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May 23, 2022

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

RE: Post-hearing comments for Docket No. OSHA-2020-004, Occupational Exposure to COVID-19 in Healthcare Settings

Dear Assistant Secretary Parker:

Thank you for the opportunity to submit post-hearing comments and evidence in support of a permanent standard to protect healthcare workers and workers in congregate settings from COVID-19. The AFT represents 200,000 healthcare workers, as well as other essential frontline workers in public services, education and higher education, totaling 1.7 million people. Our membership includes individuals who work in hospitals, home health agencies, corrections, juvenile detention, and in group homes for developmentally disabled or mentally ill adults. These workers are at high risk of exposure and infection from COVID-19. All healthcare workers and workers in congregate settings need the protection of a standard for COVID-19 from the Occupational Safety and Health Administration.

With these comments and evidence submissions, we hope to amplify the information we provided to demonstrate the need for a permanent standard with genuine input from workers. Testimony from our local leaders made clear that some healthcare employers stopped using important mitigations once the emergency temporary standard was no longer in effect.

Without the accountability of the ETS, some facilities are no longer isolating patients with suspected or confirmed COVID-19. They are allowing potentially infectious patients and family members to sit in waiting rooms with other patients and staff. They are placing infectious patients in hallways separated only by a curtain. Facilities

are dismantling COVID-19- only units and are mixing COVID-19-positive patients with the rest of the patient population. Some facilities are failing to test patients who enter facilities for outpatient procedures. Our panelists say that their facilities allow birth partners to be present for laboring patients, but fail to test them for COVID-19. Facilities are loosening restrictions on visitors, but they are not implementing controls to prevent COVID-19-positive or exposed visitors from entering elevators with others or going to the cafeteria. Even now, despite ample supplies of N95 respirators and restored supply chains, some hospitals are still requiring daylong use of one-time use devices.

**OSHA should expand the scope of the permanent standard to include workers in congregate settings.** Employees who work in corrections, group homes and similar residential facilities face risks of exposure, infection and death comparable to those experienced by nursing home workers. Many staff in these facilities perform similar close-contact work, such as feeding, toileting, bathing and dressing residents. Many facilities are older; lack rooms to allow residents to isolate; and are poorly ventilated. Centers for Disease Control and Prevention guidance does not include requirements to protect workers in these settings. We have attached testimony and documentation demonstrating the risk for these workers.

**CDC guidance is intended to reduce infection spread, not protect workers; therefore it is not the appropriate standard for OSHA.** OSHA must meet its statutory obligation to provide a standard that will reduce workers' exposure to SARS-CoV-2. The CDC's charge has never been to protect workers, but to reduce infection spread. The CDC's goal has now shifted from infection control to reducing the incidence of severe disease and hospitalization. Workers in healthcare and congregate settings have the right to be protected from exposure—after more than two years of the pandemic, they are experiencing multiple and compounding threats to their physical and mental health. This includes the significant risk of suffering from long COVID. We have attached statements from members with long COVID-19. OSHA should not incorporate CDC guidance into the permanent standard, nor should the agency offer safe harbor to employers claiming adherence to CDC guidelines.

AFT's panelists, witnesses from other unions, and aerosol scientists testified about the significant damage caused by facilities following CDC guidance, including use of contingency and crisis provision of respiratory protection, even when respirators were available. CDC's failure to fully address aerosol transmission of SARS-CoV-2 in its guidance has resulted in untold numbers of healthcare and other workers being denied effective protections—respiratory protection and enhanced ventilation. OSHA should instead pattern the standard on the California OSHA Aerosol Transmissible Disease standard, the OSHA Bloodborne Pathogens standard, and the unadopted OSHA standard for tuberculosis.

Many employer groups commented that meeting an OSHA standard and rapidly changing CDC guidance is too difficult. This is a disingenuous argument. Healthcare employers operate in a highly regulated environment. Nearly every job and task conducted in hospitals and other facilities is regulated by the Centers for Medicare & Medicaid Services and the accrediting organizations. Healthcare facilities must also meet other federal and state requirements to protect patients, protect the environment and be prepared for emergencies, in addition to meeting their obligation to protect their workforce from material harm as required by OSHA. Indeed, one benefit of a permanent OSHA standard will be the stability it will provide for worker protections.

**We urge OSHA to promulgate a permanent programmatic standard for COVID-19 that requires employers to develop a comprehensive prevention program based on periodic exposure risk assessment for all parts of the facility or operation.** This site-specific exposure assessment is crucial to protecting workers. Community transmission rates are a lagging indicator for infection within a healthcare facility. Workers most likely will be already exposed and left vulnerable if increased controls are only activated by an elevated community transmission rate. We recommend weekly assessments of exposure risk.[1] In addition, frontline workers must have genuine involvement in the development and evaluation of the prevention plan.

