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AMERICA'S UNIONS

April 22, 2022

Doug Parker
Assistant Secretary for Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, DC 20210

Re: Occupational Exposure to COVID-19 in Healthcare Settings (Docket: OSHA-2020-0004)

Dear Mr. Parker:

The AFL-CIO, a federation of 57 national unions representing 12.5 million working people in this country, and unions have led the calls for strong OSHA workplace safety standards to prevent exposure to COVID-19 for all workers since March 2020. The AFL-CIO strongly supports OSHA's promulgation of a permanent, enforceable standard to protect health care workers from significant risk of material impairment of health posed by workplace COVID-19 exposures and urges OSHA to strengthen, not weaken, the proposal.

OSHA has a long history of protecting workers from workplace exposures and regulating health care settings from infectious disease exposures. OSHA has an important role and an important obligation to require employers to use known exposure control measures to reduce exposures to hazards. Federal OSHA has regulated infectious disease exposures in the workplace for decades and state OSHA plans and federal OSHA have required exposure control measures against COVID-19 and against other aerosol transmissible diseases (California). Altogether, OSHA's infectious disease standards have been permanent for a long time, address ongoing and probable exposures for health care workers, and have been held up by the courts. Furthermore, implementing exposure control measures against other airborne infectious diseases, such as tuberculosis which federal OSHA proposed to regulate, is not new to employers. Simply, these standards have required employers to adequately plan to prevent workplace exposures.

OSHA must issue standards that prevent exposures and infections, not just hospitalizations and deaths, and must protect against the full extent of material impairment of health, including infections and Long COVID. OSHA recognized

this when it issued its health care emergency temporary standard (health care ETS) on June 21, 2021.[1]

The health care ETS was a significant step forward and provided key protections that health care workers—including hospital workers in direct patient care and environmental and cleaning workers, nursing home workers and others—have not had at any other point in the pandemic. Employers also were required to notify workers when they had been exposed to COVID-19 at work, which was critical to removing potentially infected workers with benefits to prevent additional exposures. However, this standard, which now serves as a proposal, needs to be strengthened to ensure workers are protected from COVID-19 hazards. The health care ETS did not adequately address the risks to health care workers at the time it was issued and it would not adequately address those risks today and in the future as a permanent standard.

Two years into the pandemic, we know more about what is needed to prevent COVID-19 exposures effectively and feasibly, not less. Yet, OSHA protections have been rolled back and OSHA has asked for comment on areas that would weaken a permanent standard. Collectively, we know more about aerosol transmission of SARS-CoV-2 and its application to health care settings; we know more about the waning of vaccine immunity; and we know more about continued surges and workplace outbreaks. OSHA cannot set a standard based on one point in time but needs to address the dynamic and ongoing, and very real, risks to workers. Nearly a year after the health care ETS was issued last summer to protect health care workers, the country is in between the enormous Omicron variant surge and another anticipated surge of an Omicron subvariant.

We know that the state of the pandemic remains significant, and that this virus will be with us for a very long time and possibly even become endemic at some point, further demonstrating the need for a permanent standard. At this time, COVID-19 specific protections from OSHA are critical to address prevention of aerosol transmission in the workplace and they are urgently needed. Health care workers and other workers currently have no protections for when another COVID-19 variant hits, and it will take years to a decade or more for OSHA to develop a comprehensive infectious disease standard.

Enforcement data from the health care ETS show that a standard has been an effective enforcement tool for OSHA because it is more specific than existing standards and the general duty clause. Bodies of scientific literature, exposure studies, evidence from the workplaces, and importantly, NIOSH, as it is required to do under the OSH Act, all have published important material that demonstrate strong protections are necessary and feasible, and this evidence supports this OSHA rulemaking.

In addition to our comments below, the AFL-CIO is submitting recent studies, information and workplace evidence to support our recommendations to the agency. At several instances throughout the pandemic, we have submitted peer-reviewed studies and other evidence to this docket and we also reference those submissions in the comments below.

[1] 86 FR 32385-88

I. COVID-19 poses a significant risk to health care workers and disproportionately affects workers of color.

The AFL-CIO previously submitted comments to this docket on the issue of COVID-19 risk among health care workers and other workers (OSHA-2020-0004-1500), submitted supplementary comments to the agency in September, 2021 (attached to these comments) and included all comments with additional risk evidence to OSHA's docket on Vaccination and Testing (OSHA-2021-0007-121401). The information below contains relevant and updated evidence on this issue and addresses OSHA's questions in its recent notice related to magnitude and scope of risk and the impact of the Omicron variants and COVID-19 vaccine effectiveness on health care workers.

There is no question that COVID-19 poses a significant risk to health care workers. The very nature of their work—in indoor settings, often crowded, poorly ventilated, sharing the same air with patients who may be infected with SARS-CoV-2—puts them at high risk of exposure and infection. Indeed, in issuing the health care ETS in June 21, 2021, OSHA determined that health care workers are at the highest risk of workplace SARS-CoV-2 exposure and infection of all worker groups, citing this as the rationale for prioritizing this group of workers for protection.[2]

Other factors increase further the risk of infection and serious disease outcomes for health care workers. Workers of color are disproportionately represented in many health care occupations, including in registered nurses, nursing assistants and home health aides.[3] Many of these occupations have the greatest interaction with patients, putting these workers at significant risk of exposure and infection.

Moreover, many health care workers are older, putting them at even greater risk of serious outcomes as a result of infection. According to BLS, the median age of registered nurses, licensed practical nurses (LPNs) and home health care workers is 43.1 years old or greater.[4] Overall, in all health care professional, technical and support occupations, there are nearly 2.4 million workers over age of 55, and 926,000 over age 65. In the health care industry as a whole, BLS reports more than 4.2 million workers are over age 55 with more than 1.1 million of them over age 65.[5]

A study evaluating the risk of severe COVID-19 illness among health care workers involved in direct patient care utilizing information from the National Health Interview Survey, CDC and BLS found that a large proportion of nurses, LPNs, home health aides and other health care

[2] 86 FR 32413

[3] U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Household Data Annual Averages,2021, 11. Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity. https://www.bls.gov/cps/cpsaat11.htm

[4] U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Household Data Annual Averages,2021. 11b. Employed persons by detailed occupation and age. https://www.bls.gov/cps/cpsaat11b.htm

[5]U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Household Data Annual Averages,2021. 18b. Employed persons by detailed industry and age. https://www.bls.gov/cps/cpsaat18b.htm

support personnel (32.1 to 45.5%) had one or more comorbidities that put them at increased risk of COVID-19. Of those at higher risk of adverse outcomes due to comorbidities and/or age, a large proportion were Black and Latino and many were individuals with incomes below the poverty line.[6]

Some have suggested that the risk of COVID-19 infection among health care workers is primarily due to exposures outside the workplace, and that the overall risk of infection is no greater than that experienced by the community as a whole. They claim that exposures in hospitals and other health care settings are well-controlled, minimizing the workplace risk to healthcare workers. Experience during the COVID-19 pandemic shows that this is not the case.

