April 21, 2022

Douglas L. Parker
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Health and Safety Administration
200 Constitution Avenue, NW
Washington, D.C. 20210

Subject: Occupational Exposure to COVID-19 in Healthcare Settings

Federal Register Document Number: 2022-06080
OSHA Docket Number: OSHA-2020-0004
RIN: 1218-AD36

Dear Assistant Secretary Parker:

On behalf of the American Public Health Association, a diverse community of public health professionals that champions the health of all people and communities, I write to submit comments in support of the Occupational Safety and Health Administration's efforts to develop a permanent rule to protect workers in health care settings from aerosol transmissible infectious diseases. These comments were developed in collaboration with members of the association's Occupational Health and Safety Section. As the leading and largest public health organization in the United States, we are in a unique position to clarify the importance of a regulation to protect workers that augments and strengthens guidance provided by the Centers for Disease Control and Prevention. Local, state and federal public health agencies are essential for understanding the risk factors for transmission of infectious diseases and the community controls that are needed.

However, special considerations and measures must be in place and enforced by the designated agency assigned to ensure workplaces are safe and healthy environments. That agency is the U.S. Department of Labor's OSHA. A permanent standard is urgently needed as workers in health care remain at serious risk of infections. It is important and necessary to have a comprehensive and consistent approach in health care settings, nationally.

Both the proposed deference to CDC guidelines and references throughout the Federal Register Notice to "infection control" inappropriately cede OSHA's responsibility to protect workers. OSHA must emphasize "exposure control" and worker protections. To that end, the National Institute for Occupational Safety and Health must be included in providing assistance to OSHA and state plans - as the key CDC branch responsible for worker health and safety.

An example that demonstrates this gap in public health measures for the community versus workplace health and safety is the fact that 26 states have passed laws stripping state and local public health officials of the power to enforce public health mandates such as vaccination, quarantine, and masking.[1] This puts public health decision making into the hands of elected officials instead of qualified, independent, science trained public health officials. This makes the need for a uniform national standard from OSHA even more urgent. Guidance alone does not carry the weight and strength of a regulation. Additionally, local and

state health departments differ in their expertise regarding worker protections and have given varying advice to employers for workplace protection.

There is much research that worker safety improves patient safety.[2,3,4] In addition, our workforce capacity has been impacted by the morbidity and mortality among health care workers along with the low morale and burnout due to working conditions and decreased staffing.[5] It is imperative that these trends be reversed. The Nation's Health, a publication of APHA, reported in April 2021 on the "Lost on the Frontline" by Kaiser Health News and The Guardian.[6] The project has documented more than 3,500 deaths among health care workers from COVID-19 as of April 2021, with 67% from minority populations. Personal stories of these tragic losses have also been documented by the project.

OSHA should not consider a permanent standard that is weaker than the Emergency Temporary Standard; it must be stronger. The standard must fully recognize and address aerosol transmission and require measures to control transmission and exposure including ventilation, filtration, and appropriate respiratory protection. It is critical that the standard protect all workers at risk of exposure and infection; not just those at the highest risk.

In addition, this effort provides an important foundation for a future comprehensive standard that addresses the needed preparation for all future novel aerosol transmissible infectious pathogens. The development of the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard in 2009 is a prime example of a regulation that struck a balance between regulatory mandates and public health science.[7]

APHA has been committed to the protection of the health care workforce, patients and community health, and has a long history of adopting policy statements that focus on worker protections as well as preparedness for novel and emerging infectious diseases, including:

- APHA Policy Statement 20158: *Preventing Occupational Transmission of Globally Emerging Infectious Disease Threats*
- APHA Policy Statement 20187: *The Global Prevention and Elimination of Tuberculosis Among Health Workers*
- APHA Policy Statement 20063: *Preparing for Pandemic Influenza*
- APHA Policy Statement 20052: *Developing a Comprehensive Public Health Approach to Influenza*
- APHA Policy Statement 201015: *Securing the Long-Term Sustainability of State and Local Health Departments*
- APHA Policy Statement 8928: *Occupational Transmission of Human Immunodeficiency Virus*
- APHA Policy Statement 8927: *HIV Guidelines for the Workplace*

In our most recent policy statement adopted in 2021, APHA Policy Statement 20218: *Call for Urgent Actions to Address Health Inequities in the U.S. Coronavirus Disease 2019 Pandemic and Response*, the following recommendations are made:

OSHA should:

- Enact an emergency temporary standard to protect workers not included in the June 21, 2021, health care emergency temporary standard from exposure to SARS-CoV-2

- Place the establishment of a permanent infectious disease standard as a top priority in its regulatory agenda
- Require states that do not provide OSHA coverage to public employees and farmworkers to adopt the emergency temporary standard for these at-risk populations
- OSHA should engage in timely investigations and enforcement of worker whistleblower laws in response to COVID-19 safety and health complaints.
- A work-related presumption should be established for state and federal workers' compensation systems for workers who develop COVID-19 on the job.

In addition to the specific questions posed by OSHA for comment that we address later in this document, there are additional areas of concern that must also be addressed in the standard – respiratory protection and medical removal benefits.

