April 22, 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 Health Care Settings; Occupational Safety and Health Administration Notice of Limited Reopening of Comment Period (Vol. 87, No. 56), March 23, 2022.

Dear Assistant Secretary Parker:

On behalf of more than 200 hospitals and health systems throughout the state of Florida the Florida Hospital Association (FHA) appreciates the opportunity to submit comments on the Occupational Safety and Health Administration's (OSHA's) notice of a limited reopening of the comment period on the interim final rule establishing an Emergency Temporary Standard (ETS) on Occupational Exposure to COVID–19.

Since the beginning of the COVID-19 pandemic, Florida's hospitals have been a leader in responding to challenges a novel disease presents, for patients, and hospitals and their workforce. We share OSHA's commitment to the safety of our health care workers, and since July 2021 have implemented and enforced the rules established by the original COVID-19 ETS. However, as the Covid-19 pandemic moves to its endemic phase, vaccines have become widely available and utilized by our staff, and CDC and CMS guidance has evolved, the OSHA ETS has created unnecessary redundancies and its rigidity has rendered it ineffective.

The FHA, together with hospitals and health systems, remains committed to following the science-based and sometimes quickly-evolving guidance issued by the Centers for Disease Control and Prevention (CDC). Throughout the course of the pandemic, hospitals have followed these strict, evidence-based protocols to ensure the safety of front-line staff and patients. In addition, hospitals have been community leaders in vaccinating their staff and the populace they treat. Thanks to these efforts, the majority of hospital staff are now fully vaccinated, which is the strongest protection against illness, hospitalization and death.

Hospitals, through the diligent efforts of their organizational leadership, infection control officers, hospital engineers and material managers, and other front-line staff, have helped ensure that health care workers are protected and that the latest evidence-based practices and policies are followed. Maintaining front-line workers' health and safety is central to a successful response to the pandemic, and no one has a more vested interest in doing so than the nation's hospitals.

While we acknowledge and appreciate OSHA's consideration of additional flexibility for employers and other potential changes to the Occupational Exposure to COVID–19 in Health Care Settings 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. As we have discussed, CDC guidance and recommendations have long been the national standard for safe operations and have been utilized by health care providers since the beginning of the COVID-19 public health emergency (PHE). Hospitals and health systems are held to those standards by Centers for Medicare & Medicaid Services (CMS) regulators.

Moreover, hospitals and most other health care settings are also now subject to a COVID-19 vaccination requirement, strictly enforced by CMS, which applies to all eligible staff working at a facility that participates in the Medicare and Medicaid programs, 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. Finally, as OSHA itself has acknowledged[1], the agency has sufficient authority to help protect health care employees from the hazard of COVID-19. That is, OSHA 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 health care 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 health care system that only one set of science-based standards be applied to health care providers, and that these standards be aligned across federal agencies.

Therefore, the FHA 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.

Should OSHA decide to finalize its COVID-19 ETS, FHA offers the following comments:

A.1—Alignment with CDC Recommendations for Health Care Infection Control Practices

OSHA acknowledges that evolving CDC recommendations have resulted in inconsistencies between those recommendations and some of OSHA's health care ETS provisions. The agency is therefore seeking 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.

FHA is concerned that a final rule that adopts by reference *specific versions* of CDC guidance will inevitably result in OSHA's standard becoming increasingly more outdated as the scientific understanding of COVID-19 grows and recommended health care infection control practices evolve. Embedding static versions of CDC's guidance into the ETS will lead to disparate standards that will confuse health care employers and their employees, and could result in excessive burden and, potentially, harm. The CDC is in the best position to determine how health care providers should evolve their practices to mitigate spread of the virus.

Therefore, the FHA 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 ventilation systems for COVID-19 units, that change would necessitate that hospitals are allowed a longer time to come into compliance.

A.2—Additional Flexibility for Employers

OSHA notes that some employers expressed concern that the provisions of the health care ETS were overly prescriptive. 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.

In general, the FHA supports 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 many requirements that were overly specific and complex, leading to confusion and wasted efforts. For example, the physical distancing standards and the related physical barrier requirements were overly specific, did not account for employee vaccination status or other controls in place and prevented individual health care facilities from using their internal risk assessments to use other approaches to ensure the safety of their employees, such as the use of higher-level PPE.

In fact, the FHA continues to recommend that OSHA remove the physical barrier requirements from the ETS altogether. We believe the efficacy of the barrier requirement in reducing the transmission of COVID-19 in hospitals remains unproven, especially in hospitals where multiple other controls are already routinely used (e.g. high level of vaccination, masking, ventilation). 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.

The FHA agrees that the other provisions of the ETS mentioned in this section of the notice, such as the criteria for medical removal and return to work, cleaning and aerosol-generating procedures also should be less specific, and instead refer directly to the 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 health care employees are not reasonably expected to encounter people with suspected or confirmed COVID-19. 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 health care 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.

Hospitals already have infection control policies and practices in place that protect staff. CMS's conditions of Participation impose legal obligations for hospitals that participate in the Medicare and Medicaid programs. In order to comply with the conditions of participation hospitals adhere to CDC guidance. Here OSHA is proposing a separate regulatory regime that is apparently redundant to the CMS conditions of participation.

The CDC addresses the considerations proposed by A.4 in its various COVID-19 and more general guidance documents, including which infection prevention and control measures should be taken if health care personnel are exposed to individuals with suspected or confirmed COVID-19. If OSHA were to incorporate relevant CDC COVID-19 health care 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.

However, in the absence of such specific reference to CDC live guidance, the **FHA would not support this approach as it would further drive a wedge between OSHA's rule 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.

Currently, according to CMS' interim final rule requiring COVID-19 vaccinations, staff at health care facilities must be fully vaccinated, which is defined by CMS as two weeks or more since the individual completed a primary vaccination series for COVID-19. Since the CMS rule takes preeminence in settings participating in the Medicare or Medicaid program, it would be confusing and counterproductive if OSHA, in a rule that is not intended to mandate employee vaccination, were to define "fully vaccinated" differently. However, CDC's guidance for health care workers does call out the additional protections afforded those who are "up to date" with their vaccinations, meaning that they have completed their primary vaccine course and have had any booster shots that are recommended for those in their age or risk group. CDC's guidance provides some additional flexibilities for those who are up to date with their vaccines. **FHA recommends that OSHA's definition of "fully vaccinated" be consistent with CMS' definition, and that it align additional flexibilities with those granted to health care workers who are "up to date" on their vaccines as CDC does.**

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 health care 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 health care 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.

CDC's COVID-19 Community Levels recommendations do not apply in health care settings and should not be used by OSHA. **Instead, the FHA would support OSHA's deferring to CDC guidance for health care settings, which already incorporates community transmission levels in its recommendations.**

That said, some of our larger health systems with hospitals and other health care 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 change over time. In rural communities, there may be areas of sparse population where this calculation of community transmission becomes a "small numbers" problem. That is, a very small number of individuals contracting COVID-19 can result in a shift of the community from one level to another. **If OSHA finalizes policies that link to community transmission levels, we urge the agency to 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.**

FHA appreciates your consideration of these comments. If you have any questions do not hesitate to Michael Williams, FHA's Senior Vice President of Federal Affairs at michaelw@fha.org.

Sincerely,

Mary C. Mayhew
President and CEO
Florida Hospital Association