A new study by CDC that examined case reports of all reported health care worker COVID-19 infections found that the workplace was the most frequently cited exposure to COVID-19, identified by 52% of infected health care cases with reported exposures. By comparison, household exposures were identified by 30.8% cases and community exposures by 25.6% of cases.[7] Community and household exposures certainly contribute to health care worker COVID-19 infection risk, but workplace exposures pose a significant risk, putting health care workers at an overall greater risk of infection than the community as a whole. Health care workers have faced significant workplace exposures to SARS-CoV-2 due to inadequate protections, and have been disproportionately impacted by COVID-19 infection.

A. The toll of COVID-19 on health care workers has been massive and continues to mount.

As of April 17, 2022, CDC reports 1,076,505 infections and 4,120 deaths among healthcare workers during the COVID-19 pandemic. These figures are based on very limited, incomplete, voluntary reporting.[8] According to the CDC, only 14.83% of COVID-19 case reports received to date include healthcare worker employment status, and 65.7% of those include death status.[9] Moreover, in recent months as contact tracing has been cut back in many states and localities, the proportion of cases voluntarily reporting healthcare employment status has decreased significantly.

While a large number of healthcare worker infections and deaths occurred at the beginning of the pandemic, the risk continues to be significant. During the recent surge from Omicron BA.1 variant, CDC reports there was a massive spike in infections among health care workers. Data

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[6] Gibson, Diane M, and Jessica Greene. "Risk for Severe COVID-19 Illness Among Health Care Workers Who Work Directly with Patients." *Journal of general internal medicine* vol. 35,9 (2020): 2804-2806. doi:10.1007/s11606-020-05992-y

[7] Rachael M. Billock PhD, Matthew R. Groenewold PhD et al. "Reported exposure trends among healthcare personnel COVID-19 cases, USA, March 2020−March 2021." American Journal of Infection Control, Published online: April 13, 2022, https://doi.org/10.1016/j.ajic.2022.01.007.

[8] CDC COVID-Data Tracker, Cases & Deaths among Healthcare Personnel.https://covid.cdc.gov/covid-data-tracker/#health-care-personnel (Accessed April 17, 2022).

[9] No other occupations are recommended to be identified by CDC.

based on overall case reports show 190,185 COVID-19 cases among healthcare personnel during the 10-week period from the end of December to the beginning of March 2022. During this time period, healthcare worker status was reported only in an average of 9.1% of cases.[10] (See Appendix: Chart A.)

During this same time period, CDC reports that among nursing home workers in skilled nursing facilities, a total of 339,753 cases were reported with a peak in infections in mid-January (week ending January 16, 2022) when 68,861 COVID-19 cases were reported among nursing home staff for one week.[11] (See Appendix: Chart B.)

The spike in infections among nursing home workers during the omicron surge was fast and enormous. In just a three-week period, infections among nursing home workers increased more than 500%—from 13,350 infections for the week ending December 26, 2021 to the nearly 69,000 weekly infections at the peak in mid-January. This was the fastest, exponential increase among these workers since early in the pandemic.

This massive surge in infections caused widespread illness among healthcare workers. Weekly infection and employment data from nursing home facilities show that during the omicron surge, more than 18% of all nursing home staff were confirmed with a COVID-19 infection.[12] Widespread infections led to major staff shortages, increased infections among patients and caused many health care institutions to impose crisis standards of care putting staff and patients at greater risk.

During the omicron surge, the reported rate of COVID-19 infections to CDC among nursing home staff was more than twice the rate of COVID-19 infections in the general population, reaching a peak rate of 3735.9 infections per 100,000 eligible staff per week in mid-January. This compares to the peak rate of 1,682.3 infections per 100,000 people per week in the general public reported for the same time period. The reported COVID-19 infection rate among nursing home staff continues to be higher than the reported infection rate reported for the general public.(See Appendix: Chart C.)[13] During this same time period, CDC also reports that the percentage of nursing home staff fully vaccinated is much higher than the rate of full vaccination

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[10]CDC COVID-Data Tracker, Cases & Deaths among Healthcare Personnel.

[11] CDC COVID Data Tracker - Confirmed COVID-19 Cases and Deaths among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week - United States. https://covid.cdc.gov/covid-data-tracker/#nursing-home-staff (Accessed April 17, 2022).

[12] CMS COVID-19 Nursing Home Data. Submitted data as of the week ending April 3, 2022. https://data.cms.gov/covid-19/covid-19-nursing-home-data.

[13] OSHA has requested data on the extent of COVID-19 infections among healthcare workers. The CMS COVID-19 Nursing Home Data is reported by nursing homes to the CDC's National Healthcare Safety Network (NHSN) Long Term Care Facility (LTCF) as required by CMS regulations. https://data.cms.gov/covid-19/covid-19-nursing-home-data. A public data set is posted weekly and includes detailed data on infections, vaccinations and other information (including employment information) among nursing home staff and residents at individual skilled nursing facilities subject to the CMS regulations. While this data set only includes information from one segment of the healthcare industry and does not include hospitals, assisted living facilities or other healthcare settings, it provides the most complete and consistent data collected and publicly available on COVID-19 infections among healthcare workers in the United States.

among the general population or the adult population aged 18 and older. Even with this high level of vaccination, nursing home workers remain at high risk of infection.

While infections among nursing home staff have declined significantly since the peak in January, infections and deaths among nursing home workers are still occurring and have the high probability to spike quickly again with another surge and without protections. According to the latest CDC data (week ending April 17, 2022), infections among nursing home staff are now five times the number when the health care ETS was issued in June, 2021.[14] CDC also reports that over the past three weeks, the number of infections among nursing home staff has steadily increased as the more transmissible omicron BA.2 subvariant has taken hold and become the dominant strain.

Vaccination alone is not sufficient to prevent infection. This surge in infections in January occurred concurrent with and immediately following the OSHA announcement on December 27, 2021 that the health care ETS was no longer in effect.[15] It occurred despite a high vaccination rate among nursing home staff: 82.8% to 88.4% of nursing home staff were fully vaccinated during the surge period with 27.7% to 45.7% of those vaccinated having received a booster dose, according to CDC.[16] (See Appendix: Chart C).

Previous infection also does not protect against future infection. The detailed COVID-19 nursing home data reported by CMS also show that during the period the omicron variant has been predominant, the percent of infections among nursing home staff that are reinfections has also increased significantly, from 5.7% of all positive cases the week ending December 19, 2021 to 13.6% of all positive cases the week ending March 27, 2022.[17]

Thus, the measures required by the health care ETS (i.e., respiratory protection, ventilation, physical distancing, testing, exposure notification, isolation, quarantine, medical removal protection) remain more critical than ever to prevent exposure to and transmission of SARS-CoV-2 in health care settings and must remain and be strengthened in a permanent standard to protect health care workers from infection, serious illness and death from COVID-19.

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[14] CDC COVID Data Tracker - Confirmed COVID-19 Cases and Deaths among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week - United States. https://covid.cdc.gov/covid-data-tracker/#nursing-home-staff (Accessed April 20, 2022).

[15] OSHA, Statement on the Status of the OSHA COVID-19 Healthcare ETS, December 27, 2021. https://www.osha.gov/coronavirus/ets

[16] CDC COVID Data Tracker, Nursing Home COVID-19 Vaccination Data Dashboard, COVID-19 Vaccination Coverage and reporting among Staff in Nursing Homes by week – United States. https://covid.cdc.gov/covid-data-tracker/#vaccinations-nursing-homes. (Accessed April 17, 2022).

