deferring to CDC guidance for healthcare settings, which already incorporates community transmission levels in its recommendations.** That said, larger health systems with hospitals and other affiliated facilities located in many different communities are concerned about the complexity involved in tracking the level of community transmission across all their facilities and as the levels shift continuously over time. And, in some sparsely populated areas of rural Arizona, a very small number of individuals contracting COVID-19 can result in a shift of the community from one level to another quite rapidly. **If OSHA finalizes policies**

that link to community transmission levels, we recommend that the agency develop tools and resources to help hospitals and health systems comply in a way that would not be overly burdensome and take into consideration this complexity for health systems in its enforcement of the regulation.

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

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

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

#### In Summary

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

However, if OSHA proceed with finalizing the rule, AzHHA recommends that OSHA incorporate by reference relevant CDC guidance and other standards by linking directly to the live online CDC document. We further recommend that whenever CDC substantially updates its guidance, OSHA issue an announcement indicating when compliance with the changes will be required.

Thank you for the opportunity to provide additional comments on the COVID-19 ETS and Interim Final Rule. Please feel free to contact me if you have any questions.

Sincerely,



Debbie S. Johnston  
Executive Vice President

Attachment A



August 19, 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 Mr. Frederick:

I write to you on behalf of the Arizona Hospital and Healthcare Association and our more than 80 hospital, healthcare and affiliated health system members. Thank you for the opportunity to comment on the Occupational Safety and Health Administration’s (OSHA) COVID-19 Interim Final Rule and Emergency Temporary Standard (ETS). Since the beginning of the COVID-19 pandemic, our members and their clinical staff operating at the front lines have worked tirelessly in their response efforts, including working to better understand the COVID-19 novel virus, how it is transmitted, and how it can be prevented and treated. In the Spring of 2020, an initial focus was addressing the supply chain—working to procure appropriate personal protective equipment (PPE) and other protections for staff. With the first tranche of CARES Act funding that Congress allocated to AzHHA, we purchased PPE for distribution to hospitals and skilled nursing facilities throughout Arizona. Ensuring staff are protected in fighting this deadly disease is of utmost important to AzHHA and our members.

During last summer’s and winter’s surges, we worked with other state hospital associations and the Arizona Department of Health Services on solutions to bring more staff into Arizona. More recently, we have supported public health and our members’ efforts to vaccinate their communities. These efforts include earned media, social media and tool-kit roll-outs. We know the vaccines are safe and effective—and our best defense against this disease. This is why a number of hospitals and health-systems in Arizona have begun to mandate staff vaccinations.

While we wholeheartedly share OSHA’s commitment to healthcare worker safety, we are concerned by the ETS published on June 21, 2021. It is for this reason that we have outlined above our efforts to protect hospital and healthcare workers from COVID-19 exposure and infection. And as we move into this new surge, we are additionally focused on protecting staff from the stress and burnout that has resulted from over 16 months of response efforts.

Over the past year, the country has praised the truly heroic efforts of nurses, doctors, and other clinical staff who have provided direct patient care during the pandemic. But what is often overlooked are the staff who have supported the frontline efforts—administrators, infection control officers, emergency managers, hospital engineers, supply managers and others. These individuals have worked to secure 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 to stay abreast of the latest scientific information and guidance.

And these efforts are paying off. Arizona hospitals and hospitals nationwide have done an outstanding job of protecting staff and patients even as they learned about this novel virus. Researchers have begun to document the effectiveness of these efforts. A recent study<sup>1</sup> of nearly 25,000 healthcare workers from four health systems across the country concluded that community prevalence of COVID-19 and known exposure to someone with COVID-19 outside work were more common predictors of healthcare workers contracting COVID-19 than anything about their work environment.

It is important to note the measures hospitals have taken to protect their workers, which are being proved effective, are based on evolving best practices and Centers for Disease Control and Prevention (CDC) guidance, and without need of an ETS promulgated by OSHA. In the ETS, OSHA asserts employee exposure to SARS-CoV-2 presents a grave danger for healthcare workers, and this danger is the basis for the ETS. However, a year earlier on May 29, 2020 when hospitals were treating many more suspected or confirmed COVID-19 patients and when PPE was in short supply OSHA took the opposite stance, stating there was a lack of evidence suggesting that infectious diseases, including COVID-19, to which employees may be exposed, constitute a “grave danger” requiring an ETS as an appropriate remedy.<sup>2</sup>

As of August 3, 2021, nearly 58% of Americans (and nearly 55% of Arizonans) over the age of 12 have been fully vaccinated. And while there was a slowdown in the rate of vaccinations this summer, we have begun to see an increase over the past month. Meanwhile, we know 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 healthcare personnel; as such, it is difficult to understand why, at this point, OSHA is asserting there a grave danger, a danger that OSHA contends did not exist last year when there were more deaths and hospitalizations from COVID-19, as well as no vaccines to protect against SARS-CoV-2.

