

**POST-HEARING BRIEF OF THE
AMERICAN FEDERATION OF LABOR
AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
(AFL-CIO)
ON THE
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION'S
OCCUPATIONAL EXPOSURE TO COVID-19 IN HEALTH CARE RULEMAKING
DOCKET NO: OSHA-2020-0004**

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The AFL-CIO submits this post-hearing brief in support of OSHA expeditiously issuing a permanent COVID-19 standard to protect health care workers and strengthening it compared to the emergency temporary standard (ETS) issued last year. Throughout the COVID-19 pandemic, the AFL-CIO and our unions have consistently advocated for strong COVID-19 standards to protect people at their workplaces. Under the Occupational Safety and Health Act, OSHA has an obligation to protect workers at significant risk from COVID-19 exposures. That risk still exists—regardless of worker vaccination status. Strong, enforceable mitigation measures are needed to address all forms of COVID-19 transmission, including contact, droplet and aerosol.

In addition to this brief, please refer to the additional evidence we have submitted to the record today, as well as our pre-hearing comments submitted on April 22, 2022 and three other sets of comments to the record in the past year.

I. Strong, Enforceable Workplace COVID-19 Standards are Urgently Needed and Feasible

A. There is overwhelming evidence that COVID-19, through all modes of transmission, poses a significant risk to workers.

OSHA's evidentiary record overwhelmingly demonstrates that COVID-19 is a significant workplace hazard. Expert testimony throughout the hearing made clear that COVID-19 spreads primarily through airborne transmission and through droplet and contact transmission, that vaccine effectiveness has waned over time, that new variants are and reasonably have the potential to be more transmissible, that reinfection is common and that Long COVID is debilitating. The AFL-CIO has submitted numerous studies to this record and the hearing testimony clearly supports requiring employers to provide worker protections from exposure to aerosolized COVID-19, in addition to other routes. Protections are necessary for workers who not only provide direct patient care or are in close contact with suspected or confirmed patients, but all workers who may be exposed to tiny aerosolized COVID-19 particles. This also includes the same protections for both COVID-19 vaccinated and unvaccinated workers. (Along with this brief, the AFL-CIO is submitting recent evidence on waning effectiveness of COVID-19 vaccination.)

The overwhelming support and need for OSHA to issue a standard to protect all health care workers against airborne exposure to COVID-19 was summarized well during the hearing by Dr. David Michaels, George Washington University (GWU) and former Assistant Secretary of Labor for Occupational Safety and Health:

There is no longer debate over the importance of aerosol exposure as Dr. Alondra Nelson, head of the White House Office of Science and Technology Policy has confirmed what science has long shown. COVID is airborne. Therefore, OSHA's final standard must be designed to prevent or minimize aerosol exposure and include

appropriate requirements for effective respiratory protection for all workers in all settings covered by the standard. (Tr. Day 2, p. 127)¹

The nature of health care work creates conditions that places health care workers at significant risk from COVID-19 exposures. Health care workers work in indoor, often crowded, poorly ventilated settings, sharing the same air with coworkers and patients they care for who may be infected. Risk factors considered in determining an environment that results in significant risk to COVID-19 were explained during the hearing by the experts in workplace risk assessment and hazard mitigation, the American Industrial Hygiene Association (AIHA) (testimony by Nancy McClellan):

[R]isk is based on severity and likelihood. In determining who, you need to look at the likelihood factors. Likelihood factors include intensity of their exposure, duration of their exposure, the tasks that they're performing, the kinds of personal protective equipment that may have been used, but not effectively and, too, the health status of the individuals. So it's multifactorial. And really, the only way you can wrap your arms around that is to have risk assessment applied in anticipation and recognition that you have a severe hazard. (Tr. Day 2, p. 103-104)

One million people in the United States have now died from COVID-19, and there are now an average of 280 deaths and more than 3,200 hospitalizations each day—a toll that is rising again quickly with the latest omicron subvariant (BA.2) surge.² While only three weeks have passed since the final day of the OSHA's informal rulemaking hearing for occupational exposure to COVID-19 in health care settings, the rate of new hospitalization admissions of patients with confirmed COVID-19 has increased 54%, from 0.64 per 100,000 population on May 1, 2022 to 0.97 on May 21, 2022.³ As the Association for Professionals in Infection Control and Epidemiology (APIC) testified, “[r]ight now we are still in the midst of the COVID-19 public health emergency.” (Tr. Day 2, p. 74)

B. The toll of inaction without an OSHA standard is devastating.

Previous delays in OSHA standards have cost workers their lives. According to the AFL-CIO's annual report, *Death on the Job: the Toll of Neglect*, the number of health care worker lives lost

¹Citations in this brief noted as Tr. Day #, p. # Refer to the corresponding transcript day and page numbers from the transcripts of the public hearings conducted from April 27 to May 1, 2022, as posted on [regulations.gov](https://www.regulations.gov).

²Centers for Disease Control and Prevention. COVID Data Tracker. Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory. Accessed on May 23, 2022. [covid.cdc.gov/covid-data-tracker/#trends_dailydeaths](https://www.covid.cdc.gov/covid-data-tracker/#trends_dailydeaths).; Centers for Disease Control and Prevention. COVID Data Tracker. New Admissions of Patients with Confirmed COVID-19, United States, Aug 1, 2020-May 21, 2022. Accessed on May 23, 2022. [covid.cdc.gov/covid-data-tracker/#new-hospital-admissions](https://www.covid.cdc.gov/covid-data-tracker/#new-hospital-admissions).

³Centers for Disease Control and Prevention. COVID Data Tracker. New Admissions of Patients with Confirmed COVID-19, United States, Aug 1, 2020-May 21, 2022. Accessed on May 23, 2022. [covid.cdc.gov/covid-data-tracker/#new-hospital-admissions](https://www.covid.cdc.gov/covid-data-tracker/#new-hospital-admissions).

without an enforceable health care standard was 1,552 health care workers as of the date of publication (April 26, 2022).⁴ This number is a severe underestimate since many cases were not reported and the number of lives saved by the COVID-19 emergency temporary standard in health care determined by OSHA was calculated before the increased transmissibility of omicron variants. These estimates also do not include the tens of thousands of worker lives lost or infections in industries outside of health care.

The toll for health care workers is already worse than it was when the AFL-CIO testified in the hearing on April 27, 2022 and is climbing. According to the most recent CDC data, 7,009 COVID-19 infections among nursing home staff were reported for the week ending May 15, 2022. This is an increase from the previous week and reported infections among staff have increased five-fold over the past seven weeks as the Omicron BA.2 variant and sub-variants have taken hold.⁵

As the record and the hearing testimony have substantiated, tracking acute infections, hospitalizations and deaths is critically important in the workplace but does not address significant impairment that workers face from post-COVID conditions after acute infections, otherwise known as long COVID. Findings in January 2022 by the Brookings Institute, focusing on Americans losing their health to COVID-19, identify the significant role that long COVID is likely playing in U.S. labor shortages.⁶ In the United Kingdom, the Bank of England has begun to assess this impact: There is an unexpected and significant rise in people outside the workforce who are not returning to work, largely due to long-term illness, with long COVID expected to be largely responsible.⁷ The largest proportion of those not returning due to long term illness are women, who also have been shown to bear the largest brunt of long COVID. Please refer to evidence the AFL-CIO previously submitted on long COVID in conjunction with our pre-hearing comments and to union testimony during the hearing:

Richard Andruszko, Communication Workers of America (CWA):

We also have concerns about the long-term effects of COVID, also known as long COVID. I have personally seen memory fog, embolic events, including strokes, heart attacks, pulmonary emboli, deep vein thrombosis in extremities, et cetera. We are only just beginning to understand the effects of long COVID. It is known that long COVID can

⁴AFL-CIO. April 26, 2022. Death on the Job: The Toll of Neglect. A National and State-by-State Profile of Worker Safety and Health in the United States. 31st Ed. aflcio.org/reports/death-job-toll-neglect-2022.

⁵Centers for Disease Control and Prevention. 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. Accessed May 19, 2022. covid.cdc.gov/covid-data-tracker/#nursing-home-staff.

⁶Bach, K. January 11, 2022. Is “long COVID” worsening the labor shortage? Accessed at brookings.edu/research/is-long-covid-worsening-the-labor-shortage/#:~:text=Long%20Covid%20could%20account%20for,are%20struggling%20to%20fill%20jobs.

⁷ Michael Saunders. 2022. *The route back to 2% inflation*. May 9, Resolution Foundation. Accessed at bankofengland.co.uk/speech/2022/may/michael-saunders-speech-at-the-resolution-foundation-event.

occur in people who have asymptomatic or mild COVID not just severe COVID. (Tr. Day 3, p. 115)

Lisa Baum, New York State Nurses Association (NYSNA):

In a survey conducted by NYSNA and its members last spring, over 50 percent reported experiencing long COVID symptoms, which is not surprising considering the workforce is overwhelmingly female and it has been determined that women suffer more from long COVID than men do, and over 90 percent reported adverse mental health effects. (Tr. Day 1, p. 263)

C. All health care workers must be provided protections under the permanent COVID-19 standard.

A major area of emphasis during the hearing was the fact that, largely due to the airborne nature of the virus, and the nature of exposure scenarios in health care settings, workers not involved in direct patient care, including in non-ambulatory care settings, also need strong protections from an OSHA COVID-19 standard. Health care workers testified about their working conditions and lack of protections when they were working in health care settings that were inadequately covered by the emergency temporary standard.

Sherri Dayton, American Federation of Teachers (AFT):

I think it's important to remember when you're a home health specialist, you're going to people's homes. One, you don't know what the ventilation is going to be like. It's their home, so it's apartment complexes sometimes where there's not good ventilation, maybe you can't open the windows. And people at that time, you know, in the shutdown were home, so there was like kids running around and aunts and uncles and all these people always around. So that's why I left visiting nursing. I could not get the PPE and feel safe at that job. (Tr. Day 3, p. 70)

Frank Jurgens, CWA:

The COVID protocols that might be followed in the hospital are not followed in the patient care center. (Tr. Day 3, p.103) Ninety percent of all Patient Service Center employees obtain COVID. Our nursing home phlebotomists were extremely negatively impacted. They had no PPE because it was rarely supplied by the nursing home even though it was supposed to. The phlebotomists were not being told they were drawing COVID-positive patients which they should have been. There was no guidance for management except use universal precautions, which won't prevent you from being exposed to COVID because it's airborne. (Tr. Day 3, p.105)

The couriers also have the COVID exposure risk. They go into nursing homes and pick up coolers full of COVID specimens. Some are not sealed, some are leaking. The couriers never even got hand sanitizer. They were told to look at Rite Aid or Target. When the couriers would take specimens to the lab processors, those lab processors

had to deal with all the ripped and leaking specimens all day long with no ventilation or hood to work under. (Tr. Day 3, p.107)

Robert Andruszko, CWA:

When patients come in with COVID-19 symptoms, many times they are and were fast-tracked for diagnostic imaging tests, including CT and echo MRI. In many cases, the patients are not worked up for COVID-19 until the end. This, after moving through the facilities, needlessly exposing workers as well as other patients. This certainly adds risk of exposure and contributes to the community health issue we're experiencing now. (Tr. Day 3, p.112)

