Federation of American Hospitals®

Charles N. Kahn III
President and CEO

April 22, 2022

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

Re: Comments on OSHA-2020-0004, Occupational Exposure to COVID-19 in Healthcare Settings; 87 Fed. Reg. 16,426 (March 23, 2022)

Dear Assistant Secretary Parker:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. These tax-paying hospitals account for nearly 20% of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients.

We appreciate the opportunity to submit comments on the *Occupational Exposure to COVID-19 in Healthcare Settings; Notice of Limited Reopening of Comment Period,* published by the Occupational Safety and Health Administration (OSHA) in the Federal Register on March 23, 2022 (Reopening Notice). We understand that one of OSHA's aims is to protect health care workers from COVID-19, and we share in that goal. Since the onset of the COVID-19 public health emergency (PHE), our members have been on the front lines of the PHE and have invested heavily in protecting their employees as well as caring for patients and their families, while complying with multiple regulatory structures, including federal and state laws. To avoid duplicative, confusing, and sometimes contradictory requirements, we urge OSHA to ensure that its requirements align with guidance and recommendations issued by the Centers for Disease Control and Prevention (CDC), as well as the Centers for Medicare & Medicaid Services (CMS), as discussed further below.

In the meantime, however, we are concerned about procedural issues with the Reopening Notice, as detailed in comments submitted by the US Chamber of Commerce. OSHA discusses that provisions in a final rule may depart from the initial Emergency Temporary Standard (ETS) issued

last June. However, OSHA has not provided any additional proposed regulatory language that would reflect potential changes and discusses that the list of changes described in the March 23 Reopening Notice is not "intended to list all of the potential changes from the ETS. Other changes may result after due consideration of all comments and hearing testimony."[1] Our comments below are based on the limited discussion in the Reopening Notice of any potential changes that may depart from the June ETS. Since there is not actual proposed language for any such changes nor any related regulatory impact analysis, our comments can only be limited in scope and lack the thorough review and comment that any new regulatory provisions deserve. Moreover, OSHA suggests it may finalize other changes not discussed in the June ETS or Reopening Notice, and thus the FAH and other stakeholders would not have opportunity to consider or comment on such provisions. We urge OSHA to ensure that stakeholders have the appropriate regulatory opportunity, as required under the Administrative Procedure Act, to review and comment on all such changes before they are finalized.

CONSISTENCY WITH CDC GUIDANCE

Alignment with the CDC Recommendations for Healthcare Infection Control Procedures

We agree that OSHA should align its requirements with all applicable CDC recommendations. CDC recommendations are fluid and constantly evolving – as directly evidenced by the change in recommendations since the close of the comment period for OSHA's original June ETS. Because CDC guidance changes as needed to address new developments in science and new understandings of the COVID-19 virus, OSHA should clarify that it incorporates by reference specific areas of CDC guidance, as that guidance may be amended from time to time. This provides hospitals with flexibility post-rulemaking to implement best evidence-based practices and avoids confusion and conflicts between CDC guidance and OSHA requirements.

Additional Flexibility for Employers

We strongly urge OSHA to provide a "safe harbor" enforcement policy for employers that are in compliance with CDC guidance during the period at issue. This would further align OSHA requirements with CDC guidance. Both CDC and hospitals have developed policies and best practices based on the advice and expertise of virologists, epidemiologists, physicians, employees, health care providers, and other stakeholders regarding safety strategies for managing COVID-19. It is critical that hospitals can continue to implement safety and medical protocols based on CDC guidance.

Tailoring Controls to Address Interactions with People with Suspected or Confirmed COVID-19

We support OSHA in providing flexibility in areas where healthcare employees are not reasonably expected to encounter people with suspected or confirmed COVID-19. As discussed above, OSHA should align its requirements with CDC guidance, including utilizing the same definition of outbreak. This flexibility will allow hospitals to focus their already strained resources on already-tested and established protocols that achieve CDC and OSHA goals when interacting with patients and other individuals with suspected or confirmed COVID-19 cases.

[1] 87 Fed. Reg. 16,427 (March 23, 2022).