[17] CMS COVID-19 Nursing Home Data. Submitted data as of the week ending April 3, 2022. https://data.cms.gov/covid-19/covid-19-nursing-home-data.

B. COVID-19 poses a significant risk of a wide range of adverse health impacts to health care workers and others exposed to the SARS-CoV-2 virus.

The adverse health impacts related to COVID-19 also extend well beyond the immediate effects of infection-related illness; there is a significant risk of severe short- and long-term illness, hospitalization and death. OSHA recognized and explained this in its preamble of the health care ETS. Substantial, accumulating scientific literature establishes that persistent long-term symptoms and physical and mental health changes occur in persons, including workers, who have experienced COVID-19 disease. Significant impacts on the ability to work have also been identified. President Biden recently launched a major federal government effort to respond to Long Covid and the National Academy of Sciences, Engineering and Medicine held a two-day webinar devoted to Long Covid and the impacts on disability and Social Security[18,19]

Recent research has added to our understanding of the breadth of the problem and the risk of developing Long Covid across all levels of COVID-19 illness severity, including the impact on the ability to work. In persons with mild COVID-19 (outpatient), 44% reported persistent symptoms of fatigue, shortness of breath, and difficulty concentrating 6 to 11 months after infection, leading to poorer long-term health status, poorer quality of life, and psychological distress.[20] Another study with persons who were mostly not hospitalized demonstrated long-term (some more than 12 months after infection) symptoms of fatigue, brain fog, sleep disturbance, dizziness, dyspnea, memory loss, with around 20% of respondents "unable to work due to illness."[21] Persistent neurological symptoms, including brain fog, numbness/tingling, and fatigue occurred in non-hospitalized persons having COVID-19.[22] After hospitalization, persistent symptoms of "aching of muscles (pain), fatigue, physical slowing down, impaired sleep quality, joint pain or swelling, limb weakness, breathlessness, pain, short-term memory loss, and slowing down in thinking" were common 5 months after discharge.[23]

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[18] President Biden. Memorandum on Addressing the Long-Term Effects of COVID-19. April 5, 2022. https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/memorandum-on-addressing-the-long-term-effects-of-covid-19/

[19] National Academy of Sciences, Engineering and Medicine. Long-Term Health Effects Stemming from COVID-19 and Implications for the Social Security Administration: A Workshop. March 21-22, 2022. https://www.nationalacademies.org/event/03-21-2022/long-term-health-effects-stemming-from-covid-19-and-implications-for-the-social-security-administration-a-workshop

[20] Han et al Associations between persistent symptoms after mild COVID19 and long-term health status, quality of life, and psychological distress. Influenza Other Respi Viruses. 2022;1–10. https://doi.org/10.1111/irv.12980

[21] Tabacof et al Post-acute COVID-19 Syndrome Negatively Impacts Physical Function, Cognitive Function, Health-Related Quality of Life, and Participation. Am J Phys Med Rehabil 2022;101:48–52. DOI: 10.1097/PHM.0000000000001910

[22] Graham et al Persistent neurologic symptoms and cognitive dysfunction in non-hospitalized Covid-19 "long haulers". https://doi.org/10.1002/acn3.51350

[23] Evans et al Physical, cognitive, and mental health impacts of COVID-19 after hospitalisation (PHOSP-COVID): a UK multicentre, prospective cohort study. Lancet Respir Med 2021. Published Online October 7, 2021 https://doi.org/10.1016/ S2213-2600(21)00383-0

Of the hospitalized patients who had been working before becoming infected, 17.8% "were no longer working" and 19.3% "experienced a health-related change in their occupational status". In patients who spent time in the intensive care unit (ICU), one year after discharge experienced physical symptoms were reported by 74.3%, mental symptoms by 26.2%, and cognitive symptoms by 16.2%.[24] Furthermore, 57.8% of the patients who were working before they were admitted to the ICU "reported work-related problems (eg, working less hours than before or still on sick leave)".

Health care workers may be at particularly high risk of developing Long Covid. Recent data from the United Kingdom found that among all occupations, health care workers were the third most likely to report symptoms of Long Covid. According to the UK Office for National Statistics "as a proportion of the UK population, prevalence of self-reported Long Covid was greatest in people aged 35 to 49 years, females, people living in more deprived areas, those working in social care, teaching and education or health care, and those with another activity-limiting health condition or disability."[25]

The COVID-19 pandemic has also taken a huge toll on the mental health and well-being of health care workers. A wide range of studies have documented that during the pandemic health care workers have suffered significantly increased rates of depression, anxiety, stress, PTSD and burnout.[26,27] The impact of COVID-19 has led to high rates of staff turnover resulting in severe staff shortages and threatening patient safety.[28,29,30]

The CDC has recently changed its focus from preventing exposure and infection to preventing severe disease, hospitalizations and deaths. The new community level metrics CDC announced in early March focus on hospital capacity to care for patients, not the level of virus transmission

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[24] Heesakkers et al Clinical Outcomes Among Patients With 1-Year Survival Following Intensive Care Unit Treatment for COVID-19. Published online January 24, 2022. JAMA. doi:10.1001/jama.2022.0040

[25] UK Office for National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK :7 April 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/7april2022

[26]Uphoff EP, Lombardo C et al. Mental health among healthcare workers and other vulnerable groups during the COVID-19 pandemic and other coronavirus outbreaks: A rapid systematic review. PLoS One. 2021 Aug 4;16(8):e0254821. doi: 10.1371/journal.pone.0254821.

[27] Hendrickson, R.C., Slevin, R.A., Hoerster, K.D. et al. The Impact of the COVID-19 Pandemic on Mental Health, Occupational Functioning, and Professional Retention Among Health Care Workers and First Responders. J GEN INTERN MED 37, 397–408 (2022). https://doi.org/10.1007/s11606-021-07252-z.

[28] American Hospital Association. Data Brief: Health Care Workforce Challenges Threaten Hospitals' Ability to Care for Patients. October 2021. https://www.aha.org/fact-sheets/2021-11-01-data-brief-health-care-workforce-challenges-threaten-hospitals-ability-care

[29] Health Leaders Media. Health Expert: Health worker burnout trending in alarming direction. December 15, 2021 https://www.healthleadersmedia.com/clinical-care/expert-healthcare-worker-burnout-trending-alarming-direction.

[30] Kaiser Family Foundation. Nursing Facility Staffing Shortages During the COVID-19 Pandemic. April 4, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/

in the community. There are differences in views as to whether the focus on limiting severe disease, as opposed to transmission and infection, is the best public health approach.

OSHA responsibility is different from the CDC's. Under the OSH Act, OSHA is required to protect workers from occupational exposure to hazards that pose a significant risk of material impairment to health. The permanent OSHA COVID-19 standard must protect workers against all of the significant health risks posed by exposure to SARS-CoV-2—immediate and long-term—and not be limited to simply focusing on severe acute disease, hospitalization and death.