During a CAT scan, you need to be very close to a patient, obtaining historical information, transferring, repositioning, and inserting IVs in order to administer contrast mediums. We see dozens and dozens of ER patients, inpatients and outpatients, every shift.(Tr. Day 3, p.114)

Denise D'Avella, NYSNA:

At my facility as well, COVID patients are transported in the common hallways and transported in elevators that are shared with other employees as well as other patients. They have a surgical mask on them, but that's all. (Tr. Day 1, p. 290)

Leslie Frane, Service Employees International Union (SEIU):

It's why workers like Arlita Moore are sounding the alarm and organizing to be respected, protected and paid. Arlita works as an environmental services worker in a hospital. She's responsible for cleaning and disinfecting patient rooms, a critical job in preventing the spread of infection. I want to tell her story in particular because even when higher paid employees working in the very same rooms with COVID patients got access to PPE, Arlita did not. It's hard to avoid concluding that protecting her and the other EVS workers, a workforce that is mostly black, brown and immigrant, was simply not her employer's priority. (Tr. Day 1, p. 104)

D. COVID-19 is a significant risk to all workers in other congregate work settings outside of health care.

On January 21, 2021, When President Biden took office, he issued Executive Order 13999, which directed OSHA, among other things, to consider whether to issue an ETS regulating COVID-19 exposures, and issue an ETS to regulate COVID-19 workplace exposures, and if the Agency determined an ETS was necessary, to issue one by March 15, 2021. OSHA agreed an ETS was necessary and, on April 27, 2021, forwarded a draft ETS to the Office of Information and Regulatory Affairs for review under Executive Order 12866. The draft ETS covered all workers—in and out of health care—potentially exposed to SARS-CoV-2 at work. The final ETS, published on June 21, 2021, however, was substantially narrower in scope than OSHA's draft ETS and protects only selected "healthcare" and "healthcare support service workers" from occupational exposure to COVID-19. Since then, workers outside of health care have been left

with no enforceable standards for their employers to protect them from occupational COVID-19 exposures.

The AFL-CIO has repeatedly called for workers in other high risk settings to be included in an OSHA COVID-19 standard; please refer to our previous comments and evidence in this docket. During the hearing, Shawn Bobb from the New York State Public Employees Federation (PEF), strongly advocated for and demonstrated the need for standard coverage in other congregate work settings:

During this pandemic, high rates of COVID-19 infections, illnesses, and a number of deaths were recorded among our congregate settings in New York state. Some examples include the New York State Department of Corrections and Community Supervisions, reporting 12,529 staff COVID-19 infections and 18 staff COVID-19 deaths through April 27, 2022. The New York State Office for People with Developmental Disabilities is responsible for coordinating services for New Yorkers with development disabilities. The agency provides services directly and through a network of private agencies. Through April 20 of 2022, OPWDD has acknowledged 24,320 COVID-19 infections and 49 COVID-19 deaths among both its employees and those of the private service providers. The New York State Office of Mental Health reported 4,618 staff COVID-19 infections and 12 COVID-19 deaths through April 26 of 2022. The New York state Office of Children and Family Services reported 637 staff infections through April 21, 2022. (Tr. Day 3, p.45)

E. The health care industry is familiar with regulations and they are vital in the operation of the industry.

Every industry operates under multiple regulations in order to do business—from local fire codes to food safety to transportation requirements. These existing authorities do not prohibit or remove the need for OSHA regulation, which has successfully played an important role in tandem with other regulations. In health care, regulation is how the system functions, which was emphasized by Kelly Nedrow, AFT, during the hearing:

[E]very single thing that happens in patient care is driven by regulations. The things that they document, the frequency of documentation, the way they order and administer medication, everything is driven by regulation. Granted, most of that regulatory process is geared toward reimbursement and not worker safety but there's not a single thing that happens in clinical care that is not driven by regulation. (Tr. Day 3, p. 77)

II. CDC guidance is not a substitute for an OSHA standard and employers should not be provided a safe harbor for following CDC guidance.

The evidentiary record demonstrates that allowing employers to rely on “CDC guidance” has only put workers at greater risk than when an OSHA COVID-19 standard was in effect and

enforced. Throughout the pandemic, CDC's COVID-19 guidance put workers in harm's way because it is dangerous and nonspecific in substance—weaker than an OSHA standard—and because it is not practically effective in workplaces that are governed by OSHA, the workplace regulatory authority.

A. CDC guidance does not protect workers, and in many cases has harmed workers.

Since the beginning of the pandemic, the AFL-CIO called on OSHA to issue a standard to protect workers from COVID-19, recognizing the unique role OSHA has in workplaces and that CDC guidance had never been sufficient in workplaces. CDC guidance has been frequently changed due to industry desires and political pressure instead of scientific evidence. These changes have resulted in the removal of protections for workers, increasing their risk of becoming infected and even returning sick workers to the workplace. The record includes many examples of how CDC guidance has harmed workers; below is just a selection of those testimonies on the record:

Deborah Burger, National Nurses United (NNU)

Our employers tell the nurses that they are following the CDC. For one example, one NNU member who works in a pediatric oncology unit was told to put a COVID positive patient in a room with a cancer patient who did not have COVID. She was rightfully terrified to expose a child with cancer to COVID. Based on CDC guidance, her manager proclaimed that her COVID positive patient had recovered because a few days had passed since they tested positive. The nurse insisted that they be placed in separate rooms until he received a negative COVID test. Nurses are the last line of defense for patients. Every patient, especially medically vulnerable patients, deserve to be provided with safe patient care. (Tr. Day 1, p. 231)

Shawn Bobb, PEF:

Again, the CDC guidelines didn't really advocate for these workers to have respiratory protection. Often the agencies would fall back on the CDC guidance, just completely ignoring the fact that these members are literally face-to-face with their clients providing services to these clients and putting them at significant risk of exposure. But the CDC guidance documents didn't address that so they were using that as an excuse not to provide protection. (Tr. Day 3, p. 69)

Micki Siegel de Hernandez, CWA:

While CDC has recently recognized aerosol transmission of SARS-CoV-2, they have not updated their guidance to reflect the protocols and controls that are necessary to actually protect against aerosol transmission. We in the union have had to fight against every CDC guideline that has come out throughout the pandemic and try to negotiate with employers for more protective measures. But when the CDC makes a recommendation that is harmful or wrong or such a low bar of protection, it makes any negotiation for real protections that much more difficult and sometimes impossible. Our

union has had COVID work-related preventable fatalities where the employer had been following CDC guidelines. (Tr. Day 3, p. 90-91)

David Michaels, GWU:

I think what we've seen over really the last two years or for a longer period of time, the Centers for Disease Control and Prevention are not expert in worker protections. The mechanisms to protect workers, requirements that need to be on employers, are not something that's within CDC's normal way of thinking and so they often issue recommendations that don't sort of -- they don't get it. And beyond that, you know, we've seen in the last few years the history of decisions being made by CDC that take many things into account, some that may be valid, some that are clearly not valid, decisions around saying, for example, that because we have a shortage of N95s, you don't have to use them. You know, OSHA would never simply say something like that. We have a situation where we believed, correctly of course, that all workers on oil rigs should wear fire-resistant clothing. And there was a shortage of fire-resistant clothing. And so we said, look, we expect every employer to provide fire-resistant clothing. If you can't get it, you need to show us that you did due diligence, you really tried to get some and we won't cite you. But if you just said, well, there's a shortage and you're not going to even try and your workers were at risk, you know, we would never accept that. And so similarly, when you think about how you're going to protect workers, the CDC doesn't have the right mindset. Beyond that, of course, we have this problem that they've really clung to this -- what we call the droplet dogma that clearly has been shown to be incorrect by the research by several of the people on this panel who have done remarkable work. And you've heard from Dr. Prather and Dr. Milton in particular around the scientific developments around this. And look, it's disappointing. I think the whole country is disappointed. (Tr. Day 2, p. 240-242)

Robert Andruszko, CWA:

The latest CDC guidelines were the weakest. The measures to reduce the spread such as quarantining if exposed and isolation if sick all fell apart. People are going to work sick and exposing others. The CDC guidelines got so watered down and this allowed people to start coming into work while contagious. The CDC could have prevented this mass exposure but they did not. (Tr. Day 3, p. 116)

Yet when OSHA had enforced its ETS, workers felt this harm was being mitigated. Sheryl Mount, a registered nurse testifying on behalf of the AFT, shared:

With the CDC guidelines consistently going downhill and putting healthcare workers at risk, we felt finally someone cared about our safety in the workplace. (Tr. Day 3, p. 23-39)

B. CDC does not meet OSHA's statutory obligations to protect workers, leaving them at significant risk.

OSHA and the CDC have two different statutory responsibilities as OSHA is required to promulgate the standard "which most adequately assures" no worker will suffer material impairment of health, bounded only by feasibility constraints. In previous comments, the AFL-CIO elaborated on the fact that CDC does not promulgate standards, that CDC guidance is largely developed without any stakeholder input, that it does not build or use a public, evidentiary record and that it does not always use the best available science to issue public health recommendations. This was reiterated in testimony by Dr. David Michaels:

In contrast to OSHA's evidence-based standards, CDC recommendations are not required by law to be based on the latest scientific evidence, nor do they go through any transparent public comment process as OSHA standards do. Consequently, many of CDC's science briefs and guidelines do not reflect current science, are out of date and have not been updated or corrected, and workers pay the price. A shortage of N95s, not science-based evidence about how COVID is transmitted, was the main reason CDC changed its original recommendation that N95s were better respirators to be used by healthcare workers and allowed surgical masks to be used in situations in which workers were clearly at risk and needed better protection.

Furthermore, CDC guidance is not based on the statutory criteria OSHA is required to apply when setting a standard. The different statutory goals of OSHA and CDC have resulted in confusion among employers and workers and increased risk for workers. Given the inadequacy of many of CDC's recommendations, providing a safe harbor enforcement policy for employers who are in compliance with CDC guidance, but not in compliance with OSHA standards could endanger the safety and health of that employer's workers. For that reason, providing this sort of safe harbor would conflict with the OSHA Act's requirement that OSHA standards must substantially reduce or eliminate significant risk of material impairment to health to the extent feasible and would hamper OSHA's ability to revise its approach to COVID-19 as new facts develop. (Tr. Day 2, p. 132)

However, while the agencies have two different roles and obligations, the two agencies can work together to ensure that workers and the public are protected from COVID-19. An example of how they worked together in the past was shared by Deborah Gold testifying on behalf of APHA:

OSHA has a unique expertise in things like control of aerosol exposures that frankly the people who are the main people writing CDC guidelines may not be relying on. So I think the best approach is where OSHA mandates what it believes necessary for employees and then that provides guidance to CDC as to how employees will be protected. That's the mandate that OSHA has, to take the lead on protecting employees.