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<sup>1</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777317>

<sup>2</sup> On May 29, 2020, the Centers for Disease Control and Prevention’s (CDC) data reflect that there were 44,581 hospitalizations and 1,190 deaths in the U.S. 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 – a tragic loss, but only a quarter of the number of deaths on May 29 of the previous year.

The federal government's own data – the very data OSHA cites in its ETS in noting that 1,600 healthcare workers across America have died during this pandemic – documents that, since Feb. 13, 2021, 11 deaths of healthcare workers were recorded. There were 24 weeks between February and the last week of July with fewer than five reported deaths of healthcare workers; in the period between July 7 and July 31, there were **zero** recorded deaths of healthcare workers. 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 healthcare workers fully vaccinated, and those vaccines and other protective measures working?

Our key concerns regarding the ETS are as follows:

### **Alignment with CDC Guidance**

The ETS is only partly aligned with CDC guidance. The CDC has provided critical scientific information and recommendations based on data gathered throughout the pandemic. This guidance has evolved and will continue to evolve, especially as more is known about circumstances required for those who are immunocompromised and the durability of vaccines and other the protective measures, including how these measures perform against the emergence of new variants.

It has been challenging for hospitals and other healthcare organizations to follow this evolving evidence, yet we know adherence to the most up-to-date information is essential to fighting this virus and preventing its spread. As such, hospitals regularly amend their practices to ensure the safety of both staff and patients. **Unfortunately, OSHA's ETS will complicate hospital efforts because it is at odds with CDC guidance in critical areas such as masking and social distancing.** Further, as evidence evolves and the coronavirus mutates, we expect there may be more changes to CDC guidance. 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.

### **Mini Respirator Protection Program**

The ETS would require hospitals to allow staff to wear a respirator when one is not necessary for the job being performed. Under the ETS, a hospital could choose to provide this higher level of protection, or the employee could bring in his or her own respirator. The underlying assumption in this standard is an employee's safety lies in having a higher level form of PPE. But this is a fallacy.

Workplace safety is the result of coupling the right forms of PPE with programs that assure the right fit and equip staff with the knowledge to appropriately don, doff and care for the equipment. During this pandemic, many items being sold have been represented as meeting the requirements of N95s when they in fact do not. And staff wearing face coverings that are improperly fitted, improperly donned or doffed, or improperly stored could increase the risk of disease transmission. While the ETS requires employers to provide a specific notice to employees who bring in their own respirator, we are not convinced that this will result in proper fit-testing, and could in fact compromise worker safety.

## **Definition of an “Exposure”**

The ETS contradicts the widely accepted definition used by the CDC and infectious disease experts of what constitutes an exposure. Rather, the ETS uses an overly broad definition that fails to account for the fact that healthcare personnel caring for COVID-19-positive patients in hospitals are wearing highly effective forms of PPE. It also fails to account for the vaccine status of the healthcare personnel and the length of time during which the infected person and the staff member were together. All these factors are critical to determining whether someone has truly been exposed. Failing to take them into consideration could lead to many employees being removed from their work station when there is minimal risk of exposure, in the process exacerbating existing staffing shortages.

## **Screening and Assessment**

The ETS would require entrance screenings for employees, visitors and patients. These entrance screenings include monitoring temperatures and other related symptoms potentially indicative of COVID-19. As envisioned by the ETS, this would require hospitals to place staff at all available entrances and conduct such screenings. These screenings have been recommended previously and are extremely time consuming. Hospitals, instead, should have flexibility in screening and assessing based on the level of community spread and other protective measures taken. For example, when community spread has been high, Arizona hospitals have restricted visitor access to facilities and coupled this with scalable screenings. When community spread has lowered, visitation restrictions have been eased, but visitors are required to wear face masks and social distance. Visitation in COVID-19 units has been typically reserved for end of life situations (particularly when spread is high), and in such cases visitors are required to wear appropriate PPE.