C. The Omicron variants put workers at increased risk.

The Omicron variants are now the sole SARS-CoV-2 variant circulating in the United States. It has accounted for a high number of cases and hospitalizations, but the disease severity, such as length of hospital stay and deaths, is lower than that caused by the Delta variant.[31,32] While the vaccine remains effective protection against hospitalization and death from Omicron infections after a second dose, and even more robust after receiving a booster shot, there is only moderate and waning protection against symptomatic infections.[33] With a higher rate of Omicron transmissibility (two to three times that of Delta), workers are at greater risk of becoming infected and, in turn, having the capability of infecting others, including their coworkers, unless mitigation measures are in place to reduce exposures, in addition to vaccination.[34,35] The BA.2 subvariant of Omicron now accounts for the highest percentage of new cases of infection in the U.S., with 86% of all new cases caused by the BA.2 subvariant.[36] The Omicron BA.2 subvariant also causes a high number of asymptomatic cases, with a new study from China reporting a range of asymptomatic cases ranging from 82% to 96%.[37,38] The Omicron variant also has the capability of causing reinfection in people who have previously been infected by SARS-CoV-2

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[31] Iuliano et al Trends in Disease Severity and Health Care Utilization During the Early Omicron Variant Period Compared with Previous SARS-CoV-2 High Transmission Periods — United States, December 2020–January 2022. Morbidity and Mortality Weekly Report, Early Release / Vol. 71, January 25, 2022.

[32] Lewnard et al Clinical outcomes among patients infected with Omicron (B.1.1.529) SARS-CoV-2 variant in southern California. medRxiv preprint doi: https://doi.org/10.1101/2022.01.11.22269045

[33] Chemaitelly et al Duration of mRNA vaccine protection against SARS-CoV-2 Omicron BA.1 and BA.2 subvariants in Qatar. medRxiv preprint doi: https://doi.org/10.1101/2022.03.13.22272308

[34] UK Health Security Agency SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 33, 23 December 2021

[35] Klompas and Karan Preventing SARS-CoV-2 Transmission in Health Care Settings in the Context of the Omicron Variant. JAMA Published online January 24, 2022, doi:10.1001/jama.2022.0262

[36] CDC. Nowcast, Week Ending April 9, 2022. https://covid.cdc.gov/covid-data-tracker/#circulatingVariants

[37] Garrett et al High Rate of Asymptomatic Carriage Associated with Variant Strain Omicron. medRxiv preprint doi: https://doi.org/10.1101/2021.12.20.21268130

[38] Dai Y. Rapid epidemic expansion of the SARS-CoV-2 Omicron BA.2 subvariant during China's largest outbreaks. Posted April 11, 2022. DOI: https://doi.org/10.21203/rs.3.rs-1516063/v3

(9).[39] The ability of Omicron to evade immunity from both the vaccine and from previous infection strengthens the necessity to require workplace mitigation methods to reduce or eliminate exposure through ventilation and respiratory protection. It's not possible to rely largely or exclusively on a vaccine strategy to protect workers from workplace exposures and becoming infected.

D. COVID-19 poses a significant risk to other workers in congregate settings.

As we have seen throughout this pandemic, workers in many occupations and industries outside of health care are at high risk of exposure and COVID-19 infection. COVID-19 outbreaks have been widely seen among workers employed in corrections, education, food processing, warehousing, grocery stores and congregate settings or workplaces where there is close contact and sharing of contaminated air with residents, patients, co-workers or the public. All of these workers need the protection of a permanent COVID-19 workplace standard as the AFL-CIO has petitioned and urged OSHA to issue numerous times.

II. CDC guidance is not a substitute for an OSHA standard, does not meet OSHA's statutory obligations to protect workers, and is dangerous.

OSHA requested comments on aligning with CDC guidance for health care infection control practices (A.1 of OSHA's notice) and requested comments on creating a safe harbor for employers who are following CDC guidance instead of the standard (A.2 of OSHA's notice). OSHA must not rely on CDC guidance for its own standard or permit employers to use them as a safe harbor.

OSHA's authority and obligation under the Occupational Safety and Health Act is to adopt the standard "which most adequately assures" no employee will suffer material impairment of health, over time, bounded only by feasibility constraints. Throughout the pandemic, CDC issued hundreds of guidance documents that did not meet OSHA's statutory obligation, consistently and repeatedly showing it will not protect workers to the same level that is required of OSHA. CDC has ignored its own slim recognition of aerosol transmission of SARS-CoV-2 in its guidance, refusing to emphasize ventilation and respiratory protection measures that clean the air and effectively filter the virus away from people's breathing zones, and refusing to recommend workplace policies that keep infectious workers out of the workplace. For example, the current CDC COVID-19 guidelines on infection control and prevention for health care workers still limit the recommendation for the use of N-95 respirators to health care workers caring for patients with confirmed or suspected COVID-19.[40] For other health care workers, CDC guidelines still

[39] Pulliam et al Increased risk of SARS-CoV-2 reinfection associated with emergence of the Omicron variant in South Africa. medRxiv preprint doi: https://doi.org/10.1101/2021.11.11.21266068

[40] Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic,Updated Feb. 2, 2022. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

recommend and permit the use of surgical masks to limit exposure, despite the fact that CDC now recommends that members of the public wear the most protective mask (i.e., N-95 respirator) to protect against exposure to the more transmissible omicron variant.[41]

Further, CDC guidance on COVID-19 has largely been developed without any stakeholder or public input, an evidentiary record or due process as OSHA is required. CDC has not always used the best available science to issue public health recommendations; instead, it has often largely focused on individual behavior and cost saving measures for employers. Moreover, CDC's mission and charge is to protect public health, not worker health. OSHA is the federal agency charged with this responsibility and is the agency with the authority and expertise to address workplace exposures and risks through an exposure control model—requiring employers to implement effective control measures—rather than only an infection control model that focuses on individual behavior of the public.

OSHA is not permitted to adopt public health (as opposed to occupational health) standards (See NFIB v. OSHA, S. Ct.). OSHA is required to review each CDC guideline to ensure it meets the requirements of the OSH Act to protect workers from significant risk, which cannot be automatically presumed for future guidelines. Further, agencies are prohibited from incorporating by reference new versions of voluntary standards (or CDC Guidance) without notice and comment. This practice is called dynamic incorporation. "By permitting automatic modifications to administrative regulations, without the agency conducting a rulemaking, dynamic incorporation robs the public of the opportunity to examine and comment on future changes to the incorporated material."[42]

Including a provision in a COVID standard that says compliance with CDC guidelines will be accepted as compliance with OSHA will not ensure that employees are adequately protected from COVID-19.

III. A permanent OSHA COVID-19 standard is necessary to reduce significant risk.

A. The permanent standard must fully recognize aerosol transmission of SARS-CoV-2 and require control measures to protect workers from airborne exposures.

A substantial body of scientific evidence, previously provided to the agency, has confirmed that COVID-19 is an airborne transmissible disease. More recent scientific work and assessment has added to the firmly established conclusion in support of the airborne transmissibility of the SARS-CoV-2 virus that we are providing in addition to our comment. Due to the overwhelming evidence, recognition of airborne transmission of the SARS-CoV-2 virus has now been accepted at the highest levels of our national government. The White House's Office of Science and Technology Policy has concluded that "…*most common way COVID-19 is transmitted from one*

[41] CDC, Types of Masks and Respirators, Updated Jan. 28, 2022. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html.