And CDC has the lead on public health measures and they can and should and will be integrated as OSHA makes the regulation, as happened with bloodborne pathogens. The CDC has had recommendations for vaccination and disposal of waste and whatever, but it's the mandate that OSHA has on dealing with regulated waste, on providing vaccinations, that has really carried over in hospitals and other healthcare facilities. So I think there's a constructive interplay between OSHA regulations and public health guidance and it's not a one-way direction where OSHA just relies on CDC. (Tr. Day 2, p. 35-36)

The differences in the roles played by infection control and worker safety is not unique and does not occur only at the federal level, but also they work together in health care facilities to create safer environments. Dr. Robert Harrison, University of California, San Francisco, spoke on how patient safety and worker safety are both critical parts of infection prevention in workplaces:

Hospitals and other healthcare employers are workplaces. They're unique workplaces because there are patients in these workplaces. But hospitals and healthcare employers are workplaces and as such, workers have the rights to OSHA protections and the healthcare workplace is no exception to that right. I have seen and worked with patients and colleagues for the last 40 years, since multidrug resistant tuberculosis and there's a wide variety of capacity and expertise to implement employee and occupational health programs at the institutional level. In some respects, the debate that's occurring now between OSHA protections and CDC guidance mirrors the discussion and debates I have at the micro or institutional level with my colleagues in infection prevention and infectious diseases. And this balance between patient safety and healthcare worker safety is absolutely critical. And just like we have infection prevention guidelines for patients, we need OSHA standards for workers. (Tr. Day 2, p. 138-139)

When these roles are understood and both parties do not properly work together, it leads to fewer worker protections and limits the ability to control transmission of the virus. This has occurred in many past disease outbreaks, including H1N1 and anthrax, and were outlined in submitted comments and testimony (See Tr. Day 2, p. 128-9,148-150; OSHA-2020-0004-2064).

Others specifically expressed the risk that workers have been left with when employers are only relying on CDC guidance:

Debra Waters, unaffiliated registered nurse:

However, this guidance was voluntary rather than enforceable. COVID-19 has made it abundantly clear that voluntary guidance as a means of protecting the health and safety of healthcare workers during such an event is insufficient and results in thousands of avoidable illnesses and deaths and, in turn, validates the need for a permanent standard. (Tr. Day 5, p. 33)

Tyson Gabriel, Premier Risk Management:

We also researched the recent CDC mask guidance of masks and respirators and identified several CFR violations. This continued misguidance from the federal government has added risk to the public and, in fact, has taken businesses out of the compliance with the CFR. We have had to intervene with clientele to correct the record on PPE and respiratory protection standards because their adherence to the CDC masking guidance added risk and created several OSHA violations, which means if you attempt to adhere to the CDC's masking guidelines in the workplace, an organization will be in violation of the law. (Tr. Day 5, p. 169-170)

C. CDC is not a regulatory agency and its guidance is not enforceable in the workplace.

Because CDC does not promulgate standards and regulations and it is not a regulatory agency, Congress does not appropriate inspectors nor does it have the authority to penalize employers and others who are not following its rules. OSHA has this explicit authority and obligation. CDC's recommendations are simply a guideline for local and state health departments to follow as a baseline. Nothing prevents a regulatory authority from going beyond CDC's recommendations in its guidelines.

Mary Miller, American Public Health Association (APHA):

Well, for one thing, it hasn't been applied uniformly and it doesn't really typically apply to the workplace. And the workplace is a unique environment and needs different measures than the community environment. And so -- and CDC guidelines are not enforceable typically, so -- and as I said, many -- you know, at least half -- more than half the states actually have removed public health functions, the public health officials from having an ability to enforce public -- even the CDC recommendations. (Tr. Day 2, p. 34)

Deborah Gold, APHA:

CDC guidelines are often not explicit in terms of what has to be done in this situation. There's a lot of you could, you could, you should, whatever. And I think for OSHA to enforce something, it needs to be specific. (Tr. Day 2, p. 35)

Sherri Dayton, AFT:

I just think having a standard in place would put healthcare workers at ease to know that there's something in place holding them accountable so we don't ever go back to that. (Tr. Day 3, p. 75)

Infection control experts have expressed willingness to adhere to an OSHA standard that is stronger than CDC guidance, as they adhere to other regulations. Lisa Sturm, representing APIC, explained that CDC guidance is often utilized as the floor of protections:

So in general, the CDC guidance has been basically the floor or the minimum for our recommendations across our health systems in the United States. As was talked about just previously, there are some state and even county regulations that in general do tend to be more strict, so then of course we would default to those. We would always default to the most strict regulation or requirement and that is where I would recommend your floor be. (Tr. Day 2, p. 81)

D. CDC guidance is not specific, has been confusing for employers and workers and this problem is solved by an OSHA standard.

Employers and workers have expressed that CDC's ever changing guidance has been confusing and made it difficult to know what actions to implement to protect against COVID-19 exposures. Additionally for workers, it has made it difficult to know the resources available when employers are not keeping them safe. The record includes testimony by both industry associations and health care workers.

Nancy Foster, American Hospital Association (AHA):

Hospitals and their staff need clarity from the federal agencies in identifying what actions must be taken to protect against transmission of COVID-19. (Tr. Day 1, p. 130)

Because in terms of personnel policies, mask wearing and so forth, health systems and hospitals like standardization throughout, so there would not be unique policies. (Tr. Day 1, p. 159)

Sheryl Mount, AFT:

If healthcare workers had a set of rules that everyone knew and everyone followed and every facility was doing the same, then there would be no confusion. We would do the work and get the job done. That's what we're there to do and we would be safe doing it.

However, with an enforceable OSHA standard, the roadmap on how to protect workers is clear and authoritative as expressed by Dr. David Michaels, GWU:

But, you know, you need -- employers need to know exactly what to do or how to at least process the challenges that they face to protect workers, and OSHA standards tell employers how to do that. They say this is what we expect you to do and we expect you to develop a plan. The plan has to take your situation into account, but also it has to ensure that you're looking at the hierarchy of controls, you're thinking about engineering controls first. All of those things are missing from CDC recommendations. (Tr. Day 2, p. 242)

III. Without a federal OSHA standard, workers remain unprotected from significant risk from COVID-19 exposures.

When OSHA issued the ETS in June 2021, health care workers were provided the first enforceable COVID-19 protections since the beginning of the pandemic. Employers were finally required to identify COVID-19 hazards in their workplaces and mitigate worker exposures to the virus using effective control measures. This worked, according to Roslyne Schulman from the American Hospital Association, who testified that hospitals and health systems implemented control measures when they were required:

Hospitals and health systems have provided training for staff on COVID-19, on the COVID vaccines, and on infection control practices that are particularly important in preventing the transmission of COVID. Hospitals and health systems have provided call lines and other mechanisms for staff to get their questions answered. Hospitals and health systems have improved their air filtration systems. Hospitals and health systems in one of the hardest decisions made during COVID instituted restrictive visitor policies. These policies were emotionally difficult for all involved, including patients, families and staff. But it was necessary to institute these policies to protect the workforce and to prevent transmission from hospital to community. Hospitals and health systems enacted inpatient bed management and staffing policies. These included stopping elective procedures, isolating and quarantining ill staff, and literally inventing ways to dramatically increase bed capacity to enable the cohorting of COVID patients and limit exposure for those working in other patient care areas. One system reported to us that they increased their capacity by nearly 350 percent. Hospitals and health systems undertook incredible efforts to acquire N95s and other PPE that was in scarce supply, including in some cases chartering planes to retrieve PPE that was hung up in shipping delays or working with local firms to produce PPE. And before we had access to the over-the-counter COVID tests that are so readily available now, hospitals and health systems worked to get their laboratories authorized and to obtain the supplies that were necessary so that they could test for COVID. Running these tests in their own labs allowed for much faster identification of who was COVID positive and was essential to protecting the staff. It also allowed hospitals to make testing available for staff so that they could feel safer about their own health and about interacting with their families. (Tr. Day 1, p. 133-135)

When asked during the hearing, the American Health Care Association/National Center for Assisted Living could not provide examples where they were unable to comply with the ETS requirements. (Tr. Day 1, p. 188) The health care industry can comply, and has complied, with OSHA COVID-19 regulations, and patient care regulations as described in Section I.

Since the December 27, 2021 announcement that OSHA would no longer be enforcing the ETS, many hospitals and health systems suspended these protections, including isolating and quarantining ill staff, cohorting of COVID-19 patients, providing adequate supplies of N95s and testing patients, visitors and staff—leaving workers, patients and their communities at risk. Without these protections, many more health care workers have become infected, spread the

virus at work and home, and have died. In the AFL-CIO's previous comments and testimony, we advocated that a permanent OSHA standard is necessary to protect workers from significant risk of COVID-19 exposures. The hearing further justified the need for the standard to retain and emphasize the protections in the subsections below, at a minimum.

A. Employers must have a thorough written plan to prevent COVID-19 exposures and perform ongoing hazard assessments.

A written COVID-19 plan was a critical component of the ETS and is the backbone of worker protections. Controlling exposure to COVID-19 requires identifying where and how COVID-19 exposures occur and implementing the effective layers of controls necessary to protect workers from exposures. It is critical that the plan is written as it provides transparency for employers and workers alike to know where exposures may occur and the control measures and protocols in place to prevent exposures. Sherly Mount, testifying for AFT, described the importance and value of the written plan in her workplace:

We used the ETS as a tool to demand transparency regarding our employer's COVID-19 plan and insist on a well-defined process to notify our members of exposure or possible exposure in a timely manner, as per the ETS. We ultimately and proactively discussed PPE supplies and fit testing. We did end up discovering serious issues with fit testing and poor access to N95 respirators on several of our direct patient care units. (Tr. Day 3, p. 39)

In its permanent COVID-19 standard, it is necessary that OSHA retain the requirements of a written plan, which needs to take into account all forms of transmission, including airborne as the primary route, and droplet and contact as secondary routes. A recent study found that the most recent strain of omicron has increased stability on surfaces in comparison to previous strains.⁸

OSHA must not limit plan elements and controls to only where there is close contact with or direct patient care for a confirmed or suspected case, or for a symptomatic case, as these do not account for the overwhelming evidence in the record demonstrating that the primary route of transmission is through tiny aerosol particles that travel long distances and that asymptomatic infections spread the virus. The standard should take a precautionary approach similar to that used in the bloodborne pathogens standard. This would ensure that all workers with potential exposure to COVID-19 are covered by the standard and therefore, protected from exposure. This was supported and explained by testimony from Deborah Gold, testifying on behalf of APHA:

Well, based on our experience in California -- and I'm not speaking for Cal/OSHA but just the general experience in California -- there have been situations where all employees have been required to wear respirators, for example, when there has been

⁸ Chin, A., Lai, A., Peiris, M. and Poon, L., 2022. SARS-CoV-2 Omicron variant is more stable than the ancestral strain on various surfaces. *bioRxiv*.

an outbreak in a prison or congregate living situation. Also in skilled nursing facilities. So the determination was made that the risk in those specific facilities was sufficiently high that everybody with exposure to the facility population had to be protected. In other cases, there -- in some cases in health care, for example, if people are going to be admitted, people are now provided -- patients may be provided with either rapid testing or with PCR testing or NAAT testing so that they can determine whether they are -- and may be treated as suspected cases until they are determined not to be cases. This would have been helpful in some of the exposures that occurred in labor and delivery where patients were admitted obviously on a critical basis because the woman was in labor and then -- or the person was in labor and then later showed up as positive and then employees converted and got infected. So I think that each facility should be required to look at what they're doing and who their exposure is and make those exposure determinations just as you would in bloodborne pathogens. Is there a reasonable anticipation of exposure? Not just we know there is exposure. The idea of reasonable anticipation needs to be incorporated into the standard.