[1] Oster Y., et al. Proactive screening approach for SARS-CoV-2 among healthcare workers. Clin Microbiol Infect. 2021 Jan;27(1):155-156. doi: 10.1016/j.cmi.2020.08.009. Epub 2020 Aug. 18. PMID: 32822884; PMCID: PMC7434469.

**Employers can assess exposure risk by conducting systematic surveillance testing of staff and patients who are admitted to facilities or enter for outpatient procedures.** With 50 to 80 percent of COVID-19 infections being asymptomatic or pre-symptomatic, screening alone is a weak control that must be combined with a rigorous universal testing protocol for staff and patients.[2,3,4] We have heard far too many cases of healthcare workers being exposed and infected after treating patients who were admitted for other needs.

Surveillance testing is a feasible control that can be done in multiple ways, including weekly pooled testing for staff. OSHA can offer a programmatic approach for employers, but the standard must require exposure assessment. The infection rate must be recordable and reportable to OSHA, to workers, and to the authorized collective bargaining agent. The standard should require employers to include their testing protocols and any updates in their written plan.

**The standard should emphasize the need for a set of layered mitigations ranked by the hierarchy of controls.** Written plans must demonstrate overlapping controls, including isolation, ventilation, testing, and ready access to fit-tested respirators and eye protection in addition to vaccination and screening. OSHA should require evidence of efforts to apply multiple mitigations within written plans.

**Higher requirements for ventilation in all covered settings are critical elements that will help to demonstrate robust overlapping controls.** The standard must require hospitals to adhere to ASHRAE 170 and ASHRAE COVID-19 guidance. Ventilation maintenance plans/protocols should be included in the written plan. OSHA should incorporate ASHRAE COVID-19 guidance for outpatient clinics, congregate facilities and other settings covered by the standard.

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[2] Johansson M.A., et al. SARS-CoV-2 Transmission from People Without COVID-19 Symptoms. JAMA Netw Open. 2021 Jan. 4;4(1):e2035057. Erratum in: JAMA Netw Open. 2021 Feb 1;4(2):e211383. PMID: 33410879; PMCID: PMC7791354.

[3] Furukawa N.W., et al. Evidence Supporting Transmission of Severe Acute Respiratory Syndrome Coronavirus 2 While Presymptomatic or Asymptomatic. Emerg Infect Dis. 2020 July;26(7):e201595. doi: 10.3201/eid2607.201595. Epub 2020 June 21. PMID: 32364890; PMCID: PMC7323549.

[4] Stadler R.N., et al. Systematic screening on admission for SARS-CoV-2 to detect asymptomatic infections. Antimicrob Resist Infect Control. 2021 Feb. 27;10(1):44. doi: 10.1186/s13756-021-00912-z. PMID: 33640031; PMCID: PMC7912536.

Because enhanced ventilation is not possible in home health settings, these workers must be provided with fit-tested respirators. We have heard of many cases of home health nurses being denied facemasks as well as respirators. Surveillance testing should apply to workers and patients in home health settings as well.

**The standard should require employers to demonstrate preparedness planning and capacity for surge conditions.** Our panelists described facilities that were unprepared and reactive. This includes investing in and maintaining stockpiles of personal protective equipment. Hospitals can invest in elastomeric respirators or PAPRs and CAPRs as a feasible means of maintaining and storing a sufficient supply of respirators. Elastomeric respirators are inexpensive to buy and maintain. Adding training on use and disinfection of elastomerics to the existing respiratory protection program would be a feasible means of being prepared for surges. We have attached a webinar, for your consideration, about a hospital that implemented elastomeric use in 2020.

**The standard should require employers to demonstrate planning and capacity to create temporary isolation and negative pressure rooms.** Many hospitals attempted to enhance ventilation or create temporary airborne infection isolation rooms (AIIRs) without guidance. The National Institute for Occupational Safety and Health has created guidance and instructions on creating temporary AIIRS and ventilated headboards. We recommend that OSHA incorporate NIOSH's evidence-based guidance.

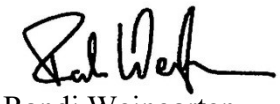
NIOSH's evaluation shows that expedient isolation rooms can be as effective as permanent AIIRS, which cost approximately $30,000 more than traditional patient rooms. Ventilated headboards have been shown to successfully remove 99 percent of infectious-sized aerosol in NIOSH's laboratory testing.[5] NIOSH provides detailed instructions and videos on its website. The devices are cost-effective and can be stored during normal times. They are a highly feasible and evidence-based engineering control that any hospital or critical access hospital should be able to

[5] Ventilated Headboards | NIOSH | CDC

construct with planning. The AFT developed webinars on these temporary isolation controls. These materials and other resources are attached for your consideration.

We thank you for this opportunity to advocate for our members and all healthcare and congregate setting workers. We look forward to a permanent programmatic standard for COVID-19 that requires employers to develop a comprehensive prevention program and to develop surge capacity. We know that healthcare workers and workers in congregate settings have been carrying a heavy load for far too long. OSHA must meet the challenge to provide a permanent standard.

Sincerely,



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