In Arizona, hospitals continue to focus on the health and safety of our workforce and our patients. We believe strongly in the effectiveness of the vaccines and the effectiveness of the programs our members have put in place to protect patients and staff. OSHA should not impede these effective programs by instituting other, unproven strategies.

**We urge you to withdraw this ETS. If, however, OSHA declines to do so, we recommend that it be allowed to expire at the end of the six months and not be published as a final rule.** Protecting our workforce and our community requires that hospitals 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.

Sincerely,



Debbie S. Johnston  
Executive Vice President

Attachment B



December 4, 2021

Mr. Jessie Atencio  
Director, Division of Occupational Safety and Health  
Industrial Commission of Arizona  
800 W. Washington St, Suite 203  
Phoenix, AZ 85007

***Re: Notice of Proposed Rulemaking to Adopt R20-5-602.02, Incorporating by Reference the Federal Occupational Safety and Health Administration's COVID-19 Healthcare Emergency Temporary Standard (Subpart U, COVID-19 Healthcare)***

Dear Mr. Atencio

I write to you on behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospital, healthcare and affiliated health system members. Thank you for the opportunity to comment on the Division of Occupational Safety and Health's (ADOSH) COVID-19 Notice of Proposed Rulemaking, which incorporates by Reference the Federal Occupational Safety and Health Administration's (OSHA) COVID-19 Healthcare Emergency Temporary Standard (ETS)/Interim Final Rule published in the Federal Register June 21, 2021.

Since the beginning of the COVID-19 pandemic, our members and their clinical staff operating at the front lines have worked tirelessly in their response efforts, including working to better understand the COVID-19 novel virus, how it is transmitted, and how it can be prevented and treated. In the spring of 2020, an initial focus was addressing the supply chain—working to procure appropriate personal protective equipment (PPE) and other protections for staff. With the first tranche of CARES Act funding that Congress allocated to AzHHA, we purchased PPE for distribution to hospitals and skilled nursing facilities throughout Arizona. Ensuring staff are protected in fighting this deadly disease is of utmost important to AzHHA and our members.

During the summer 2020 surge in Arizona, we worked with other state hospital associations and the Arizona Department of Health Services on solutions to bring more staff into Arizona, efforts that have continued through 2021. Also in 2021, we have supported public health and our members' efforts to vaccinate their staff and communities. These efforts include earned media, social media and tool-kit roll-outs. We know the vaccines are safe and effective—and our best defense against this disease, which is

why many hospitals and health systems in Arizona began to mandate staff vaccinations even before the federal government promulgated rulemakings to require vaccination.

We are wholeheartedly committed to protecting our healthcare workforce; however, we are concerned by elements of the federal ETS published on June 21, 2021, which ADOSH is incorporating by reference into R20-5-602.02. It is for this reason that I have outlined above our efforts to protect hospital and healthcare workers from COVID-19 exposure and infection.

Our detailed comments on the proposed rule and standards our outlined below.

### **Justification for the ETS**

Over the past year and a half, the country has praised the truly heroic efforts of nurses, doctors, and other clinical staff who have provided direct patient care during the pandemic. But what is often overlooked are the staff who have supported the frontline efforts—administrators, infection control officers, emergency managers, hospital engineers, supply chain managers and others. These individuals have worked to secure 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 to stay abreast of the latest scientific information and guidance.

And these efforts are paying off. Arizona hospitals and hospitals nationwide have done an outstanding job of protecting staff and patients even as they learned about this novel virus. Researchers have begun to document the effectiveness of these efforts. **A recent study<sup>1</sup> of nearly 25,000 healthcare workers from four health systems across the country concluded that community prevalence of COVID-19 and known exposure to someone with COVID-19 outside work were more common predictors of healthcare workers contracting COVID-19 than anything about their work environment.**

It is important to note the measures hospitals have taken to protect their workers, which are being proved effective, are based on evolving best practices and Centers for Disease Control and Prevention (CDC) guidance. Hospitals and health systems were implementing these practices long before OSHA promulgated its COVID-19 ETS six months ago. OSHA asserted in their ETS that employee exposure to SARS-CoV-2 presents a grave danger for healthcare workers, and this danger is the basis for the ETS. However, a year earlier on May 29, 2020—before vaccines were available and when hospitals were treating large numbers of suspected or confirmed COVID-19 patients and when PPE was in short supply, OSHA took the opposite stance, stating there was a lack of evidence suggesting that infectious diseases, including COVID-19, to which employees may be exposed, constitute a “grave danger” requiring an ETS as an appropriate remedy.<sup>2</sup>

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<sup>1</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777317>

<sup>2</sup> On May 29, 2020, the Centers for Disease Control and Prevention’s (CDC) data reflect that there were 44,581 hospitalizations and 1,190 deaths in the U.S. 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 – a tragic loss, but only a quarter of the number of deaths on May 29 of the previous year.