Others testified to the need for this assessment to be thorough and ongoing:

Micki Siegel de Hernandez, CWA:

I think this all goes back to the need for a very thorough hazard assessment. And the hazard assessment -- obviously COVID is the hazard, but the assessment looks at what the specific circumstances are for each separate environment, what's the interaction -- what is the work that's being done by the healthcare provider, what is the interaction with the patient or patients, how large is the room, what's going on in that space, what is being performed in that space. So you have to start with a thorough hazard assessment before you can determine sort of what all of the potential controls are. (Tr. Day 3, p. 122)

Robert Andruszko, CWA:

Early on in the pandemic we were intubating respiratory patients in distress. Over time, we saw the mechanical ventilation damaged lungs and patients couldn't be weaned resulting in more poor outcomes and deaths. Since then, practice standards and criteria for intubation have changed and more treatment regimens switched to high flow of oxygen without mechanical ventilation. With this, there's more opportunity for aerosolization and much higher level exposure to healthcare workers. It is a good thing to recognize different treatment options and to improve treatments, but you also have to look at the additional risk to workers and adjust protections accordingly to make sure they are protected. In other words, a hazard assessment has to be ongoing. (Tr. Day 3, p. 117)

Robert Andruszko, CWA, also testified to the feasibility of these requirements that make a difference:

Take tuberculosis as an example of airborne illness. There are many protections that the hospitals already have in place when dealing with TB patients. We use airborne protections for TB patients. The TB patients are isolated in an airborne infection isolation

room. Healthcare workers must wear specific PPE, including N95s, CAPR and others. There's a decon room when healthcare workers leave the patient's room, so it's totally feasible to have airborne protections and they exist, although there would be need for more isolation rooms or temporary isolation rooms for COVID-19 patients. Unfortunately, airborne protections are not implemented for COVID because the CDC does not recommend airborne protections. (Tr. Day 3, p. 116)

B. Workers and their representatives must be involved in the hazard assessment and the development and implementation of the COVID-19 plan.

In its permanent standard, it is necessary that OSHA retains the provision from the ETS that requires the employer to seek the input and involvement of non-managerial employees and representatives in the hazard assessment and development and implementation of the plan. When the ETS was in effect, this provision allowed workers and their representatives to provide the job expertise necessary to identify and control exposures.

MJ Burke, testifying for the American Federation of Government Employees (AFGE), explained the value of worker participation and that this involvement was able to address at least four significant exposure scenarios in only six months of the ETS:

Oh, yeah, because I think for me the employee knows faster than the employer knows when someone's become infected. So it can be anything. They know the practices on the work unit specifically. For example, just before we came on the last panel, you were talking -- or there was a panelist that was discussing issues of what happens if they don't have any rooms and they prematurely move people who are positive and there's a question in the end-user mind, i.e., the healthcare worker, if they should be doing that or not. So these are the situations in regards to like, for example, at our monthly meetings, COVID meetings, that I bring up. It's like, okay, we had an employee report this is a safety issue, why are you moving this person when there's other beds available or what's the harm of just keeping this guy or girl under respiratory protection for a few more days if they're not moving at a higher level of care? So I think it's important. We have caught at least four employees reporting issues up through me as a safety rep back through the COVID plan that were labeled by the safety committee as serious because our employees, I feel, are actively engaged. (Tr. Day 3, p. 176-177)

This sentiment was shared by Sheryl Mount testifying on behalf of AFT:

Although we had the opportunity to sit down with management and address our pandemic-related issues, we had no real teeth to force our employer to address our serious safety concerns in real time until the OSHA ETS was issued in June of 2021. We used the ETS requirements to drive our committee agendas. Although it was not perfect, we thought it was a starting place and recipe for success to finally get all healthcare facilities covered under the ETS on the same page. (Tr. Day 3, p. 23-39)

Without this provision through an enforceable standard, MK Fletcher from the AFL-CIO testified that their unions have expressed that some employers were hostile to partnership on health and safety and resisted worker involvement. This viewpoint was also shared by Milly Rodriguez of AFGE, who stated:

Although the current administration is supportive of workers and their unions, full participation has been slow-going. We feel strongly that workers and their representatives can make valuable contributions to their workplace COVID plans, and the standard should require their participation. Otherwise, employers will continue to resist employee involvement. (Tr. Day 3, p. 155)

However, this provision should be strengthened since many employers do not actively engage and use input from employees that is intended by the provision. The AFL-CIO recommends the following employee participation language based on previous OSHA standards, including Cal/OSHA's process safety management standard (8 CCR 5189):

Employee Participation

- (1) Employers shall develop and implement a written plan of action regarding the implementation of the employee participation required by this section.
 - (a) Employers shall consult with employees and their authorized representatives, including soliciting and obtaining input identifying those situations in the workplace with occupational exposure, developing, implementing and reviewing the effectiveness of the exposure determination and COVID-19 infection control plan, ensuring employee participation is representative of the job tasks and COVID-19 hazards in the workplace.
 - (b) Employers shall provide to employees and their representatives access to hazard analyses, controls, and all other information required under this standard.
- (2) Employers shall make available to affected employees and their authorized representatives all information required to be developed by this standard, including the plan, upon request in electronic and hard copy. The plan must be available at the worksite for employees at all times.

C. Employers must have a designated COVID-19 safety coordinator in charge of the plan.

The provisions for at least one designated COVID-19 safety coordinator must be maintained and required for all workplaces where COVID-19 is a significant hazard. It is critical for a knowledgeable person to have authority to implement the plan to reduce exposures and address COVID-19 hazards onsite.

Requiring a designated person on site with knowledge and authority for a significant hazard has been included in many OSHA standards including silica, beryllium, and many others. This

element is critical for COVID-19, as one of the most important ways to ensure workers are protected is to have an individual onsite that can assess local surges, readily identify where transmission is occurring and can occur, and take action to ensure corrective actions are taken. It is also very important to have this primary contact for the plan. Without this requirement of a designated person, the provisions of the rule would be much less effective. The designated person should be provided specific training. Premier Risk Management clearly demonstrated the need for and feasibility of a competent designated safety coordinator during cross examination:

Tyson Gabriel:

I think if you get into a position where, as a medical facility, you're looking to establish a competent pandemic response, you should involve industrial hygienists and safety professionals as far as qualified personnel. Competent personnel, much like we've seen in the construction industry, they can go through training to get them up to that level and also be given directors on how to manage the program there at the site level. I think that's the kind of direction that we need to go with that. As the example that I talked about with my friend, he was just appalled when he went in and investigated and found that the people that they were relying on didn't have any structured understanding of basic CFR requirements. We really think that this will help the medical field especially because we need to see medical workers protected the most right now and also be able to have them have long-term success with future pandemics and future exposures that are going to be coming down the path. (Tr. Day 5, p. 172-173)

Jessica Schifano, OSHA:

Based upon your risk assessment experience, do you find it's helpful to have a single person in charge? (Tr. Day 5, p. 173)

Tyson Gabriel:

I do, yes, and that could be a competent person. Giving them a basic understanding of the foundations of how the program is supposed to be implemented and operated, I think that will deliver and alleviate a lot of the problems. One of our clients, when we work with them, for example, I'll go into a business that may not have hundreds of employees but it might have maybe 50 employees, 40 employees. And what I will do is I will train competent personnel on how to manage the program at their micro level. I think that that's the kind of thing that we need to look at for the medical industry, to give them the capability to be able to manage it at their site level that also have an understanding where to go to for long-term capabilities, especially if we have something that changes. That's one of the things with this standard that I recommend that we do, to come up with a foundation. But then we also leave room open for the different pathogen that might be coming down the pipe. (Tr. Day 5, p. 173-174)

Speaking of his experiences as a nurse in an assisted living facility, registered nurse Steven Bailey testified on behalf of NYSNA, on the benefits of having a designated COVID-19 coordinator, stating:

As an aside, we do, in my facility, have a full-time infection control preventionist that has worked well in our facility. (Tr. Day 1, p. 271)

D. Patients with COVID-19 or suspected to have COVID-19 must be identified and cohorted.

The screening provisions of the ETS, while inadequate for reasons further explained in section IV. A and in previous AFL-CIO comments, have been sporadically applied and phased out since the ETS has been under the non-enforcement policy. There are many examples of the rollback and non standardization of screening procedures in the record, including testimony by registered nurses:

Richard Andruszko, CWA:

So those types of examples also with outpatients who are coming in for diagnostic testing, they don't need to have a negative PCR test. Yet, they're mingling with the same patients who are going for a procedure who have had a PCR test prior to their procedure. They might be having a lung biopsy, some sort of surgery, whatever. The regulations stipulate they have to have a PCR test prior to their procedure, but yet in the very next holding bay, there's someone going for a diagnostic test who is not held to the same standard. It's not protective. There are too many gaps. It's a safety net with holes in it, so we have to close those holes. (Tr. Day 3, p. 126-127)

MJ Burke, AFGE:

Now, different hospitals have started to kind of phase out that a little bit. I think other hospital systems, not VA specifically, have moved to just like sometimes a phone app defaulting, other things like that. I'm not so sure -- I think people become numb to just saying yeah, yeah, yeah, give me the sticker or yeah, yeah, yeah, or passing the sign, et cetera. But basically the rule has to be you can't be symptomatic when you go into immune compromised areas. So I don't know how you exactly enforce that with visitors especially going into these areas without a person doing a confirmation. I think that's in the interest of everybody. (Tr. Day 3, p. 178)

The ETS provision that required patient screening and management had resulted in employers cohorting patients who were confirmed to have COVID-19 from other patients. However, this practice now differs from facility to facility. The permanent standard should be clear that confirmed COVID-19 patients, suspected patients, and other patients should be cohorted appropriately. Several in the health care field, including registered nurse Matt Calzia, emergency room nurse Sherri Dayton, and safety and health director Lisa Baum (clarifying statements of a registered nurse) all shared the changes they have seen in recent months when employers have neglected to separate positive patients:

Matt Calzia, AFT:

Dedicated COVID-19 units are being dismantled and COVID-19 patients are being placed in the general population. Home health agencies who are mostly free of regulations around us are resorting to the broad guidance of the CDC against picking and choosing which guidance to follow as it suits the business model. We are in a better place, but without clear rules and regulations we are more vulnerable to the next surge or the next emerging disease and the whims of hospital administrators. (Tr. Day 3, 28)

Sherri Dayton, AFT:

For a period of time, we had two different waiting rooms. It was the same room, but they were separated by distance. So one side of the waiting room was COVID symptoms, or the sick waiting room, and the other one was non-sick, like if you came in for a sprained ankle or if you came in for stitches or something like that, something we knew that wasn't COVID related. That doesn't happen anymore. We never during the ETS put patients in the hallway. If they had COVID symptoms, they had to be in a room where at least we could shut the door. We never had the capacity to put all of them in negative pressure rooms, but at one point they did try to have some air scrubbers and wait 30 minutes between that room and get it cleaned and all that stuff. But all of that has pretty much gone out the window. Currently, if we do have a patient in a room and they have COVID symptoms, whether they get discharged or they get admitted, housekeeping goes immediately in there and cleans the room and we put another patient in there. There's no ventilation or air quality procedures at all at this time. (Tr. Day 3, p. 81)

Lisa Baum, NYSNA:

I just want to add to that. What Ms. Robin is discussing is common practice now in most hospitals. They are not designating specific areas for COVID patients, COVID positive patients, and on units with COVID negative patients and staff are assigned to both. So they are going from one patient to the other. And the horrific situation that one of the NNU speakers spoke about COVID positive patients being put in with severely immunocompromised cancer patients has gone on at our facilities as well. (Tr. Day 1, p. 288)

Yet, it is clear that hospitals and health facilities can and have effectively identified and cohorted patients when required to. Showing the feasibility of hospitals to cohort patients based on their COVID-19 status during normal conditions and surges, Roslyne Schulman, testifying on behalf of the American Hospital Association stated:

But my understanding is that many hospitals cohort patients based on their COVID-19 infection status. And some hospitals indeed have opened up -- reopened old facilities or opened up offsite locations as units that handle COVID-19 patients or, on the other hand, or handle COVID patients who do not have COVID. So there is a cohorting potentially by unit, by floor or in some cases, particularly during the large surges, in completely different facilities. (Tr. Day 1, p. 144-145)

E. Effective respiratory protection is vital to protect workers exposed to COVID-19 and must be provided and made available, along with appropriate training, to all health care workers, without retaliation.

Respiratory protection must be provided by employers in all workplaces where there is a significant risk of COVID-19 exposure as it is necessary to protect workers from exposure to an airborne infectious pathogen. The ETS required employers to provide workers who are exposed to suspected or confirmed cases of COVID-19 a respirator and for those performing aerosol-generating procedures (AGPs) on a suspected or confirmed case. However, as discussed in previous comments and throughout the evidentiary record, all workers with potential exposure to an airborne disease must be provided a respirator and not just those in with direct contact, close contact or performing AGPs.

Additionally, OSHA must require employers to provide access to respirators to all workers, even when not required to be worn under the standard. The CDC has recommended that the public wear the most protective mask that fits well.⁹ At a minimum, N95s should be provided to every worker so they have equal access to this critical personal protective equipment to perform their jobs safely.

A respirator is not automatically effective because it is worn for a host of reasons. OSHA must require all employers to provide access to respiratory protection in full compliance with OSHA's respiratory protection standard. When OSHA has not had an enforceable COVID-19 specific standard, access to respiratory protection has been difficult for workers. And even while the ETS was being enforced, workers have not had access from their employers to adequate supplies of N95s, still told to reuse them between patients. Many health care workers and experts testified on the difficulty of accessing respiratory protection without a COVID-19 standard and reuse practices that are still occurring:

Sherri Dayton, AFT:

We have had to fight for protections we got. We ended up going on strike in October 2020. And as a result, we finally gained the right to decide for ourselves when we needed a new N95. However, we are still reusing N95s to this day in April 2022. (Tr. Day 3, p. 33)

Leslie Frane, SEIU:

But we certainly saw a marked improvement in access to PPE. And I would say that's particularly true for the lower paid and less skilled job titles where -- to just recap the story of Arlita Moore that I told earlier, far too often, even when the supply chain problems loosened up a little bit, employers said, okay, well, for nurses and respiratory therapists, I get it, but there was an incredible willingness to allow EVS workers, dietary workers and sometimes even nurses' aides, despite how hands on they are, to make do without PPE or lesser PPE, surgical masks versus N95 respirators, for example, and

⁹ Centers for Disease Control and Prevention. Types of Masks and Respirators. Updated January 28, 2022. Accessed at cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html.

also just patterns of required reuse where workers were told to store their mask in a paper bag and reuse it over and over again. And when the ETS was lifted -- again, we don't have data on this of course, it's all anecdotal -- but the number of times that workers reported that, well, now they're saying a surgical mask is good enough again even -- or now they're saying -- we're going back to sort of having to fend for ourselves as well as the many examples -- and I believe that Adelina testified to this earlier -- of where workers just had to provide their own or in many cases -- and I would say this is especially true on home care workers where the union became their source of PPE because their employers were simply not providing it. (Tr. Day 1, p. 109-110)

Dr. Kimberly Prather, University of California, San Diego:

This slide shows a serious inconsistency in healthcare precautions. It has been shown during this pandemic that many respiratory activities such as talking and singing produce more aerosols than many common aerosol-generating medical procedures as shown in this slide. Yet healthcare workers were given N95s or AGMPs, but not when they are possibly near COVID positive patients based on CDC guidance, within six feet for minutes. The reality is that you can get infected with COVID by being near an individual, in the same corridor, break room, bathroom or elevator for far less than minutes and surgical masks will not properly protect you from this. (Tr. Day 2, p.158)

Debra Waters, unaffiliated registered nurse:

I think the most concerning thing that other professionals brought to me was that the limitations on PPE and reusing single-use PPE, it seemed like there was a miscommunication when the CDC announced that PPE was no longer in short supply, it was readily available for healthcare organizations. I think many expected with the ETS and with this announcement by the CDC that they would be able to use PPE in the normal infection prevention practices that we had prior to COVID-19 and that did not occur. Nurses continued to reuse single-use PPE for days on end. They continued with the decontamination processes, although the decontamination had slowed down at that point because when the ETS came out we were in the lower dip of the waves of COVID-19. (Tr. Day 4, p. 40)

A strong OSHA standard can prevent hazardous respirator practices. Working in the state of Oregon, where a state standard is still being enforced in health care Matt Calzia, AFT, testified:

I wanted to just circle back on something you had asked around the expiration of the ETS and point out that Oregon has a COVID standard. And I think one thing that I heard today that was really shocking and concerning was when Ms. Dayton mentioned they're still reusing respirators. There's no shortage anymore. So that is a choice that is not being -- that's a very concerning choice that the employer is making and that is not occurring here anymore. I think that's because we do have that standard in place that prevents that. (Tr. Day 3, p. 65-66)

As the AFL-CIO has commented previously, when respiratory protection is required under the standard, or employer-provided respirators are worn by workers, the OSHA respiratory

protection program must fully apply. In the 2022 publication by the National Academy of Sciences, Medicine and Engineering (NAS) Frameworks for Protecting Workers and the Public from Inhalation Hazards, the committee recommended OSHA establishes risk levels for infectious agents and then ensure that NIOSH-certified respirators be required in the context of a full OSHA respiratory protection program, not the “mini-respiratory protection program” and not a voluntary program.¹⁰ This critical recommendation was made because there are many widely-accepted limitations to the effectiveness of respiratory protection and the complete OSHA respiratory protection program was created to address these limitations.

Additionally, N95s are the minimum protection that should be provided and many environments may require additional respiratory protections, including elastomerics and PAPRs. A standard would encourage health care employers to invest in more protective, reusable respirators. Dr. Kevin Hedges, Canadian Aerosol Transmission Coalition/Workplace Health Without Borders International testified:

For healthcare workers treating suspected or confirmed patients, in some situations an N95 might not be good enough. There's a benefit this to using elastomeric respirators. They're reusable. There's huge cost benefits. And there may be some situations where there's poor ventilation where purifying respirators may be needed. In other parts of the hospital, you know, patients are coughing, you know, or there's certain situations where there could be an airbreak in the hospital, for example, that's kind of a trigger where they need to react fairly quickly, then they really should be thinking about a respirator protection program. It's really a life skill for healthcare workers. It's not just a select few having the training and being part of the respirator protection program. It should be a life skill. Moving forward, it should be a life skill. (Tr. Day 5, p. 100-101)

F. Workers have the right to know when they have been exposed to COVID-19 on the job.

OSHA must require that employers notify workers of workplace COVID-19 exposures. The ETS provisions required employers to notify workers of exposures when there was close contact with a COVID-19 positive person or worked in a well-defined portion during the transmission period. This provision resulted in many workers finally having access to critical information they needed to know in order to be temporarily removed from work, receive a test, and take actions to protect themselves, their families, their patients and their communities. Testimony from the hearing showed that notification of exposures no longer occurs without an enforceable standard, placing workers at further risk.

Sheryl Mount, AFT:

Being an emergency room nurse, we don't always get the COVID result back while they're still in the emergency room. As a matter of fact, frequently we do not. The results

¹⁰ National Academies of Sciences, Engineering, and Medicine. Frameworks for protecting workers and the public from inhalation hazards. Washington, DC: The National Academies Press, 2022. <https://doi.org/10.17226/26372> (Accessed May 23, 2022).

don't come back until they are up on the floors. I can tell you that we do not get notified. If they come in as a patient under investigation and they have COVID symptoms, then we are using our N95s and all of that. But if they come in as like a cellulitis or something like that and we swab them and they happen to come back positive for COVID once they get up on the floor because we did their admission swab, we do not get notified of that. That's not happening. (Tr. Day 3, p. 62)

Adelina Ramos, SEIU:

So, for example, we just had a breakout like two, three weeks ago. A lot of us didn't know there was a breakout because they didn't inform us. So how we found out that there were employees that test positive, it was because we went to work on that specific unit and then we were told that we have to wear the correct PPE because our employee that was working on that specific unit test positive and then they test the residents and one of the residents was positive also. But not everyone was informed. Not everyone in the facility knew that that was going on. (Tr. Day 1, p. 90)

But these notification provisions were not strong enough. OSHA needs to ensure that all potentially exposed workers are notified of exposure by fully recognizing airborne transmission. Testifying on behalf of APHA, Deborah Gold provided a strong recommendation to ensure all those exposed are properly notified:

I would say that you would -- personally for COVID-19, I would notify people who the facility -- that the employer knows were actually in the vicinity of that patient or that case or suspected case if they weren't a patient. I would notify them that they have been exposed. And if there's a judgment to be made about whether they need to be sent further on to talk to a physician or a licensed healthcare professional, it should be done after the notification or at the -- because for one thing, often only the employee knows what the actual duration and intensity of exposure was. People move around all the time in health care and these other facilities and a supervisor may not know that you spent 20 minutes, you know, trying to deal with some need of a patient that was not a patient to whom you were even assigned to provide care, right? So, you know, they've called for you from the hallway or whatever and you've come in. So I think that once the person has been notified, the opportunity to provide input into that exposure investigation is key. (Tr. Day 2, p. 31-32)

Without an enforceable COVID-19 standard, some employers track the COVID-19 status of workers, along with other key information such as occupation, vaccination status, and work restrictions. Requiring employers to notify workers of an exposure is reasonable and feasible, and serves to provide workers with vital personal health information. Testimony by Dr. Melanie Swift, representing the American College of Occupational and Environmental Medicine (ACOEM), shared information about the tracking system used in many hospitals:

I'm at the Mayo Clinic in Rochester, Minnesota. And we, as almost every single medical center occupational health program in the country, has an electronic tracking system that

we use for our healthcare workers with a feed from the HR system that has their job and other key demographics in it and allows us to track things like vaccination, other work requirements, exposures, et cetera. So those systems should be used to track all COVID positive employees. And those systems should have reporting capability that allows you to, one, identify clusters. So we have that. I think most systems have the ability to do that in different ways. And then secondarily, to establish exposure events or incidents within that system that can link other exposed personnel to that index case, whether that index case is a coworker or a patient. Additionally, those tracking systems include work status. Is that person released to return to work or not? And can trigger notifications in reporting and, in many cases, notices to supervisors about when a worker is removed from work and return to work or has a restriction. (Tr. Day 2, p. 46-47)

G. Exposed and infected workers must be provided paid leave to quarantine and isolate in order to prevent the spread.

Exposed and infected health care workers must be removed from the workplace and provided paid leave when required to quarantine or isolate. The AFL-CIO has previously provided detailed comments on the critical nature of the long-standing medical removal and medical removal benefits provisions to prevent further transmission of the virus to others. Without an enforceable COVID-19 standard, and as the CDC issued crisis guidelines allowing sick, infected health care workers return to work, employers stopped employee health management programs, and symptomatic health care workers have continued to be assigned to work shifts. Testimony from health care workers and industry alike shared that symptomatic workers have been reporting to the worksite during 2022, even during the winter omicron surge:

Sheryl Mount, AFT:

Unfortunately, the ETS expired during the fourth surge in the last week of December 2021. Hundreds of our members, both vaccinated and unvaccinated, developed COVID-19-like symptoms. They were unable to get tested. The employers' hotline for reporting symptoms and requesting testing broke down. They were unprepared, even though there was every reason to believe a surge was coming soon to report the Omicron in New York. [Employees]¹¹ experiencing symptoms were unable to get through to the hotline and were being placed on hold for four to five hours just to schedule the required testing as per hospital policy to report to work. Even when members were getting through, appointments for employee COVID-19 testing appointments were limited and not available for two to three days. One would think by the fourth surge and close to two years into this pandemic that employee COVID-19 testing would be the one thing that would be up and running like a well-oiled machine. Many members, including myself, never were able to get tested and reported to work because our symptoms were not that bad and just thought we could wear our PPE and social distance. (Tr. Day 3, p.40-41)

¹¹ The transcript in the record has an error. It reads "Employers" instead of "Employees."

Frank Jurgens, CWA:

They're saying that that employee was not infectious anymore. Even though they were still testing positive for COVID, they were "not" positive and there was no standard to say otherwise. (Tr. Day 3, p. 150)

Liya Robin, NYSNA:

St. John's Riverside Hospital asked me to return to work after five days since I was asymptomatic. I didn't return to work since I was on vacation and decided to keep my days of vacation. Before I tested positive, I had staff around me who was positive five days ago working closely with me and negative other sick patients that were not COVID positive. We all had to share the same kitchen, same restroom. The positive staff were using the non-fit tested N95 around the staff and the patient. None of us had a space to remove our masks safely to eat or drink. Staff was scared to say no to the return-to-work call after five days because of the scare to lose their job. As far as I understood, that was the case of almost all hospitals since they are horribly understaffed.

Leslie Frane, SEIU:

I can't underscore enough how important the paid leave provisions in the ETS were for the financial security of workers who contracted the virus or had a close contact exposure and needed to quarantine. Having paid sick leave meant they were no longer forced to make the difficult choice between going to work sick and potentially infecting others or not getting paid at all. And this is especially true for part-time workers and low wage workers like home care workers who are the least likely to have access to paid time off....The ETS was a game changer for many healthcare workers. And when it lapsed, despite a significant surge in cases, many employers began rolling back protections for workers. In many work sites, we saw a swift return to pre-ETS conditions in terms of paid leave and respiratory protections and a deepening of existing and glaring disparities, particularly in the treatment of low wage positions predominantly held by black and brown workers.(Tr. Day 1, p. 106-107)

Roslyne Schulman, AHA:

But, again, you know, consistent with CDC guidelines, you know, if there is, you know, extreme shortage and the surge in patients, then providing protective measures to the extent that you can for somebody who may be experiencing symptoms and bringing them in is possible in order to care for the patients, which of course is what hospitals do, is -- our primary objective is ensuring that patients are cared for. (Tr. Day 1, p. 148)

Nancy Foster, AHA:

I would say our hospitals that anecdotally have said to us they have brought people back in during a surge have done so with a lot of thought. They have put those individuals in areas where the patients are COVID 19 positive or have otherwise put them in an isolated work situation so that they can contribute to the work that needs to be done, but are not in a position to expose other patients certainly and they are wearing N95s or

higher grade respirators to do source control in order to protect people as well as possible. (Tr. Day 1, p. 148-149)

H. Employers must continue proper cleaning and disinfection procedures.

OSHA must continue to require employers to implement cleaning and disinfection procedures to address contact transmission of COVID-19. While the primary transmission route of SARS-CoV-2 is airborne, the virus can also spread through contact and droplet transmission. The continued need for cleaning and disinfection was supported by testimony from NNU and a registered nurse representing CWA:

Rocelyn De Leon-Minch, NNU:

Yeah, I think the permanent standard should follow the precautionary principle and also based on the scientific evidence, while aerosol transmission is the significant and predominant mode. We also know that there are studies that have found infections of SARS CoV-2 in fecal aerosol and in urine and in other specimens. So I think it would be dangerous to ignore contact transmission as another mode, right? And so we want to be able to prevent transmission and that includes preventing cross-contamination in all areas of facilities.

I think definitely, when you are in units with suspected and confirmed units, you know, requires frequent cleaning and disinfection and to make sure that healthcare workers who are in charge of cleaning those areas are provided respiratory protection and other PPE so that they can be protected from those chemicals and also to follow what's listed under the EPA list in environmental cleaning protocols that will disinfect the virus, SARS CoV-2, effectively. (Tr. Day 1, p. 238)

Deborah Burger, NNU:

And also, I think you need to understand that patients don't always stay in their rooms. They're moving from different units for various procedures and medical imaging. So those viruses get transmitted as the patient is being transported to the different unit. So it is crucial that there be extreme measures for cleaning all areas in the hospital and other patient care settings. (Tr. Day 1, p. 239)

Robert Andruszko, CWA:

Cleaning is always necessary and part of our established routine. (Tr. Day 3, p. 114)

I. COVID-19 specific training must be ongoing and continue to be provided in an interactive way.

Training requirements are critical components of every OSHA standard. OSHA must include strong training provisions that ensure comprehensive COVID-19 training is provided in a language and literacy level that the employee understands, is interactive, and allows for questions and answers by a knowledgeable person. When this does not occur, training is not as

effective. Certified nursing assistant (CNA), Adelina Ramos, testifying on behalf of SEIU shared changed employer training practices that resulted in less effective respiratory protection training:

The training as -- in the past practices, the trainings that we did receive in our facilities, it's totally different than what we've been receiving. It was more hands on on training that we did receive. We would have our infection control person do a specific training like, for example, if we have a flu come in...she would go over for minutes how to use a proper PPE and we have to do like a demonstration. If we're not doing it right, she would correct us. But lately, the past few years, it's been like we have to watch videos online. It's more like we have to read and they'll tell us like, you know, this is the website that you guys have to do this and you guys have to go on, log in and read about it and then we have to answer questions. And, I mean, a lot of older people, they're not as techie as the younger generation, so -- and a lot of employees feels like they -- they don't know how to -- they don't do well with reading. They like to do training like hands on, not so much on a computer. And we told our employers that we should go back to that, but -- and they were saying they don't have time because they don't have enough staff to do it, so it's always like around the question. They would just tell us to go online and do it. (Tr. Day 1, 88-89)

Employers can and have provided COVID-19 training on infectious control practices, and have previously established call lines for questions. Nancy Foster, AHA, testified:

Hospitals and health systems have provided training for staff on COVID-19, on the COVID vaccines, and on infection control practices that are particularly important in preventing the transmission of COVID. Hospitals and health systems have provided call lines and other mechanisms for staff to get their questions answered. (Tr. Day 1, p. 133)

IV. Provisions of the ETS must be strengthened and it is technologically and economically feasible to do so.

A. The standard must require adequate screening of individuals entering health care facilities for COVID-19.

In our previous comments, the AFL-CIO has provided evidence that the simple symptom-based screening required in the ETS has not been adequate and did not consider asymptomatic and pre-symptomatic transmission. This was reiterated in testimony by Shawn Bobb representing the PEF:

I would like to take the opportunity to say a screening, especially for symptoms, is not effective. We know that a significant amount of people are asymptomatic. As somebody mentioned earlier, you have people who have mild symptoms who would think they have a cold or allergies or something of that nature. We have facilities where screening is done, but the screening for symptoms, we still have instances where we have locations

where the inmates or the clients have no exposure except through the workers or visitors and we still get outbreaks in these facilities. So screening for just symptoms alone doesn't work. (Tr. Day 3, P. 83-84)

Since the ETS was issued, COVID-19 testing has become widely available and must be incorporated into screening requirements. OSHA should use existing screening models that involve routine testing to serve as a baseline in the health care industry. The Centers for Medicare and Medicaid has screening criteria, and a testing protocol for both patients and workers that can be examined and are currently in use in health care industry.¹²

Health care administrators have already been requiring test-based screening based on regulatory requirements under CMS as LaShuan Bethea, testifying on behalf of the American Health Care Association/National Center for Assisted Living, stated:

And so I'll just reemphasize that CMS has put out pretty proscriptive guidelines in terms of requirements around screening and so skilled nursing facilities are required to follow those guidelines. It's a regulatory requirement. (Tr. Day 1, p. 187)

However, only effective testing strategies should be required by the standard. At-home or unsupervised testing or self-attestation is not reliable enough for OSHA to ensure the virus is mitigated in the workplace to the extent feasible. Supervised PCR testing is the most reliable method. Rapid antigen testing may be useful under circumstances while waiting for the results of a PCR test is not feasible, but should not be relied upon as a definitive screening tool in health care settings.

Availability and testing capacity is already in place in many health care facilities and can be done in other facilities as well. The American Hospital Association shared that some facilities have already received accreditation to perform PCR testing in-house. Having this accreditation already increases the ability for the health care system to effectively and quickly utilize test-based screening and reduce costs of contracting laboratory testing.