[42] See the following article at p. 33-34 and the footnotes (n.194 and 198) citing previous OSHA statements that this practice is not permitted. https://www.acus.gov/sites/default/files/Revised-Draft-IBR-Report-10-19-11.pdf

person to another is through tiny airborne particles of the virus…".[43] Recent scientific work has demonstrated and confirmed airborne transmission, including a scientific perspective that all respiratory viruses, including SARS-CoV-2, are aerosol-transmitted.[44,45,46,47,48] Airborne transmission results in both long range exposures to the virus, more than six feet, and exposures in close proximity to a source.[49,50] Detection of airborne SARS-CoV-2 has been found in health care settings, including hospitals and nursing homes.[51,52] The increased transmissibility of the Omicron variant and airborne transmissibility of the virus places health care workers at further elevated risk of contracting COVID-19 in their workplaces without specific control measures to prevent exposure.[53,54]

As with all hazards to which workers are exposed, OSHA requires implementation of the hierarchy of controls to either eliminate or reduce the exposure and protect workers. The hierarchy applies to exposure to an airborne infectious agent, such as SARS-CoV-2 in health care settings. The most effective control in the hierarchy is to remove as much of the virus from the air as possible utilizing ventilation and filtration. The White House's Office of Science and Technology Policy has recently emphasized ventilation and filtration as necessary to protect

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[43]Dr. Alondra Nelson, head of the White House Office of Science and Technology Policy, *Let's Clear The Air On COVID*, March 23, 2022, https://www.whitehouse.gov/ostp/news-updates/2022/03/23/lets-clear-the-air-on-covid/

[44]Jimenez et al Echoes through time: the historical origins of the droplet dogma and its role in the misidentification of airborne respiratory infection transmission. Electronic copy available at: https://ssrn.com/abstract=3904176

[45]Tang JW, Tellier R, Li Y. Hypothesis: All respiratory viruses (including SARS-CoV-2) are aerosol transmitted. Indoor Air. 2022; 32:e12937. doi:10.1111/ina.12937

[46]C. C. Wang et al., Airborne transmission of respiratory viruses Science 373, eabd9149 (2021). DOI: 10.1126/science.abd9149

[47]Peng et al Practical Indicators for Risk of Airborne Transmission in Shared Indoor Environments and Their Application to COVID-19 Outbreaks. Environ. Sci. Technol. https://pubs.acs.org/doi/10.1021/acs.est.1c06531

[48]Fox-Lewis et al Airborne Transmission of SARS-CoV-2 Delta Variant within Tightly Monitored Isolation Facility, New Zealand (Aotearoa). Emerg Infect Dis. 2022;28(3):501-509. https://doi.org/10.3201/eid2803.212318

[49]A. Mikszewski, L. Stabile, G. Buonanno, et al., Increased close proximity airborne transmission of the SARS-CoV-2 Delta variant, Science of the Total Environment, https://doi.org/10.1016/j.scitotenv.2021.151499

[50]Nazaroff WW. Indoor aerosol science aspects of SARS-CoV-2 transmission. Indoor Air. 2021;00:1–31. doi:10.1111/ina.12970

[51]de Sousa et al Detection and isolation of airborne SARS-CoV-2 in a hospital setting. Indoor Air. 2022;32:e13023. doi:10.1111/ina.13023

[52]Linde et al Detection of SARS-CoV-2 in air and on surfaces in rooms of infected nursing home residents. medRxiv preprint doi: https://doi.org/10.1101/2022.02.16.22271053

[53]UK Health Security Agency SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 33, 23 December 2021.

[54]Klompas and Karan, Preventing SARS-CoV-2 Transmission in Health Care Settings in the Context of the Omicron Variant. JAMA Published Online: January 24, 2022. doi:10.1001/jama.2022.0262

people from exposure to airborne particles containing the SARS-CoV-2 virus.[55] Ventilation techniques to be used are readily available and feasible for use in health care settings. The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), the widely accepted authority on ventilation and filtration, has identified practical solutions for controlling exposure to infectious aerosols in buildings, including health care facilities.[56] Portable ventilation air cleaners equipped with HEPA filters have been demonstrated to be effective in cleaning the air of hospital and other building rooms.[57,58,59] NIOSH has developed a ventilated headboard to reduce health care worker exposure coming from infected patients and provided practical do-it-yourself instructions for building these devices.[60] For addressing surge capacity during a pandemic, temporary airborne infection isolation rooms (AIIRs) can be feasibly constructed that can reduce health care worker exposure to airborne infectious agents.[61,62,63] OSHA must include specific ventilation and filtration requirements in a permanent standard to adequately address the airborne transmissibility of COVID-19 and has enough information to do so.

Respiratory protection is necessary to protect health care workers from exposure to an airborne infectious agent like SARS-CoV-2, yet not the only control measure needed due to the limitations of personal protective equipment. Workers wear respirators to prevent the inhalation of many hazards across many industries, including health care. For all workplaces covered by OSHA, employers must provide devices approved by NIOSH as part of a fully compliant OSHA respiratory protection program required by 1910.134. Respirators have been demonstrated to be effective in protecting health care workers from COVID-19 and provide protection against

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[55]Dr. Alondra Nelson, head of the White House Office of Science and Technology Policy, *Let's Clear The Air On COVID*, March 23, 2022, https://www.whitehouse.gov/ostp/news-updates/2022/03/23/lets-clear-the-air-on-covid/

[56]ASHRAE. ASHRAE Position Document on Infectious Aerosols. Approved by ASHRAE Board of Directors April 14, 2020

[57]Buising KL, et al. (2021). Use of portable air cleaners to reduce aerosol transmission on a hospital coronavirus disease 2019 (COVID-19) ward. Infection Control & Hospital Epidemiology, https://doi.org/10.1017/ice.2021.284

[58]Conway-Morris, A., Sharrocks, K., Bousfield, R., Kermack, L., Maes, M., Higginson, E., ... & Navapurkar, V. (2021). The removal of airborne SARS-CoV-2 and other microbial bioaerosols by air filtration on COVID-19 surge units. *Medrxiv*.

[59]Lindsley et al Efficacy of Portable Air Cleaners and Masking for Reducing Indoor Exposure to Simulated Exhaled SARS-CoV-2 Aerosols — United States, 2021. Morbidity and Mortality Weekly Report, Early Release / Vol. 70, July 2, 2021

[60]NIOSH. Ventilated Headboards. CDC.gov/niosh/topics/healthcare/engcontrolsolutions/ventilated-headboard.html

[61]NIOSH. Expedient Patient Isolation Rooms. CDC.gov/niosh/topics/healthcare/engcontrolsolutions/expedient-patient-isolation.html

[62] Minnesota Department of Health, Office of Emergency Preparedness. Airborne Infectious Disease Management. Methods for Temporary Negative Pressure Isolation.

[63]Lee and Jeong. Rapid expansion of temporary, reliable airborne-infection isolation rooms with negative air machines for critical COVID-19 patients. Amer. J. Infect. Cont. 48 (2020) 822-824.

aerosols unlike a surgical mask or other face mask.[64] The minimum level of respiratory protection that must be provided to protect health care workers from aerosols is an N95 filtering facepiece respirator (FFR).[65] Reusable respirators, such as elastomeric half mask respirators or powered air purifying respirator, are preferable in the health care industry as they can be cleaned and disinfected safely for reuse, do not result in low supplies of N95 FFRs or contribute to surge pricing of disposal PPE.[66,67]

B. The permanent standard must protect all health care workers at risk of workplace exposure to SARS-CoV-2, not just those involved with direct patient care of individuals with suspected or confirmed COVID-19 and must protect health care workers from all of the adverse health outcomes of COVID-19, not only hospitalization or death.

