AHCA AMERICAN HEALTH CARE ASSOCIATION
NCAL NATIONAL CENTER FOR ASSISTED LIVING

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August 19, 2021

The Honorable James Frederick
Acting Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor

Docket No. OSHA-2020-0004

Dear Mr. Frederick:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 14,500 non-profit and proprietary skilled nursing facilities (SNF), assisted living communities (AL), sub-acute centers, and homes for individuals with intellectual and developmental disabilities (ID/DD). By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

The COVID-19 pandemic has created and continues to create unprecedented challenges for our entire health care and public health system. AHCA/NCAL and its members appreciate the importance of standards that ensure the health and safety of the healthcare heroes who care for this nation's most vulnerable. AHCA/NCAL appreciates the opportunity to comment on OSHA's Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS) and thanks OSHA for extending the comment deadline.

Long-Term Care (LTC) communities (SNF, AL, and ID/DD) serve as a permanent home for millions of older Americans and individuals with ID/DD nationwide. [1, 2] These individuals rely on the care and services provided in their communities including assistance with activities of daily living (ADLs – bathing, toileting, dressing, eating, and transferring) and instrumental activities of daily living (IADLs – managing finances, preparing meals, medication management, housework, etc.). LTC communities strive to provide a home-like environment with engaging activities and a sense of community to ensure a fulfilling life for all residents.

LTC facilities have been at the forefront of this pandemic. COVID-19 is an easily transmissible virus that presents more serious symptoms in older individuals with co-morbidities, making it a perfect storm for congregate living settings serving this population. Since February 2020, LTC facilities have been adhering to numerous evolving guidance/requirements from the Centers for Medicare and Medicaid (CMS), the Centers for Disease Prevention and Control (CDC), and state and/or local authorities aimed at preventing the spread of COVID-19. These include infection control measures such as symptom screening, routine testing, cleaning, and the use of Personal Protective Equipment (PPE). LTC providers are working tirelessly to continue to keep their

[1] https://www.ahcancal.org/Data-and-Research/Documents/FastFacts_SNCCs.pdf
[2] https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx

residents and staff safe by following existing and evolving guidance/requirements from CDC, CMS, and state and/or local authorities.

Conflict and/or confusion between the OSHA ETS, changing CDC guidance, CMS regulations, and other state and local requirements adds a huge burden for facilities trying to comply and make evidence based clinical and operational decisions. Given that standards already exist in this setting to ensure the health and safety of staff, we recommend that the ETS not be continued beyond six months and not be converted into a permanent standard. While the ETS is in place, and as OSHA continues to improve it, AHCA/NCAL and its members have identified several areas of significant concern that we would like to bring to the agency's attention. We believe that if these comments (noted below) are addressed, these standards will be more successful in meeting the intent and purpose of protecting workers by ensuring practical application and consistent compliance.

If OSHA intends to promulgate a permanent airborne infectious disease rule, we request that OSHA work with long term care providers to develop airborne infectious disease standards that are feasible, protect employees, and allow for providers to be fully prepared and supported in the face of any infectious disease outbreak. AHCA/NCAL would be willing to work with OSHA on this and help with identifying stakeholders to participate in these efforts.

Thank you in advance for your consideration of the issues we raise and our associated recommendations.

Should OSHA have any questions regarding our comments and recommendation or would like to meet to discuss further please contact Clifton Porter, AHCA/NCAL's Senior Vice President of Government Relations at cporter@ahca.org. We would also be happy to connect OSHA directly with some of our members to hear firsthand the impact of this ETS on our nation's caregivers and the individuals they serve.

Sincerely,

Clifton J. Porter II
Senior Vice President
Government Relations
American Health Care Association/National Center for Assisted Living

Accuracy of OSHA's Estimate of Cost

Comment: OSHA underestimates the percent of workers that use each type of PPE and some of the costs of PPE. AHCA/NCAL surveyed providers (small to large SNF, AL, ID/DD) about the percent of workers that use each type of PPE and the per unit cost. Providers reported the percentage of PPE use for staff with ranges from as low as OSHA's estimate all the way up to 100% for each type of PPE. The table below highlights the variation in PPE costs.

Minimum and Maximum Cost Per Unit		
	Minimum Cost	Maximum Cost
Surgical Mask	$0.14	$5.00
N95 Respirator	$1.95	$6.00
Gown	$1.00	$5.00
Protective Eyewear	$1.01	$12.00
Fit Test Kit	$50.00	$1,000.00
Cost per Employee to Fit Test	$100.00	$160.00

OSHA's cost estimates also do not consider the increase in costs that can occur in the event of a shortage. For instance, during the height of PPE shortages at the start of the pandemic, we had one provider report they spent $70,000 to fit test their employees when they received a different type of N95 masks than previously used. While providers are currently operating at conventional capacity, these guidelines need to consider the possibility of future shortages in their cost impact.