As of December 4, 2021, nearly 63% of Arizonans have been vaccinated based on the Arizona Department of Health Services Dashboard, with over 57% fully vaccinated. Moreover, our members report much higher vaccination rates among their staff, upwards of 90% for those that adopted mandatory vaccine programs before the Centers for Medicare & Medicaid Services (CMS) mandate was released and subsequently enjoined. Meanwhile, we know 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 healthcare personnel; as such, it is difficult to understand why OSHA this past summer was asserting a grave danger, a danger that OSHA contended did not exist last year when there were more deaths and hospitalizations from COVID-19, as well as no vaccines to protect against SARS-CoV-2.

The federal government's own data – the very data OSHA cited in its ETS in noting that 1,600 healthcare workers across America have died during this pandemic – documents that, since Feb. 13, 2021, 11 deaths of healthcare workers were recorded. There were 24 weeks between February and the last week of July with fewer than five reported deaths of healthcare workers; in the period between July 7 and July 31, there were **zero** recorded deaths of healthcare workers. 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 healthcare workers fully vaccinated, and those vaccines and other protective measures working?

AzHHA understands ADOSH's authority to modify the federal standards is limited—that state standards must be “at least as effective,” as those adopted by OSHA. As of this writing, OSHA has not adopted a final rule, and the ETS expires December 21, 2021. **With this in mind, we urge ADOSH to not finalize its rulemaking unless and until OSHA publishes a final rule. We remain hopeful that OSHA will address the many concerns that AzHHA and other stakeholders raised with the Interim Final Rule and ETS.**

Our key concerns regarding the ETS as proposed by OSHA are as follows:

### **Alignment with CDC Guidance**

The ETS is only partly aligned with CDC guidance. The CDC has provided critical scientific information and recommendations based on data gathered throughout the pandemic. This guidance has evolved and will continue to evolve, especially as more is known about the circumstances required for those who are immunocompromised and the durability of vaccines and other the protective measures, including how these measures perform against the emergence of new variants, such as Delta and Omicron.

It has been challenging for hospitals and other healthcare organizations to follow this evolving evidence, yet we know adherence to the most up-to-date information is essential to fighting this virus and preventing its spread. As such, hospitals regularly amend their practices to ensure the safety of both staff and patients. **Unfortunately, OSHA's ETS will complicate hospital efforts because it is at odds with CDC guidance in critical areas such as masking and social distancing.** Further, as evidence evolves and the coronavirus mutates, we expect there may be more changes to CDC guidance.

Even in the short period of time between OSHA publishing its ETS in the Federal Register and the comment deadline for the Interim Final Rule, the following CDC guidance documents were 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.

The lack of alignment with current evidence-based guidance from CDC is concerning. Hospitals have been working since the beginning of the pandemic 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 healthcare providers previously pursued to create a safe environment of care were not actually safe. We fear these inconsistent and overly strict requirements will ultimately lower hospital employees' morale and worsen persisting personnel shortage in hospitals.

### **Physical Distancing and Physical Barrier Requirements**

AzHHA members are concerned the ETS physical distancing and barrier requirements do not account for employees' vaccination status or adherence to rigorous PPE protocols. With the growing number of hospitals and health systems mandating the vaccination of their workforce— even before the CMS mandatory rule was published and subsequently enjoined, the physical distancing requirements are becoming more difficult to manage for healthcare employers. Many are concerned they will be cited for violation of this requirement despite their best efforts.

Hospitals believe the requirement to keep employees at least six feet away from all other persons hinders staff education, negatively impacts staff morale, and impedes hospitals' exhausted workforce from doing their job efficiently – all when hospitals are already taking many other precautions for the benefit of employee safety. As such, AzHHA believes the ETS physical distancing requirements should be amended to better account for healthcare worker and community vaccination status.

**AzHHA recommends the physical barrier requirement be removed 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.

While OSHA cited certain studies and CDC guidance in the preamble to the interim final rule to support the barrier requirements, the American Hospital Association found upon investigation that 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 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 healthcare 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, is once the COVID-19 public health emergency ends, state and local fire marshals may 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 Code 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.”