The health care ETS did not fully recognize or address airborne transmission of SARS-CoV-2 as a major, if not the primary mode of exposure. Control measures were directed to limiting exposures from close contact, largely focused on direct or close contact with patients with suspected or confirmed COVID-19 infection. This approach fails to recognize that asymptomatic transmission is responsible for a large proportion of infections, and that airborne transmission of the virus puts workers and others well beyond three or six feet at risk of significant exposure and infection when working in crowded indoor settings with inadequate ventilation.

The permanent standard must protect all health care workers who have workplace exposure that puts them at significant risk of disease. This includes close or regular contact with patients whose infection status has not been determined by testing, in addition to those who are suspected or confirmed with infection. This must include all environmental service workers, food service workers and others who may be in patient rooms after they are occupied, but before there has been an opportunity for any virus to have dispersed.

OSHA acknowledged this issue in their issuance of the health care ETS: "Of note is that some health care associated employees who are expected to have less close contact with patients represented a greater percentage of cases than some healthcare employees that are expected to have close and direct patient contact." 86 FR 32403. However, OSHA has indicated that it is considering limiting certain protections to areas where health care workers are exposed to patients with suspected or confirmed disease, eliminating protections such as facemasks and

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[64]Andrejko et al. Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection — California, February–December 2021. Morbidity and Mortality Weekly Report. Early Release / Vol. 71, February 4, 2022.

[65]Friese et al. Respiratory Protection Considerations for Healthcare Workers During the COVID-19 Pandemic. Health Security Volume 18, Number 3, 2020. DOI: 10.1089/hs.2020.0036

[66]Brosseau et al. Elastomeric Respirators for All Healthcare Workers. AJIC: American Journal of Infection Control (2020), https://doi.org/10.1016/j.ajic.2020.09.008

[67]Brosseau. Are Powered Air Purifying Respirators a Solution for Protecting Healthcare Workers from Emerging Aerosol-Transmissible Diseases? Annals of Work Exposures and Health, 2020, Vol. 64, No. 4, 339–341. doi: 10.1093/annweh/wxaa024

medical removal for other workers. The AFL-CIO strongly opposes any such limitation. As we have set forth, healthcare workers remain at significant risk of infection from workplace exposure to SARS-CoV-2. The protections in the permanent standard should be broadened and strengthened, not narrowed and weakened.

C. The permanent standard must not assign different levels of protections to workers based on their COVID-19 vaccination status.

Two shots of m-RNA vaccines have been effective in protecting people against COVID-19, particularly against serious illness and death. However, the protection offered by two shots has waned over time.[68] Two doses also provide limited protection against symptomatic infection resulting from exposure to the Omicron variant, which is the only variant currently in circulation in the United States.[69,70] In response to the waning protection, a third vaccine dose (booster) has been approved for use in the U.S. The booster increased protection against Omicron mortality but for infection, the protection waned over time.[71,72,73,74] In response to the waning protection of the booster against Omicron infection, a fourth dose has now been approved for use. A recently published study in Israel reported that a fourth dose demonstrated an initial improvement in protection against Omicron infection and severe COVID-19 compared to three doses.[75] However, by the eighth week after administration of the fourth dose, the protection against infection had declined nearly completely while protection against severe COVID-19 did not wane at all. Another recent study in Israel of a fourth vaccine dose did show the fourth dose had increased protection against infection, symptomatic infection, hospitalization, severe COVID-19, and death.[76] However, the study time period was too short (30 days) to see any trends in waning effectiveness.

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[68] Andrews et al Duration of Protection against Mild and Severe Disease by Covid-19 Vaccines. N Engl J Med. Published on January 12, 2022, at NEJM.org, DOI: 10.1056/NEJMoa2115481

[69] Andrews et al Covid-19 Vaccine Effectiveness against the Omicron (B.1.1.529) Variant. N Engl J Med. Published April 21, 2022, at NEJM.org, DOI: 10.1056/NEJMoa2119451

[70] CDC Nowcast. Week ending 4/9/2022 https://covid.cdc.gov/covid-data-tracker/#nowcast-heading

[71] Andrews et al Covid-19 Vaccine Effectiveness against the Omicron (B.1.1.529) Variant. N Engl J Med. Published April 21, 2022, at NEJM.org, DOI: 10.1056/NEJMoa2119451

[72] Arbel et al BNT162b2 Vaccine Booster and Mortality Due to Covid-19. N Engl J Med 2021;385:2413-20. DOI: 10.1056/NEJMoa2115624

[73] Abu-Raddad et al Effect of mRNA Vaccine Boosters against SARS-CoV-2 Omicron Infection in Qatar. Published on March 9, 2022, at NEJM.org. DOI: 10.1056/NEJMoa2200797

[74] Patalon et al Waning Effectiveness of the Third Dose of the BNT162b2 mRNA COVID-19 Vaccine. medRxiv preprint doi: https://doi.org/10.1101/2022.02.25.22271494

[75] Bar-On et al Protection by a Fourth Dose of BNT162b2 against Omicron in Israel. Published on April 5, 2022, at NEJM.org. DOI: 10.1056/NEJMoa2201570

[76] Magen et al Fourth Dose of BNT162b2 mRNA Covid-19 Vaccine in a Nationwide Setting. Published on April 13, 2022, at NEJM.org. DOI: 10.1056/NEJMoa2201688

As demonstrated above, even though health care workers have been vaccinated, a significant number have been infected and spread the virus. This is because health care workers have been exposed to very high doses of SARS-CoV-2 and while vaccines are an important layer of protection, exposure control measures are necessary to reduce transmission and exposures to the virus to eliminate significant risk. Where vaccinated and unvaccinated workers have had different protections from their employers throughout the pandemic, it has not adequately protected workers and it also has caused massive confusion and chaos among the workforce.

D. Health care workers need medical removal and medical removal benefits to reduce significant risk from workplace COVID-19 exposures.

The health care ETS required employers to remove employees who have been infected with SARS-CoV-2 or experienced an exposure at work from the workplace and provides payment for workers who must be removed. These medical removal provisions are critical and essential both for the monitoring and medical management of infected and exposed workers and to prevent further transmission of the virus to others. Provisions that require employer payment of infected or exposed workers who must be medically removed to prevent future transmission are necessary to encourage reporting and to support and protect infected and exposed workers.

Medical removal and medical removal benefit requirements in OSHA health standards is a long-established policy and practice. Such provisions were first included in OSHA's lead standard promulgated in 1978, which required the removal of workers from jobs with high environmental lead exposures based upon elevated blood lead levels or a medical determination that removal was warranted. The lead standard required the maintenance of the employee's full earnings, seniority, and other employment rights and benefits (1910.1025(k)). Similar requirements have been included in numerous OSHA health standards (methylene chloride 1910.1052(j), cadmium 1910.1027(l), benzene 1910.1028(i), formaldehyde 1910.1048(l), and methylenedianiline 1910.1050(m)).