OSHA's assumption that the physical barriers required by the ETS have already been installed in nursing homes and other long term care settings prior to the ETS is not accurate. Some barriers have been installed, but not to the extent required by the ETS. In many cases, physical barriers detract from a home-like environment that long term care facilities strive to provide. This is discussed in more detail below.

OSHA includes time estimates for implementing the requirements in the ETS based on the average number of residents in the buildings. However, the average number of residents OSHA utilized is significantly less than the public data from CMS' Care Compare and CDC's National Health Safety Network (NHSN) system. The table below provides an overview of the average number of beds and residents in each LTC setting. These actual average number of residents will significantly increase the actual cost of implementation above what OSHA estimates.

	Average Number of Beds	Average Number of Residents
SNF	73.7	106
AL	35	28
ID.DD	14	11.4

Throughout the pandemic, LTC providers have spent countless dollars to obtain needed and necessary PPE to ensure staff are safe, even improvising and trying to find creative solutions when PPE was unobtainable due to worldwide shortages. LTC providers are committed to

keeping staff and residents safe but the financial constraints and burdens they face must be recognized. Approximately 62% of SNF resident care is paid for by Medicaid. Medicaid typically pays below the actual cost of care limiting the amount of money SNFs must spend on implementing the ETS requirements.[3] Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) are almost entirely Medicaid funded, and Medicaid reimbursement for these centers do not cover 100% of costs in all states. This applies as well to some ALs that accept Medicaid. AL is primarily private pay which means increased spending may be passed on to residents, exacerbating already existing financial barriers to accessing AL. The reimbursement structure for LTC providers makes implementation of the requirements of this ETS burdensome.

Recommendation: OSHA should update the cost estimates of implementing the ETS by utilizing the data sources mentioned above and consulting with various providers around the country to obtain cost estimate ranges. OSHA should also take into consideration the possibility of additional PPE shortages, which can drastically impact availability and cost.

Paperwork Burden Estimates

Comment: LTC providers already have numerous reporting requirements due to COVID-19, from both federal agencies and local or state authorities. For example, SNFs are required to report weekly via NHSN numerous data elements including suspected and confirmed COVID-19 infections among residents and staff, PPE and hand hygiene supplies, resident beds and census, ventilator capacity and supplies, staffing shortages, and most recently, vaccine uptake. Many SNFs also have extensive and often duplicative state reporting requirements. AL providers face state reporting requirements and in some cases, states also require ALs to report data to NHSN. While ICFs/IID providers do not have national reporting requirements, the majority must report cases to state and/or local authorities. Paperwork and reporting requirements divert valuable time and resources that should be focused on resident care.

Recommendation: AHCA/NCAL asks that OSHA work with federal agencies and local or state authorities on streamlined reporting requirements and minimize duplicative reporting to reduce burden on providers and limit time away from resident/patient care. Alternatively, instead of requiring providers to report duplicative data elements, OSHA can explore options to query existing databases.

Recognizing Good Faith Efforts and Providing Support

Comment: LTC has been hit extremely hard by this pandemic and continues to confront substantial staffing challenges. In a recent survey by AHCA/NCAL, 94% of SNFs and 81% of ALs reported a shortage of staff within the last month. Both provider types have indicated that in the last year, staffing challenges have increased.[4] The same staffing challenges hold true for ID/DD providers. While many of these standards are already in place in facilities/communities,

[3] NIC Skilled Nursing Data Report, 2020

[4] Workforce-Survey-June2020.pdf (ahcancal.org)

some of the new standards require a level of resources that many do not currently have available and will take extended time to fully implement.

For example, designating a COVID-19 workplace safety coordinator is extremely difficult for small or independent facilities with limited resources from both a staffing perspective as well as financially due to census impacts from COVID-19. Furthermore, the timeline for full implementation of the ETS is unrealistic considering other requirements LTC providers face and ongoing day to day COVID-19 management. In the proposed rule, OSHA indicates that they will honor providers good faith efforts in many areas, such as with physical barriers. Yet, good faith efforts are not mentioned in the inspection procedures OSHA has made available on their ETS website.

Recommendation: OSHA should recognize good faith efforts towards meeting these standards, allowing flexibility for full implementation beyond the designated deadlines if the facility is working towards full implementation. This includes ensuring compliance officers implement this recognition of good faith efforts when evaluating compliance with the ETS. This should include more specific guidance to compliance officers when determining "good faith," and specific allowance for *de minimis* notices to employers who are attempting to comply but have not achieved full compliance at the time of inspection. We hope that OSHA will address any enforcement in an educational, non-punitive manner. Furthermore, we ask OSHA to provide more resources to LTC facilities in all states through their OSHA consultation.