Requirements for Vaccinated Workers

The FAH appreciates OSHA's flexibility in permitting hospitals to determine which requirements are appropriate based on the vaccination status of the individual worker involved, the general vaccination rate of the entire staff, and the general vaccination rate of the community. Moreover, this approach should align with CDC requirements whenever possible and avoid conflicts with state and local laws when applicable.

Triggering Requirements Based on the Level of Community Transmission

Regarding the use of the level of community transmission as a trigger for controls, OSHA should align its requirements to CDC guidance. Under the CDC's current guidance for healthcare workers, hospitals can take into account the level of community transmission of COVID-19 in determining safety measures (*e.g.,* implement certain controls in areas of substantial or high transmission, but not require similar controls in areas of low or moderate transmission). This allows each hospital to tailor its approach to the populations and communities it serves and appropriately allocate resources.

ALIGNMENT WITH CMS' VACCINATION MANDATE

Limited Coverage of Construction Activities in Healthcare Settings

In considering whether employers that engage in construction work in hospitals should be covered by OSHA requirements, OSHA should strive to align with CMS' Omnibus COVID-19 Health Care Staff Vaccination mandate (Mandate).[2] In the Mandate, CMS acknowledged that there are many infrequent non-health care services and tasks performed in or for a health care facility by vendors, volunteers, and professionals and stated it would be overly burdensome to mandate vaccinations for each of those individuals who enter the facility.[3] Therefore, CMS recommended that hospitals consider frequency of presence, services provided, and proximity to patients and staff in determining appropriate safety protocols.[4]

It is similarly burdensome to enforce other restrictions upon these individuals such as requiring employers to provide proof of vaccination. First, there are HIPAA barriers in obtaining information from employers. In addition, the individuals working in construction are typically transient, change on a day-to-day basis, and thus difficult to track. Moreover, these individuals are typically not in close proximity to patients and medical staff nor other clinical operations. Therefore, OSHA should permit hospitals the ability to determine whether the hospital extends ETS coverage to construction workers or a subset thereof.

Vaccination—Booster Doses

OSHA should follow CMS' definition of fully vaccinated. As such, "fully vaccinated" should be defined as when an individual completes the full course of the vaccine dosing (whether

[2] 86 Fed. Reg. 61,555 (Nov. 5, 2021).

[3] *Id*. at 61,571.

[4] *Id*.

two shots or one), rather than the full course of the vaccine dosing plus 14 days. Further, it would be premature to go further than the definition of "fully vaccinated," given the current CDC guidance on vaccinations and boosters is both in flux and optional based on a variety of factors including the vaccine received during the primary vaccination series, age, and immunocompromised status.

STATE LAW GOVERNS

Vaccination—Employer Support of Employee Vaccinations

It would be appropriate to permit individual states to decide whether there are paid time requirements for employees to receive a COVID-19 vaccine. OSHA need not interfere with pre-existing state law by creating a federal mandate related to wage and hour laws, particularly given that states are better situated to determine such requirements. Moreover, the June ETS was originally issued when vaccines were in short supply, and there were other limitations to receiving a vaccine such as priority groupings and limited access points. Thus, any related OSHA requirements should take into account that vaccines are now widely available and convenient to obtain, including on weekends and after hours, with and without an appointment, and at multiple locations.

EVOLUTION OF SARS-CoV-2

The Potential Evolution of SARS-CoV-2 into a Second Novel Strain

Additionally, OSHA requests comment on the evolution of SARS-CoV-2 into a second novel strain. The future is nebulous, and we are still learning about SARS-CoV-2, its variants, and transmissibility. It is difficult to anticipate the precise measures that may be needed to address a subsequent strain and thus we believe it would be ill-advised at this point to attempt to anticipate the next strain and automatically apply a rule to such an unknown strain.

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Thank you for your consideration of these comments and your continued collaboration with stakeholders to implement effective policies that assist hospitals and hospital systems in protecting their employees, patients and families, and local communities, while meeting the varied challenges of the PHE. If you have any questions, please contact me at 202-624-1534, or any member of my staff at 202-625-1500.

Sincerely,