**For these reasons, AzHHA recommends the physical barrier requirement be removed from the ETS and rules adopted by ADOOSH.** 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.”

### **Vaccinated Staff; flexibility**

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 guidance 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.”

AzHHA 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.

AzHHA 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 previously adopted additional flexibility for fully vaccinated staff to encourage vaccination are forced to retrench to OSHA’s far more onerous standard.

### **Mini Respirator Protection Program**

The ETS would require hospitals to allow staff to wear a respirator when one is not necessary for the job being performed. Under the ETS, a hospital could choose to provide this higher level of protection, or the employee could bring in his or her own respirator. The underlying assumption in this standard is an employee’s safety lies in having a higher level form of PPE. But this is a fallacy.

Workplace safety is the result of coupling the right forms of PPE with programs that assure the right fit and equip staff with the knowledge to appropriately don, doff and care for the equipment. During this pandemic, many items being sold have been represented as meeting the requirements of N95s when they in fact do not. And staff wearing face coverings that are improperly fitted, improperly donned or doffed, or improperly stored could increase the risk of disease transmission. While the ETS requires employers to provide a specific notice to employees who bring in their own respirator, we are not convinced that this will result in proper fit-testing, and could in fact compromise worker safety.

### **Definition of an “Exposure”**

The ETS contradicts the widely accepted definition used by the CDC and infectious disease experts of what constitutes an exposure. Rather, the ETS uses an overly broad definition that fails to account for the fact that healthcare personnel caring for COVID-19-positive patients in hospitals are wearing highly effective forms of PPE. It also fails to account for the vaccine status of the healthcare personnel and the length of time during which the infected person and the staff member were together. All these factors are critical to determining whether someone has truly been exposed. Failing to take them into consideration could lead to many employees being removed from their work station when there is minimal risk of exposure, in the process exacerbating existing staffing shortages.

### **Screening and Assessment**

The ETS would require entrance screenings for employees, visitors and patients. These entrance screenings include monitoring temperatures and other related symptoms potentially indicative of COVID-19. As envisioned by the ETS, this would require hospitals to place staff at all available entrances and conduct such screenings. These screenings have been recommended previously and are extremely time consuming. Hospitals, instead, should have flexibility in screening and assessing based on the level of community spread and other protective measures taken. For example, when community spread has been high, Arizona hospitals have restricted visitor access to facilities and coupled this with scalable screenings. When community spread has lowered, visitation restrictions have been eased, but visitors are required to wear face masks and social distance. Visitation in COVID-19 units has been typically

reserved for end of life situations (particularly when spread is high), and in such cases visitors are required to wear appropriate PPE.

### **ETS Alignment with Proposition 206**

Proposition 206, the Fair Wages and Healthy Families Act , gives the Industrial Commission of Arizona authority to enforce and implement the Act’s minimum wage and earned paid sick time requirements. Under Prop. 206, employees may accrue earned paid sick time. Earned paid sick time is leave time that is compensated at the same hourly rate (but no less than minimum wage) and with the same benefits, including health care benefits, that an employee would have received for the work hours during which earned paid sick time is used. Employees may use earned paid sick time in the following circumstances:

- Medical care or mental or physical illness, injury, or health condition of the employee or any of the employee’s family members (see the definition of “family member” in Arizona Revised Statutes § 23-371 to see who qualifies as a family member);
- A public health emergency affecting the employee or a family member of the employee pursuant to Arizona Revised Statutes § 23-373; and

AzHHA members have requested clarification for how the requirements under Proposition 206 will interface with paid time off requirements under the OSHA ETS. **We urge ADOSH to provide clarification in conjunction with any finalized rule.**

### **Conclusion**

In Arizona, hospitals continue to focus on the health and safety of our workforce and our patients. We believe strongly in the effectiveness of the vaccines and the effectiveness of the programs our members have put in place to protect patients and staff. We have urged OSHA not to impede these effective programs by instituting other, unproven strategies. **In fact, in previous comments to OSHA, we requested the Administration to withdraw its ETS, or alternatively to allow it to expire at the end of the six months and not be published as a final rule.**

**If OSHA does finalize its ETS, we respectfully urge ADOSH to work with OSHA to maximize use the state’s general duty clause to effectuate the outcomes that OSHA desires under the federal standards.**

Sincerely,



Debbie S. Johnston  
Executive Vice President