And before we had access to the over-the-counter COVID tests that are so readily available now, hospitals and health systems worked to get their laboratories authorized and to obtain the supplies that were necessary so that they could test for COVID. Running these tests in their own labs allowed for much faster identification of who was COVID positive and was essential to protecting the staff. It also allowed hospitals to make testing available for staff so that they could feel safer about their own health and about interacting with their families. (Tr. Day 1, p. 134-135)

The widespread use of testing as a screening tool is included throughout the evidentiary record. Robert Andruszko testifying on behalf of CWA shared his familiarity with the testing capacity of a western New York hospital system:

¹² [cms.gov/files/document/qso-20-38-nh-revised.pdf](https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf)

The particular hospital systems in western New York we deal with do have the capacity to do testings. One of the larger systems has done labs and testing and turnaround facilities, which actually Frank is a part of who already testified. The other major healthcare systems with a lot of resources, I do understand that as technology starts to unfold, we should be contemplating these things that will be available shortly, because they've developed over the last two years very significant changes in the way PCR testing is done and they've fast-tracked it. Now, it's more about capacity because I know in our labs, there's thousands of tests that are being done now. Initially, they only had the ability to do 200 tests. Then it grew to 800 tests. Then it grew to 1,000 tests. Now it's like 3,000 tests a day which our lab can accommodate with quick turnaround time. Those are 24-hour turnaround times I'm citing. The immediate ERs, they're able with the Cepheid to get a 30-minute turnaround time. The capacity's somewhat limited in how many tests they can do at one time, but those are specific to ER patients and those coming in emergently. (Tr. Day 3, p. 127-128)

Other health care workers shared that they have also seen widespread testing done in health care systems within their states, which was corroborated by the American Hospital Association:

Sheryl Mount, AFT:

And it is typical in Connecticut across the bigger healthcare organizations, Harvard Healthcare and Yale that are doing this now. (Tr. Day 3, p.63)

Sherri Dayton, AFT:

And just down the road in another facility, we're hearing that they do test all patients. (Tr. Day 3, p.64)

Roslyne Schulman, AHA:

Many hospitals test patients that are coming in for COVID as a prerequisite to admission. (Tr. Day 1, p. 144)

Yet, another representative of the American Hospital Association shared that the majority of testing is of those who are symptomatic and that outpatient procedures are often screened through at-home rapid tests. As previously discussed, these limited screening protocols are inadequate and do not adequately address asymptomatic and presymptomatic transmission, and at-home tests can not be relied upon as conclusive. Limited test-based screening protocols were explained by Nancy Foster, American Hospital Association:

Now that we've seen a diminution of the number of hospitalized patients, frankly, with COVID, certainly we are testing anyone who is symptomatic. We are asking those or giving those individuals, those patients who are coming in for an elective procedure, an at-home test so that they can do their own testing prior to coming in and then asking them to provide the results to us or in some cases we're doing it on our own. The emergent cases are a little more problematic. You can't actually ask them to do their own test in advance. So there we rely on the symptom checker or if they know if they have

been exposed. Oftentimes we are testing them if there's any chance they've been exposed. And then individuals who we believe not to have been exposed and not to be under consideration of having COVID likely would not be tested unless they began to show symptoms while in the hospital. (Tr. Day 1, p. 145-146)

While the AFL-CIO strongly urges OSHA to issue a permanent standard with strong screening provisions, if a facility cannot properly screen an individual prior to treatment, the agency must require employers to take a universal precautionary approach to protect workers. This was explained in testimony by Micki Siegel de Hernandez, CWA:

If you don't test for COVID patients, visitors, employees, then you must protect workers because of the potential that someone could be infected. You can't turn a blind eye to this risk. This is why until COVID infection can be ruled out, an unknown COVID status must be treated as a potential COVID case and workplace protections must be enacted accordingly. (Tr. Day 3, p. 99)

B. A permanent standard must include clear requirements for effective and adequate ventilation and these are feasible to require in a permanent standard.

As a key part of the hierarchy of controls, ventilation is effective at removing as much virus from the air as possible before it reaches people's breathing zones. The need for OSHA to implement the hierarchy of controls and include ventilation requirements in a standard were heard throughout the four days of testimony (Tr. Day 1, 261 p. 35, 261; Tr. Day 2, p.100, 113, 127, 140, 170, 176; Tr. Day 3, p. 54-55, 96;Tr. Day 4, p. 168), including from Dr. Lisa Brosseau, University of Minnesota Center for Infectious Disease Research and Policy, who stated that after implementing enclosures, isolation, limiting the number of sources and duration in a shared space, and frequent testing to eliminate sources, ventilation is the next best control measure, stating:

Controls that interrupt the pathway from source to receptors such as dilution or building ventilation and local exhaust ventilation such as portable air cleaners with high efficiency filters are the next best controls in the hierarchy. (Tr. Day 2, p. 176)

A permanent standard should provide clear ventilation requirements, including having all health care facilities adhere to ASHRAE 170 as a baseline for new construction and renovations, which has broad support in the record, and requiring employers to perform a risk assessment to determine the type of ventilation changes necessary in a setting. The record contains testimony by experts on aerosols and industrial hygiene on simple ways to perform an assessment to determine the level of ventilation necessary:

Dr. Kimberly Prather, University of California, San Diego:

Finally, the last slide shows a simple CO2 sensor that can be used to assess the level of ventilation in a room. The goal is to have the air as fresh as outside, which is about 420

ppm and the value as low as possible. Somewhere less than 800 ppm is considered safer. Humans produce CO₂ when we speak, which can build up in poorly ventilated spaces. So CO₂ levels can be used to check areas and improve ventilation. Even though the virus is invisible, you don't have to fly blind when trying to clean indoor air. The right side shows how adding filtration can be -- it can be effective in a hospital. Filtration quickly removes the virus from the air and lowers risk of inhalation. It is key in most healthcare settings. You don't -- a lot of healthcare settings, you can't just open the window and let in fresh air. (Tr. Day 2, p. 160-161)

Nancy McClellan, AIHA:

And as it stands, there are very good tracer programs. There are now surrogates for aerosols that would mimic what an infectious agent could do and there are tracer studies that can be run in order to ventilate the evaluation of your ventilation system that can determine whether you have proper mixing, whether you have sufficient fresh air being brought in and what your clearance rates are. And so there are tools out there readily available, broadly applied that are actually being utilized in many large organizations and small organizations in order to run those tracer studies. (Tr. Day 2, p. 105)

Showing the value and feasibility of performing a risk assessment to determine ventilation levels needed, Micki Siegel de Hernandez, testifying on behalf of CWA, provided detailed examples of how to perform a risk assessment and provide appropriate ventilation options in real health care settings:

We've talked about ventilation a lot. Ventilation is a very broad category. It could refer to an HVAC system which can vary from area to area in a facility. It could refer to portable air filtration units with HEPA filtration that can be moved. It can refer to rooms that patients are in. We've heard several people talk about the airborne infection isolation rooms. And there may be some temporary rooms that are set up in certain circumstances for patients. So going back to your question, just let me give you an example of how this might play out. In the emergency department where we have lots of patients, people coming in, COVID status unknown, that would be a perfect area if you're looking at ventilation. Obviously, the risk is high. It's high and it's unknown just how high. In an area like that, then, one, you would want to look at the kind of ventilation that is being supplied by the HVAC to that area so you could potentially increase the air supply. If not, that would be a perfect situation where you may have additional portable air cleanliness required. You're still going to need respiratory protection for workers. The PCS that Frank spoke about -- and he spoke about the waiting room and also the drawing room that he works in, I don't even know if they a HVAC system in those outpatient locations. Again, a perfect place where you could have portable air filtration units. In certain areas, if you had a number of controls to reduce the risk to a certain level, then it may be possible to sort of ease up on certain other protections. We haven't spoken about employees' break rooms. These have been treated as like a neutral area, as if no COVID transmission can occur. And these are areas, again, indoor spaces, nobody is wearing any kind of respiratory protection so that would be -- and people have

to eat. They have to eat and take a break and rest. That would be a perfect example of where you really needed to amp up the amount of ventilation that is being provided. You may have administrative controls limiting, if you could, the number of people that are in the room and so on. So there's a relationship. As one control is lessened, it made need to be that others are increased. (Tr. Day 3, p. 121-124)

It would have been possible to have built a safe, temporary airborne infection isolation room. There are resources that exist. There is expertise that exists within OSHA to help guide that. Again, the CDC, their guidance was not at all helpful in that regard. We haven't even spoken about ventilated headboards for patients and which type of ventilation measure is implemented or how an HVAC system could be improved. That will really be very site-specific. And even within sites, department- or area-specific, part of the assessment that would need to be done. (Tr. Day 3, p. 149)

OSHA should not only require an assessment to determine the current level of ventilation and improvements that are necessary, but provide a roadmap for employers to improve their ventilation systems—through the standard and through appendices. There are a myriad of engineering controls to improve existing ventilation systems for COVID-19. Testifying on behalf of the AIHA, Nancy McClennan provided a wide array of examples of engineering controls within ventilation systems that have been implemented by industrial hygienists, including additional benefits and addressing barriers to implementation:

There's stand alone and there's -- into HVAC systems you can install ultraviolet. You can install upper room ultraviolet. You have portable ultraviolet. You have ultraviolet that can be applied to any part of the room.

You also have filtration units where you have HEPA filtration/MERV filtration that can be added into a unit. They can be stand alone. It can be part of your HVAC system. And a lot of the systems have even been engineered so that they're quiet. I know that a lot of the feedback that we get from them is that if they're over a speech interference level of noise, people unplug them and don't use them. Again, it's defeated. But if you employ that in your ventilation system and improve filtration without getting a static pressure drop, you're farther ahead.

There's also strength in some of the ionization technologies for reducing the transmission either through agglomeration of particles because they're impacting the aerosols that are curing the infectious agent. There's also a number of technologies that are -- other ionization like dry hydrogen peroxide is out there. And I know that in the past, there's been a lot of pushback on that because there was very little research evidence. But like many aspects of research that have gone on during this pandemic, they're catching up and they're starting to provide something more than anecdotal evidence of efficacy and there's substantial proof of safety through Underwriter Laboratories certifications and what have you.

So there's a number of technologies out there, some better than others, that address airborne transmission even though the focus at the beginning of the pandemic was looking at chemical agents in order to address surface disinfection. Some of these air disinfection technologies also can have a value added impact on surface transmission because not only do they address what's in the air, but they can -- because they're addressing what's in the air, they also address what lands on a surface. For instance, ultraviolet at a germicidal wavelength if installed in, say, light fixtures, will move the air across the UVC and then return it clean. And because of that cycle, it's not only improving your air changes per hour, but it's also delivering continuously disinfected air. As a collateral effect of that, it also reduces surface contamination. So for other infectious agents where surface contamination is an issue, it turns into a long-term solution that not only addresses SARS-CoV-2, but it can also impact other pathogens that we have down the road. (Tr. Day 2, p. 115-118)

Health care systems have been able to adhere to ventilation standards and improve their ventilation systems throughout existing health care systems. According to the American Hospital Association, which also expressed strong support for OSHA's incorporation of ASHRAE 170 in their pre-hearing comments (OSHA-2020-0004-2057):

Hospitals and health systems have improved their air filtration systems. (Tr. Day 1, p. 133)

While the current state of ventilation in hospitals is – there are many hospitals have adopted some of the components of the ASHRAE 170. (Tr. Day 1, p1. 149)

Requiring specific ventilation measures is commonplace in OSHA standards that include a permissible exposure limit, but have also been integrated in programmatic standards. In Cal/OSHA's Aerosol Transmissible Disease standard (8 CCR 5199), there are specific requirements for airborne infection isolation rooms and areas that include minimum air change rates, minimum outdoor air supply ventilation rates, and daily assessment requirements. Specific ventilation requirements are also seen in OSHA's silica standard for construction (1926.1153) under the specified exposure control methods provisions, when employers do not have to conduct exposure monitoring or adhere to a permissible exposure limit. The standard requires specific ventilation methods, including filters with 99% or greater efficiency, HEPA filters, and minimum air flow requirements, for tasks that are known to have a significant risk of exposure.