Respiratory Protection

While the hierarchy of controls is critical in preventing workplace injury and illness, when infectious diseases are involved, respiratory protection is paramount. Respiratory protection is essential and has been inadequate for workers during the pandemic, including availability of and access to supplies; the appropriate selection of respirators; proper fit testing; and sufficient training on their use. CDC has continued to promote the use of surgical masks which are not considered to be protective in most health care settings. Lives have been altered and lost among workers, patients and ultimately the community due to the disregard for and absence of necessary respirators. More information is provided below in our response to question A-1.

OSHA has long experience with its Respiratory Protection Standard in many industries, including in health care. This should remain the main direction of respiratory protection for COVID-19 and other aerosol transmissible infections.

Medical Removal Protection (MRP)

A protective, preventive health measure in conjunction with health reporting and surveillance efforts is used to provide temporary removal of workers from either further exposure or risk of exposing others; current wages and benefits are protected for the duration of the leave. This is a more certain remedy than state workers' compensation programs which vary drastically across the country. Examples of MRP programs include:

- The OSHA Lead Standard of 1978 has had Medical Removal Protection under CFR 1910.1025(k).[8]
- The Cal/OSHA Aerosol Transmissible Disease Standard of 2009 has included current language for MRP Title 8 CCR § Aerosol Transmissible Diseases (h)(8).[9]
- Similar provisions currently under the Cal/OSHA Emergency Temporary Standard COVID-19 Title 8 CCR 3205.

APHA comments on A. Potential Changes From the ETS

A.1—Alignment with CDC Recommendations for Healthcare Infection Control Practices:

APHA has worked closely over the years with CDC and has supported its role as the primary national public health agency. As public health professionals, we rely on the knowledge and resources of CDC.

However, over 50 years ago, the recognition that protecting worker health and safety required an enforceable system of standards resulted in the Occupational Safety and Health Act. Of course, OSHA regulations are based on science and engineering, and the CDC, particularly NIOSH, provide important leadership in standards development. OSHA uses robust stakeholder involvement to develop regulations which then become legal mandates for minimum protections in the workplace. CDC guidance cannot create this kind of stable mandate, since, as we have seen during the COVID-19 pandemic, it has not provided a stable platform for regulatory enforcement.

In creating OSHA, Congress recognized that employers control working conditions, and therefore must have the primary responsibility to provide a safe and healthful workplace and institute protective measures for recognized hazards. In analyzing the difference between public health recommendations and workplace health and safety regulations we see several key issues:

1. In health care, exposures to infectious diseases and other hazards cannot be avoided through exclusion of infected patients, or instructions to stay home. The health care system relies upon health care workers' in-person contact with treating patients. Maintenance of a healthy workforce is not only important to each individual worker, but to society's ability to respond to an infectious disease emergency.
2. Additional control measures can be available in health care that are not available in the community. For example, aerosol transmissible infection isolation rooms can be used to limit the exposures to others in the environment, including workers.
3. As a matter of justice, workers who provide services to infectious patients should not be put at avoidable risk to perform this work.
4. The OSHA rulemaking process includes a robust opportunity for participation by workers and their representatives, including unions and community-based organizations, as well as the health care organizations and researchers who are also involved in the development of CDC recommendations.
5. OSHA mandates can be used by public and private entities for preparedness, for example to develop stockpiles of respirators and other personal protective equipment , and to identify, maintain, and create capacity for aerosol transmissible infection isolation and other engineering and work practice controls.

The experience with bloodborne pathogens, particularly Hepatitis B, proves a good illustration of the difference between a simple requirement to follow CDC recommendations and an OSHA regulation. Hepatitis B infection was recognized as a hazard to health care workers before 1980 who were identified as being at increased risk for infection. Following the licensing of the first HBV vaccine in 1981, the Advisory Committee on Immunization Practices recommended that health care workers be vaccinated. The recombinant vaccine was available in 1986. New HBV infections in health care workers fell from greater than 10,000 to fewer than 400 in 2002 after the OSHA mandates under the BBP Standard were put in place.[10] Similarly, studies have shown that the federal Needlestick Injury Prevention Act of 2000 and the subsequent amendments to the Bloodborne Pathogens standard increased the use of devices with sharps injury prevention features and reduced the incidence of needlesticks and other sharps injuries among hospital workers.[11,12] Mahoney et al (1997) and

Beltrami et al (2000) provide data demonstrating the dramatic decrease in the incidence of Hepatitis B among health care workers.[13,14]

The experience of the California OSHA State Plan, Cal/OSHA, also illustrates how independent OSHA mandates work to both improve worker health and safety and support strong public health guidance. In 2009 California adopted the Aerosol Transmissible Diseases Standard to protect health care workers, and other workers in higher risk environments. The ATD Standard came into effect during the 2009 H1N1 influenza pandemic and was used to enforce certain protective measures in health care. During the decade since adoption of the standard, inspections were conducted regarding exposures to TB, influenza, and measles, and the ATD Standard was also part of California's planning for Ebola.