Improving the Consistency with Guidance from the other Federal Agencies and State and/or Local Authorities

Comment: As noted above, LTC providers have been and continue to follow guidance/requirements from the CDC, CMS, and state and/or local authorities. There are several places throughout the guidance where OSHA outlines infection control or other healthcare measures, such as in the areas of PPE use, cleaning measures, requirements for aerosol generating procedures, exemptions for vaccinated employees, etc. Some of these areas are consistent with other guidance/requirements that providers are currently following, while other areas appear to introduce inconsistencies. This adds a layer of confusion for providers and interferes with the abilities of professionals to make good, clinical decisions. Furthermore, the CDC guidance, which many CMS, state and/or local requirements are based on, changes rapidly based on new data, which will likely introduce more inconsistencies and/or render these standards out of date.

For instance, there are at least two PPE requirements stated in the ETS that are inconsistent with CDC guidance, as follows:

- In section (f)(1)(ii) OSHA indicates that employers must *"provide a sufficient number of facemasks to each employee to comply with this paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (e.g., patient care reasons)."* In their guidance to healthcare workers, CDC requires the opposite "*To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to*

wear the same respirator or well-fitting facemask throughout their entire work shift when the respirator or facemask is used for source control." [5]

- In a note in section (f)(2)(ii) OSHA goes beyond CDC Guidancewhen "encouraging" the use of "elastomeric respirators or PAPRs" instead of N95's during aerosol-generating procedures. [6]

There are also inconsistencies between OSHA and the CDC on exemptions for vaccinated workers. OSHA exempts fully vaccinated workers from paragraphs (f) masking, (h) distancing and (i) barrier requirements where there is no "*reasonable expectation that any person with confirmed or suspected COVID-19 will be present*." The CDC currently provides the following guidance for vaccinated healthcare workers *"In general, fully vaccinated HCP should continue to wear source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in- person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance from others*." [7] It is unclear what OSHA means by "reasonable expectation" – whether that is meant to hinge on vaccine status, symptom screening, rate of COVID-19 in the community, outbreak status, or a combination of the above. This leads to confusion for providers which will likely lead to inconsistent application of the exemption and detract from meeting the intent and purpose of these standards.

Recommendation: OSHA should direct employers to follow guidance from the CDC, CMS, and state and/or local authorities or remain silent on specific infection control measures to allow existing guidance/requirements to stand on their own.

Providing Medical Removal Protection Benefits

Comment:

The OSHA ETS requires employers to provide medical protection benefits to all workers removed from the workplace for COVID-19 exposure or illness, regardless of vaccination status. This eliminates an important incentive employers can provide to staff that are hesitant to be vaccinated.

Vaccine uptake in LTC has varied significantly among residents and staff. After the initial rollout of the vaccine through the CDC's Pharmacy Partnership for Long Term Care, the CDC reported a 77.8% uptake among residents and a 37.5% uptake among staff. [8] To help improve uptake, AHCA/NCAL launched its #GetVaccinated campaign and providers have worked tirelessly to improve uptake among staff. The most recent data from the CDC's NHSN reports a 61.1% vaccine uptake rate among staff. [9]

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[5] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
[6] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
[7] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html
[8] https://www.cdc.gov/mmwr/volumes/70/wr/mm7005e2.htm
[9] https://www.cdc.gov/nhsn/covid19/ltc-vaccination-dashboard.html#anchor_1594393306

Vaccine uptake is an extremely complex and challenging issue. And unfortunately, the "movable middle" is shrinking, and large portions of unvaccinated individuals are indicating they are simply unwilling to get the vaccine.[10] Yet with the spread of new variants, high vaccination rates are extremely important to protecting the health and safety of LTC residents and staff.[11] Providers are having to take creative approaches to encouraging vaccine uptake. One of those approaches is to provide additional benefits to staff that are willing to be vaccinated, in accordance with state employment laws. This might include paid time off to get the vaccine and for any side effects, and paid leave for COVID-19 related sick leave.

In addition, the employer is required to provide paid time off for employees who contract COVID-19, regardless of where they contracted COVID-19. This makes employers responsible for employee actions outside of the facility.

Recommendation: Allow providers to offer paid removal from work benefits contingent on vaccine status. We also ask that OSHA reconsider their authority on issuing rules for exposures outside the workplace.

COVID-19 Plan

AHCA/NCAL agrees that LTC facilities should have an organized approach to manage COVID-19 in place at this point and enhance those existing protocols where necessary with a focus on workplace health and safety. However, the COVID-19 plan required by OSHA seems overly prescriptive, particularly for those facilities who are already aggressively responding to these standards. For example, conducting "hazard assessment" is simply a paperwork exercise for many facilities who are already aware of their hazards from the work done over the course of the last year.