There are additional ventilation resources for employers readily available to them and many are already in the evidentiary record.¹³ Testifying on behalf of the American Federation of Teachers, Sara Markle-Elder shared other resources available:

¹³ OSHA-2020-0004-0751; OSHA-2020-0004-1880; OSHA-2020-0004-0426; OSHA-2020-0004-0593; OSHA-2020-0004-0722; OSHA-2020-0004-0753; OSHA-2020-0004-1875; OSHA-2020-0004-0448; OSHA-2020-0004-0449; OSHA-2020-0004-0750; OSHA-2020-0004-0754; OSHA-2020-0004-0749.

Many hospitals attempted to enhance ventilation or create temporary airborne infection isolation rooms with portable HEPA filtration units. As Nancy McClellan of AIHA explained yesterday, permanent ventilation solutions are best. However, we recommend that OSHA incorporate NIOSH's evidence-based approach for temporary expedience isolation rooms for surge conditions. NIOSH has created guidance and instructions on creating temporary AIIRs in ventilated headboards. NIOSH's evaluation shows that expedient isolation rooms can be as effective as permanent AIIRs which cost approximately \$30,000 more than traditional patient rooms. Ventilated headboards have been shown to successfully remove 99 percent of infectious-sized aerosols in NIOSH's laboratory testing. NIOSH provides detailed instructions and videos on their website. The devices are cost-effective and can be stored in normal times. They are a highly feasible and evidence-based engineering control that any hospital or critical access hospital can employ and should be required to plan for it. (Tr. Day 3, p. 56)

C. OSHA must retain the requirement for employers to maintain a COVID-19 log according to current recordkeeping standards and include occupational data, and must require the reporting of outbreaks to OSHA.

The AFL-CIO has called for strong reporting and recordkeeping requirements since the beginning of the pandemic to use real time information to mitigate workplace exposures and build systematic data of COVID-19 infections, workplace outbreaks, hospitalizations and death occurring in workplaces. These calls were supported by testimony explaining how records are used by OSHA, public health authorities, employers and worker representatives:

Dr. David Michaels, GWU:

I mean, the reason that OSHA keeps -- OSHA requires employers to maintain logs of injuries and illnesses is not to provide the information to OSHA. That's of secondary importance, though it's of some importance. But the idea is to tell employers that there is an elevated risk of some harm in the facility, whether it's injuries, COVID or silicosis, whatever that is. I would think that if you see multiple cases, it's incumbent upon the employer to investigate and to look for, you know, is it possible that it's because of certain practices that are occurring in the workplace and then to respond appropriately. (Tr. Day 2, p. 207)

And I think there are plenty of examples where public health authorities have said if I had known, if we had known about the outbreak at that workplace, we could have intervened more easily. I think we all recognize that OSHA can't send inspectors to follow up on even a small percentage of these outbreak reports if they're required. On the other hand, OSHA could treat them as they treat severe injury reports and conduct a rapid response investigation, have a compliance officer or area director or just -- or a contractor contact the safety health office at the hospital involved, the healthcare facility that reports it and say, okay, what have you learned and what do you plan to do about this? And I think that would be very effective beyond simply getting the report. (Tr. Day 2, p. 209)

Micki Siegel de Hernandez, CWA:

Can I just add in my conversations both with this Local 1168 and with other locals across the country, we've been working to collect the COVID plans, OSHA logs, and the COVID logs. So in this particular case, they were just received, where I think we're still waiting for the COVID logs and to see if we can sort of make that connection. To see for the illnesses that we are aware of, that the union is aware of if they are actually appearing on either of those items. On an OSHA log, it will be easier to tell. On a COVID log, obviously we don't get that with names or titles, but we may be able to figure out sort of time frames of people who have come forward and that we know about who were ill. (Tr. Day 3, p. 144)

MJ Burke, AFGE:

And so when I talked about the logs, I did use the logs specifically because I wanted to see in a certain work area if we had more prevalence. And if we did, what we could do as an after action to lower that. For the VA, we look at one day of loss or more as related to that. So that was helpful. I mean, we did create some after-action plans for our doctors. And specifically as we surged, even though we had a lot of exposures and people out, what we -- what I used the logs for specifically is to create, hey, you know, like on this unit we had seven or eight around this 14-day time frame. Uhm, that followed some changes in policy. (Tr. Day 3, p. 174-175)

Deborah Gold, APHA:

The California Department of Public Health has defined outbreaks in the context of COVID-19, and I think that that's an appropriate place to start, whether it's one or more cases or three or more cases or in larger -- but once we have evidence that there is transmission within the facility, that should certainly be considered an outbreak. And often that evidence is we now have a case where we would not have expected that case to be. For example, if the prison has been closed to visitors, the prison and a prisoner or inmate contracts illness -- if somebody who's kind of limited to that exposure within the facility contracts disease should trigger further investigation by the facility as to how that case occurred and that should then lead to defining an outbreak. (Tr. Day 2, p. 25-26)

Requiring the additional reporting reporting and recordkeeping requirements would not be overly burdensome for employers. As Dr. Melanie Swift, American College of Occupational and Environmental Medicine testified, most hospital systems are already recording this information:

I think employers need a tracking system embedded within their occupational health system that manages other exposures and infections in healthcare workers. I can speak for my institution and several others that I'm familiar with. I'm at the Mayo Clinic in Rochester, Minnesota. And we, as almost every single medical center occupational health program in the country, has an electronic tracking system that we use for our healthcare workers with a feed from the HR system that has their job and other key demographics in it and allows us to track things like vaccination, other work requirements, exposures, et cetera. So those systems should be used to track all COVID

positive employees. And those systems should have reporting capability that allows you to, one, identify clusters. So we have that. I think most systems have the ability to do that in different ways. And then secondarily, to establish exposure events or incidents within that system that can link other exposed personnel to that index case, whether that index case is a coworker or a patient. Additionally, those tracking systems include work status. Is that person released to return to work or not? And can trigger notifications in reporting and, in many cases, notices to supervisors about when a worker is removed from work and return to work or has a restriction. (Tr. Day 2, p. 46-47)

V. There are additional benefits to a permanent OSHA COVID-19 standard.

A. Health care workers are more likely to remain in jobs where they are safe.

This theme was ubiquitous throughout the hearing. OSHA must issue a strong, comprehensive COVID-19 standard in health care to protect health care workers.

Micki Siegel de Hernandez, CWA:

We feel strongly that a permanent COVID-19 standard in healthcare will definitely help with that by establishing standards that an employer does have to follow. So far workers who may still be considering leaving, that may help in knowing that there will be some protections in place. Right now, there just aren't. There's just nothing enforceable in terms of protection. (Tr. Day 3, p.139-140)

Richard Andruszko, CWA:

I think that some things are irreparable. The violation that occurred at the time, some people will never come back. They left, they're not coming back, they feel violated. Others, this is their career. They're going to stick it out. They want to stick it out. They want assurances that they're supported, not just in protections. Staffing and everything else comes into place and obviously compensation, but it does start with safety. And that the employers can't say no, sorry, we only have five masks today, we have ten people, figure it out. That's not acceptable. (Tr. Day 3, p. 141)

Jean Ross, NNU:

Nurses have told us and we know from experience, in the future, you will retain the nurses you have and you will recruit new ones once they know they are safe. And that safety has to rely on that permanent OSHA standard for COVID-19. (Tr. Day 1, p. 246)

Leslie Frane, SEIU:

This scaling back of protections increased risk in work sites where chronic short staffing has reached crisis levels. Now, traumatized or fearing for their own health and safety, healthcare workers are reconsidering the jobs they loved. In fact, nearly 1 in 5 healthcare workers have quit their position since February 2020. Up to 30 percent are currently thinking about leaving. That percentage is especially high for nurses, and

nursing homes are experiencing average turnover rates of around 100 percent. (Tr. Day 1, p. 107)

B. A standard would create a reliable demand for respirators and other PPE.

Early on and throughout the pandemic, the glaring lack of planning for the nation's personal protective equipment led to catastrophic consequences for workers and the public. As a result, shortage induced crisis standards were instituted early in the pandemic; these endangered workers. Some of the dangerous federal policies allowing reuse of disposable PPE infected many workers, but employer PPE reuse practices still continue today (see III. E. above). Crisis standards are no longer needed and cannot become the industry norm; a crisis is not an opportunity to race to the bottom.

Further, when U.S. manufacturers stepped in to make equipment, there were no clear standards to estimate the amount that would be used and required. As Nicholas Smit from the American Mask Manufacturer's Association (AMMA) stated during cross examination:

So AMMA was actually formed at the end of February 2021. And when we formed AMMA, there was over 51 manufacturers, and we wrote an open letter to the CDC and the U.S. government with our monthly production capacity and what we had currently available at the time in our warehouses. And that's why the FDA and the U.S. government declared the PPE shortage over. Manufacturers had tens of millions or hundreds of millions of N95s available since last year. They're just simply not being used. (Tr. Day 2, p. 267)

An OSHA standard significantly addresses these gaps in demand and supply. As Matt Calzia, AFT, also stated during his testimony, it would improve the situations in rural hospitals as well:

So we don't have the same sharing of knowledge and resources between, say, the academic centers down to rural agencies, and they don't have the same access to the knowledge base and the technology. So if we had more regulation with more directives so that that sharing is mandated and that we get to a point where -- I think they have the capability to do it, it's a matter of being compelled to do it is, I think, a big factor. (Tr. Day 3, p.60)

C. A permanent standard would spur technological innovation to prevent occupational exposures to airborne diseases.

OSHA standards have always led to innovations in technologies that have saved lives. Even during the short time the COVID-19 ETS was in effect, technologies were created, modified, and adapted in a timely manner. A permanent COVID-19 standard will lead to greater emphasis in this area since employers will be more confident investing in technologies under a permanent standard, and innovators will be confident there is demand for their product. This is an opportunity for OSHA to lead the market and spur technology innovations as its rules are

intended to do. Testimony below demonstrates this for testing, and this also is true for engineering controls, employer software and other tools.

Richard Andruszko, CWA:

The other major healthcare systems with a lot of resources, I do understand that as technology starts to unfold, we should be contemplating these things that will be available shortly, because they've developed over the last two years very significant changes in the way PCR testing is done and they've fast-tracked it. (Tr. Day 3, p. 127-128)

In conclusion, OSHA has built a broad evidentiary record to promulgate a strong, comprehensive standard that ensures employers protect workers from COVID-19. This permanent COVID-19 standard must be stronger than the ETS, not weaker. The agency is obligated by Congress to protect workers from significant risk from workplace hazards, including COVID-19 and must use its independent, workplace regulatory authority to require strong, effective measures are in place. We urge the agency to expeditiously issue this standard; working people's lives are on the line.