The medical removal benefit provisions of the health care ETS were much more limited than comparable provisions in other OSHA standards. Employees of employers with 10 or fewer employees are excluded from the requirement for employer payment for workers who are removed from the job. The health care ETS also allowed employers to cap wage payments at $1400/week and to require the use of an employee's earned vacation or sick leave to cover removal costs. All of these limitations shift the costs to and place an unacceptable burden on workers.

The requirements for medical removal and medical removal benefits must be maintained and strengthened in the permanent COVID-19 standard so that all workers covered by the standard have the full benefit of medical removal protections and benefits, as afforded by OSHA for other workplace hazards.

The permanent COVID-19 health care worker standard must require employers to bear the full costs of medical removal, just as they are required to bear the costs of compliance for all of the other provisions of the standard. There is no reason or rationale for shifting costs of removal protection to employees. Workers employed at smaller facilities must be provided full medical removal benefits; these workers need and deserve the same protection as workers at larger facilities. There must be no cap on payment of lost wages or the allowance to rely on other employee benefits. Every other OSHA standard that includes medical removal protection has explicitly required the maintenance of the employee's full earnings, seniority, and other employment rights and benefits. The only allowed offset has been for payments received by the employee through a workers' compensation program.

The permanent standard must also require that employers make available and provide all COVID-19 vaccinations required or recommended by the federal, state or local government or by the employer at no cost to the employee. The health care ETS requires employers to provide up to 4 hours of paid time for vaccination and recovery, but OSHA has indicated that it may drop this requirement in the permanent standard for workers subject to the CMS vaccination rule. (87 Fed. Reg. 16428, (March 23, 2022.) CMS regulations require the vaccination of health care workers at health care facilities designated under the rule and vaccinations are mandated by many other government authorities and employers.[77] But CMS does not require that employers provide health care workers the opportunity to be vaccinated and recover from any side effects on paid time, unlike the health care ETS. The permanent standard should maintain the health care ETS requirement for paid time for vaccination and recovery for all workers covered by the standard.

The permanent OSHA COVID-19 standard should support and encourage employee vaccination for all workers covered by the standard. This should include all COVID-19 vaccinations recommended by CDC to stay up to date. There should be no exclusion for workers who are also subject to the CMS regulations. Such an exclusion would disproportionately impact low wage workers, who are at the greatest risk of infection and severe outcomes from COVID-19. One of the largest barriers for low wage workers to receiving vaccination is the difficulty of access and scheduling problems which will only increase as the government programs to offer and pay for vaccinations are cut back. OSHA should be supporting vaccination of all health care workers, not creating barriers to and placing the burden on workers.

IV. COVID-19 recordkeeping and reporting requirements should be maintained and expanded.

The health care ETS included a number of important provisions requiring the recording of COVID-19 in the workplace and reporting of work-related COVID-19 cases resulting in hospitalization or deaths to OSHA (1910.502(q) and 1910.502(r)). These requirements build off the existing OSHA injury and illnesses recording and reporting requirements set forth in OSHA's injury and illness reporting regulations under 29 CFR 1904 and are currently in place

[77] Medicare and Medicaid Programs; Omnibus COVID–19 Health Care Staff Vaccination, 86 Fed. Reg. 61555 (November. 5, 2021) https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23831.pdf

under 29 CFR 1904. The AFL-CIO strongly supports these requirements and recommends strengthening this language to protect workers.

A. Recording COVID-19 cases

In addition to requiring the recording of work-related COVID-19 infections on the OSHA 300 injury and illness log, the health care ETS requires that employers maintain a separate workplace COVID-19 log and enter each positive COVID-19 case that is identified in an employee whether or not the case is work-related.[78] The purpose of the COVID-19 log is to assist with the tracking of COVID-19 cases that occur among workers, and to identify and evaluate potential workplace exposures to other employees. The COVID-19 log is treated as a confidential medical record. Individual case information is available to an employee or their authorized representative upon request. A version of the log without the employee's name, contact information or occupation is available to employees or their representatives.

The COVID-19 log provides a critical source of information not only to track individual cases, but to assess the prevalence of COVID-19 among a facility's workforce and the potential risk of COVID-19 exposure to workers. Unions have utilized the information from the COVID-19 logs to evaluate and compare the COVID-19 infection risk at workplaces in order to seek additional protections where needed. However, the utility of the COVID-19 log is limited since it does not provide sufficient information to identify the type of work the employee performed that may have contributed to the employee's exposure.

The AFL-CIO urges OSHA to modify the information on the COVID-19 log to include "job title" as is required on the OSHA 300 log. In addition, we believe access of employees and representatives to information on the COVID-19 log should be treated in the same manner as access to information on cases on the OSHA 300 log treated as "privacy cases." Under 1904.29(b) employers are instructed not to include the name of the employee on the OSHA 300 for privacy cases. Such cases include mental health illnesses, HIV, hepatitis, tuberculosis and needlestick injuries. The permanent COVID standard should provide employees and their representatives access to the COVID-19 log without the employee's name or contact information, but include job title and other required case information.

The health care ETS requires that the COVID-19 log be maintained for the duration of the regulation. OSHA has indicated it is considering changing this requirement to limit maintenance of the information on the log to a one year period from the date the case is recorded. The AFL-CIO strongly objects to this limited retention period. The information on the COVID-19 logs has great utility beyond immediate case tracking. The information can be used to evaluate trends in COVID-19 infections overtime (well beyond a year) and can be useful to employees for

[78] The log must contain the employee's name, contact information, occupation, location where the employee worked, the date of the employee's last day of work, the date of the positive test or diagnosis, and the date the employee first had symptoms, if any. 1910.502(q)(ii)(A).

supporting workers compensation claims and disability for work-related COVID-19, including for Long Covid.

Moreover, as OSHA is well aware, data and information on COVID-19 infections among workers in the United States is sorely lacking. There are no requirements to report industry, occupation or other employment information on COVID-19 case reports. There have been only limited efforts to collect and report this information. The COVID-19 logs provide the most complete source of information on COVID-19 infections among health care workers in the United States. This information should be available to the government, states and researchers to help evaluate and assess the extent of COVID-19 among workers to assist with efforts to protect workers going forward.

The AFL-CIO recommends that the permanent COVID-19 standard require the maintenance of the COVID-19 log for five (5) years following the end of the calendar year that these records cover, the same retention that is required for the maintenance of the OSHA 300 injury and illness log.

B. Reporting COVID-19

The health care ETS updated OSHA's regulations for reporting work-related COVID-19 hospitalizations and deaths to require that for health care workers, such cases be reported to OSHA within 24 hours of the employer learning of the hospitalization or eight hours in the case of an employee COVID-19 death. This modification clarified the existing confusing injury reporting requirements which OSHA had interpreted requiring reporting of cases within 24 hours of exposure for hospitalizations and within eight hours of knowledge of deaths that had occurred within the past 30 days, rendering them ineffective for identifying serious COVID-19 cases and many deaths. The permanent COVID-19 standard should maintain the requirement for reporting hospitalizations within 24 hours and deaths within eight hours of the employer's knowledge of the event/case.