Recommendation: Rather than dictating use of a written COVID-19 specific plan overseen by a COVID-19 workplace safety coordinator, OSHA inspectors should look for adherence to the components of the plan. Employers who need the extra support can use the template plan, and those with all the elements already in place can forego use of the written plan but adhere to the requirements with existing policies, procedures, and practices.

Physical Distancing and Physical Barriers Requirements

Comment: On March 13, 2020, after the outbreak in Kirkland, Washington, CMS put in place regulations that included following CDC recommendations on infection control to protect residents and staff. Many states followed suit. Among the requirements included a restriction of visitation. For a full year, these residents were not allowed to see their family, engage in fulfilling activities or enjoy dining with their fellow residents and friends. These measures were necessary to protect residents and staff, but the social isolation and loneliness also took a significant toll on the health and mental well-being of residents.[12]

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[10] https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-april-2021/
[11] https://www.cdc.gov/mmwr/volumes/70/wr/mm7017e2.htm
[12] https://www.aarp.org/caregiving/health/info-2020/covid-isolation-killing-nursing-home-residents.html

The rollout of the vaccine to LTC facilities nationwide resulted in a significant drop in cases and deaths in facilities. [13] With this evidence, CMS, in consultation with CDC, revised their guidance, allowing facilities to open visitation, dining and activities based on vaccination status and outbreak status. Again, states followed suit. CDC goes as far as allowing visitation without masks or distancing when both visitors and residents are vaccinated.[14]

We are very concerned that OSHA's standards related to physical distancing and physical barriers in non-patient care areas will require providers to restrict or limit visitation, which conflicts with CMS' intent for providers to facilitate visitation. We are also concerned that it will detract from providers ability to create a home-like environment, which is supported by CMS regulation §*483.10(i) Safe Environment* and the *CMS HCBS Final Rule* which includes assisted living. In a LTC facility, there are very few spaces that residents do not utilize. A visitation area may be considered a non-patient care area, for example, but requiring distancing and barriers in that space would be extremely limiting for residents and their visitors. Also, requiring distancing, signage, and physical barriers will reduce the home-like environment, impacting quality of life for residents.

Recommendation: If providers are following masking and any distancing guidance issued by the CDC, CMS, state and/or local authorities they should be seen as meeting "good faith" compliance of the physical barrier requirements in the ETS.[15]

Health Screening and Medical Management - Notifications

Comment: The OSHA ETS requires notification of impacted employees and other employers within 24- hours of a confirmed case of COVID-19 among anyone who was in the building, including vendors, customers, visitors. It is common in LTC to use contract staff in areas such as housekeeping, dietary and therapy. Also, given the current staffing crisis, many LTC providers are using agency or PRN (as needed) staff. This makes an extensive notification requirement such as this extremely challenging in our setting, and unreasonable to expect in 24-hour timeframe. Furthermore, the notification requirements would require an individual with human resources background to navigate the complicated legal and ethical boundaries of the notification process. This further adds to the resource and financial burden of the ETS.

Further, the notification to other employers presents a significant challenge due to the common use of contract, agency and PRN staff mentioned above. These individuals may have several other employers, that LTC providers may not be aware of. In addition, notifying another employer of a COVID-19 exposure without releasing the name of the employee seems unproductive and unnecessary.

Recommendation: OSHA should remove the required notification to other employers and limit

[13] https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-long-term-care-deaths-and-cases-are-at-an-all-time-low-though-a-rise-in-ltc-cases-in-a-few-states-may-be-cause-for-concern/
[14] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html
[15] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

the scope of notifications to full-time employees. OSHA should also extend the time requirement from 24 to 48 hours.

Training Requirements

Comment: OSHA's provided resources for the ETS have been helpful to providers to understand and implement the ETS. AHCA/NCAL thanks OSHA for their diligence in providing resources to help providers comply with the ETS.

Recommendation: We request that OSHA continue to update and provide training and resources to help providers meet the demands of the ETS.

Recordkeeping Requirements

The OSHA ETS requires employers to maintain logs of all employees who have contracted COVID-19, regardless of whether it was contracted at work or another location. They also require employers to produce those logs to the individual staff member or any other person with confidentiality. This introduces the same challenges discussed in the notifications section.

Recommendation: OSHA's mission is to ensure safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance. However, in this recordkeeping requirement OSHA is requiring that employers keep record of hazardous exposures outside the work environment. We urge OSHA to eliminate this requirement and reconsider their authority on issuing rules for events outside the workplace.