In February 2020, Cal/OSHA issued guidance regarding how the ATD Standard applied to COVID-19 under what the standard calls a "novel or unknown pathogen", requiring the use of respiratory protection and, unless infeasible, the placement of COVID-19 cases and suspected cases in aerosol transmissible infection isolation rooms or areas with other engineering controls. Although there remained significant pressure to eliminate or reduce requirements for respirators (for example, only for high hazard procedures), particularly due to failures in private and public stockpiles, the standard's requirements were often cited by the California Department of Public Health in supporting respirator use with confirmed and suspected COVID-19 cases. California also sought to expand the supply of N95 respirators through state contracts with new respirator suppliers for NIOSH certified respirators, which began to ease the shortage during the summer of 2020.

During the past two years, the challenges in respirator supply was a major factor determining CDC guidance. Lack of a clear CDC mandate for respirator use for all patient contact with confirmed and suspected COVID-19 cases, led many health care organizations to limit the provision of respirators. While in a pandemic it is generally not possible to identify the source of any individual infections, there have been reports of health care workers contracting COVID-19 and developing serious illness, when denied respirators by their employer.

As OSHA requires in the Bloodborne Pathogens Standard,[15] APHA recommends relying on CDC and other public health guidance for medical follow-up for exposure incidents and for determining exclusion requirements to prevent further infection in the workplace.

A.2—Additional Flexibility for Employers:

As we stated in response to question A.1, OSHA standards need clear and enforceable requirements. Using CDC guidance to create a "safe harbor" may provide a rationale for reducing protections, regardless of whether those protections are feasible for the specific employer. It also undermines more protective public health recommendations from state or local public health departments.

A.3—Removal of Scope Exemptions:

APHA recommends removing scope restrictions based on screening practices or on employee vaccination status. Screening procedures, while one important aspect of controlling exposures to COVID-19 and other aerosol transmissible diseases are not sufficient to remove

requirements such as respiratory protection. COVID-19 is transmissible prior to an individual developing any identifiable symptoms. Currently available COVID-19 vaccines appear to have reduced the risk to an individual of developing serious illness or death. However, experience to date is that vaccination does not completely prevent contracting or transmitting the disease.

In regards to scope, APHA also recommends clarifying that in congregate living facilities, such as residential care facilities for the elderly, the entire facility comes under the standard, not just the persons providing health care and that the limitations in 1910.502(a)(3)(Ji) do not apply to these facilities

> "Where a healthcare setting is embedded within a non-healthcare setting (e.g., medical clinic in a manufacturing facility, walk-in clinic in a retail setting), this section applies only to the embedded healthcare setting and not to the remainder of the physical location."

A.5 – Vaccination

Vaccines must be a part of a multi-pronged approach and is not to be relied upon for full protection. All workers regardless of vaccine status must be protected in the same way. Protections should not be limited/lessened for health workers based on vaccination status. At this point there is no way to determine if or how long one's current vaccine status is protective, particularly as new variants arise.

We recommend that any vaccine programs must be:

- Provided at no cost to employees;
- Provided during work time; and with paid time off provided for side effects;
- Like the BBP standard, there must be an educational component for workers to be a fully informed decision regarding the vaccine, side effects, risk of COVID, etc.; and
- Include a declination process for those choosing not to receive the vaccine.

A.7 – Recordkeeping and Reporting: New Cap for COVID-19 Log Retention

Surveillance of COVID-19 is critical to be able to assess patterns by occupation and work location. Data on workplace COVID exposures and cases has been hindered by lack of a standard. In addition, it is important that CDC include industry and occupation in any national disease surveillance systems and in recommendations for Electronic Medical Records. NIOSH can provide expertise to improve these systems.

Surveillance information can be used to evaluate areas within the worksite and occupation groups where additional prevention efforts are needed, and to identify occupation groups that may be at higher risk of disease. A COVID-19 log can require the collection of information often lacking in other public health surveillance systems (i.e., occupation and industry), either because the system lacks the necessary data fields, or public health staff are overburdened and unable to collect information on case follow-up.

Recordkeeping for COVID-19 illnesses should remain in line with the 5 years already required in CFR Title 29, Part 1904.33, Recording and Reporting Occupational Injuries and illnesses.[16] Consistency in these requirements makes is useful for workers and employers

alike to follow through more easily without having different sets of rules for different conditions.

Employer reporting requirements in the permanent standard should be broadened to include outbreak reporting to OSHA with three or more COVID cases at a single facility within 14 days whether they are work-related, similar to other states like California and Virginia have required.

APHA comments on C. Information for Economic Analysis

C.1.1 – Covered Industries

The scope of this standard must include all settings where health care is provided, including but not limited to correctional facilities, homeless shelters, residential care facilities and care provided at home by health and personal care aides. In addition, occupational groups in health care settings should be based exposures including janitorial, housekeeping and maintenance staff, for instance.

Thank you for taking our comments into consideration as you work to develop this important public health standard to protect the nation's health care workforce.

Sincerely,

Georges C. Benjamin, MD
Executive Director

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