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[1] 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.[2]

As of August 3, 2021, nearly 58% of Americans (and nearly 55% or 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.

---

[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777317

[2] 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