The AFL-CIO again urges OSHA to strengthen the reporting provisions in the permanent standard to include a requirement for the employer reporting of COVID-19 workplace outbreaks to OSHA as a number of states—including California, Nevada and Virginia—have done. We recommend that OSHA utilize a threshold of either two or three COVID-19 infections occurring among workers at a workplace within the past 14 days, whether or not the cases are work-related.

This information is critical to identifying in real time those workplaces that may pose a higher risk of exposure and infection, and will assist OSHA, public health agencies, employers and unions to focus outreach and prevention efforts where they are most needed. As OSHA has recognized, outbreak information that has been collected by states is one of the only sources of information available to assess the prevalence and risk of COVID-19 in different sectors. Employer reporting of workplace outbreaks is even more important as states and localities cut back on their contact tracing efforts, which has been one of the only other sources of information to gather data on COVID-19 occurring by work setting or industry. OSHA should collect and make workplace outbreak reports publicly available by posting weekly reports listing facilities with reported outbreaks (the number of outbreaks and cases)—similar to the type of reporting that is done by the State of Oregon and other states and by the CMS for COVID-19 infections in

skilled nursing facilities.[79] These existing state and CMS COVID-19 reporting initiatives demonstrate that outbreak and case reporting by employers and collection by the government is feasible and provides valuable information for responding to COVID-19.

C. Reporting and recording requirements across workplaces is a critical surveillance and protection tool.

At a minimum, as part of this rulemaking we urge OSHA to expand all of the COVID-19 recordkeeping and reporting requirements to all employers subject to the 1904 injury and illness recording and reporting regulations. Specifically, this final permanent standard should require all employers to: 1) maintain a workplace COVID-19 log; 2) report hospitalizations and COVID-19 deaths to OSHA within 24 hours and eight hours, respectively, of employer knowledge of the event; 3) report workplace COVID-19 outbreaks to OSHA; and 4) make this information available to employees and employee representatives. OSHA attempted to do some of this through the now vacated vaccination/test ETS, so that there would be a uniform OSHA requirement for reporting COVID-19 hospitalizations and deaths for all workers, so this is still needed.

These expanded recording and reporting requirements would greatly assist in the identification and prevention of SARS-COV-2 exposures, infections and deaths among workers. It would also finally provide critical and much needed information about the risk of and impact of COVID-19 among workers in the United States. It is the least that OSHA should do to help prevent future exposures to the virus and unnecessary COVID-19 infections, serious illness, disability and death.

V. OSHA must fully account for the full range of health and economic impacts in its analysis for the permanent standard.

Having significant requirements in place in health care settings under the health care ETS and through a permanent COVID-19 standard prevents individual infections, hospitalizations, deaths and Long Covid. Prevention of these health outcomes have direct benefits, but also indirect benefits such as fewer costs associated with medical surveillance, exposure notification, medical removal protection, and recordkeeping.

The benefits to the rule go beyond preventing negative health outcomes. Healthcare workers have and are facing an intense burden to care for patients while fearing for their own safety and that of their colleagues and families, and through intense periods of work and exhaustion with limited support, leading to demoralization, physical and mental stressors and increased staff

[79] CMS regulations (42 CFR 483.80(g) issued on May 8, 2020 require skilled nursing facilities to report COVID-19 infections and deaths among residents and staff on a weekly basis, but there is no similar CMS requirement for reporting COVID-19 infections among healthcare staff by hospitals or other healthcare employers.

attrition.This has been well documented throughout the pandemic and OSHA should consult a variety of existing available evidence and reporting on this subject. The turnover and cost impact of COVID-19 staff turnover and sick hours to hospitals has been enormous, even in data just prior to the winter Omicron surge, when conditions worsened.[80,81] The increased work burden has taken a documented toll on workers mental health, a result also seen in other pandemics.[82] Main risk factors for the burnout and exhaustion include working in a high risk environment, working with inadequate and insufficient materials, the perceived threat of illness, and the lack of COVID-19 specialized training—all are risk factors that would be addressed through stronger protections in a permanent standard.[83]

In response to the situation, the American Hospital Association issued a data brief outlining the increased costs due to reduction in staffing, with an estimated $24 billion over the course of the pandemic.[84] When workers are provided the protections necessary to prevent workplace infections and reduce the physical and mental stressors of the work through permanent COVID-19 protections, they are more likely to stay in the industry providing an economic benefit.

In assessing the feasibility and costs for the permanent standard, OSHA should also consider current technology available and the technology developed. Permanent COVID-19 protections also ensure that developments around ventilation, respiratory protection and other measures will be adopted and implemented. As mentioned above, NIOSH has published detailed and extensive materials on ventilated headboards and airborne infection isolation rooms and some employers have adopted these measures; however, a standard requiring strong measures will increase adoption and lower costs throughout the industry. Investment in reusable protections (e.g., ventilated headboards, elastomerics and PAPRs), ensures employers will have what is needed and prevent their participation in surge pricing and supply shortage bidding—reducing costs long term.

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[80] Premier Inc. PINC AI Data Shows Hospitals Paying $24B More for Labor Amid COVID-19 Pandemic. October 6, 2021. Available at: https://www.premierinc.com/newsroom/blog/pinc-ai-data-shows-hospitals-paying-24b-more-for-labor-amid-covid-19-pandemic.

[81] Hendrickson, R.C., Slevin, R.A., Hoerster, K.D. et al. The Impact of the COVID-19 Pandemic on Mental Health, Occupational Functioning, and Professional Retention Among Health Care Workers and First Responders. J GEN INTERN MED 37, 397–408 (2022). https://doi.org/10.1007/s11606-021-07252-z.

[82] Uphoff EP, Lombardo C et al. Mental health among healthcare workers and other vulnerable groups during the COVID-19 pandemic and other coronavirus outbreaks: A rapid systematic review. PLoS One. 2021 Aug 4;16(8):e0254821. doi: 10.1371/journal.pone.0254821.

[83] Galanis, P., Vraka, I., Fragkou, D., Bilali, A. and Kaitelidou, D., 2021. Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis. *Journal of advanced nursing*, *77*(8), pp.3286-3302.

[84] American Hospital Association. Data Brief: Health Care Workforce Challenges

Threaten Hospitals' Ability to Care for Patients. October 2021. AHA.org/system/files/media/file/2021/11/data-brief-health-care-workforce-challenges-threaten-hospitals-ability-to-care-for-patients.pdf

VI. **All workers at significant risk need the protection of a permanent OSHA COVID-19 standard.**

Health care workers continue to face significant risk of infection, serious disease and death from workplace exposures to SARS-CoV-2. They need protection from a strong, enforceable permanent OSHA standard. While health care workers face some of the greatest risks, workers in other settings also are at significant risk - working for prolonged periods in crowded indoor or enclosed spaces, in close contact with others with inadequate ventilation. Workers in meatpacking, poultry, food manufacturing, agriculture, corrections, warehousing, transportation, education and other congregate settings have suffered widespread infections, with many workplaces experiencing large COVID-19 outbreaks resulting in hospitalizations and deaths. Outbreak reports from states including Washington and California show that infections and outbreaks in these industries continue; workers remain at significant risk.

For more than two years, the AFL-CIO has been calling upon OSHA to do its job to protect all workers from COVID-19. We renew that call and urge OSHA to move forward with a permanent COVID-19 standard that will protect all workers from COVID-19 infections, serious illness and death.

Sincerely,

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