Electronically submitted via www.regulations.gov

Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

August 2, 2021

Mr. James Frederick
Acting Assistant Secretary of Labor for
Occupational Safety and Health
Occupational Safety and Health Administration
200 Constitution Avenue, NW
Washington DC 20210

Re: Occupational Exposure to COVID-19; Emergency Temporary Standard, OSHA-2020-0004,

Dear Acting Assistant Secretary Frederick:

On behalf of the Association of American Medical Colleges (AAMC or the Association), we thank you for the opportunity to provide comments on the Occupational Safety and Health Administration's (OSHA) interim final rule establishing an Emergency Temporary Standard (ETS) for occupational exposure to COVID-19. We share OSHA's commitment to protecting health care workers from exposure to COVID-19. However, we believe implementation of the rule should be delayed and the ETS regulations be modified in several areas that would still ensure employee safety.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC member teaching hospitals through their expert faculty physicians, health care teams, and cutting-edge medical technology, provide care for all, including complex patients who are often unable to receive care elsewhere. While the COVID-19 pandemic has posed enormous challenges and placed tremendous stress on our entire health care system for the past 15 months, teaching hospitals, medical schools, teaching physicians, and researchers have mobilized on all fronts to treat and mitigate COVID-19. For academic medical centers, ensuring the health and safety of their health care workers and the patients they serve has been of primary importance. They have made substantial investments to achieve this goal as well as comply with the Centers for Disease Control and Prevention (CDC) guidelines related to COVID-19. Our members have supplied personal protective equipment to employees, increased cleaning and disinfecting

standards, followed additional infection control standards, established protocols for screening employees and visitors, provided employee training, made structural changes to facilities, and much more.

As the COVID-19 pandemic evolves, there will be a need to continually update the ETS regulations. We believe that putting these requirements into regulation instead of guidance will make it more difficult for OSHA to have the flexibility to adapt quickly to changes and to incorporate recommendations for workplace standards identified by medical professionals and scientists as the appropriate standards.

Our members continue to respond on the front lines of the COVID-19 pandemic, including putting in place a variety of safeguards to ensure employee safety. We are concerned that it will take significant effort and divert resources for teaching hospitals to review this complex ETS and make any necessary changes to comply, particularly given the resources they already are devoting to treating patients and protecting both patients and employees from the impact of COVID-19 and evolving variants. Therefore, we request that OSHA delay implementation of the COVID-19 Health Care Emergency Temporary Standard for at least six months to understand the complexities associated with implementation of the new ETS standards.

OVERARCHING CONCERNS

We share OSHA's commitment to workforce protections for COVID-19. However, the COVID-19 Health Care ETS standard, which is detailed and complex, became effective on June 21, 2021, immediately upon publication in the Federal Register. This provided virtually no time for health care facilities to thoughtfully review this rule, understand the requirements, and to request and receive clarification on ways to ensure patient and employee safety as the public health emergency (PHE) changes. The ETS imposes requirements that are different from, or in direct contrast to, the CDC and state or local health department guidance. Compliance with this rule will require some academic medical centers, and their associated health care facilities, to make significant modifications to their hospital policies and procedures, and undertake structural changes to their facilities, such as installing physical barriers. These changes are difficult to implement in a short time frame, especially at a time when health care facilities are still addressing challenges resulting from the COVID-19 PHE.

The CDC's guidance and recommendations have been the standard for safety throughout the COVID-19 public health crisis, and CMS has held health care providers accountable to comply with those standards. It is important to have alignment between the CDC standards, CMS requirements, and OSHA standards to create more certainty on the best ways to protect employees, patients and visitors and to ensure that the requirements are in line with evolving science and literature.

In addition, some requirements in the ETS are confusing to health care workplaces, thus creating unnecessary burden. Throughout the PHE, the CDC has provided guidance on the precautions

that are essential to protect health care workers from exposure to COVID-19 and to decrease the transmission of the virus. This includes guidance on face coverings, physical distancing and barriers, hand hygiene, infection control, and other areas. Some of the provisions within the ETS seem to contradict the CDC guidance that health care facilities have been following. For example, the ETS provisions addressing physical distancing and barriers do not align with current CDC guidance for vaccinated and unvaccinated individuals.

With regard to enforcement of these new standards, the AAMC requests that OSHA inspectors consider providers' good faith efforts to meet these standards, particularly since providers had no advanced notice of the requirements or the implementation date. Inspectors should allow flexibility beyond the deadline to achieve compliance when providers show they are working towards full implementation. Further, we recommend that inspectors be given guidance to focus on education rather than imposing penalties when assessing compliance with the new requirements, especially if there is a good faith effort by the provider. We ask OSHA to provide resources to providers through email or phone support to respond to questions on implementation of these standards.

In addition to these overarching concerns regarding the rule, our feedback on specific provisions in the ETS follows.

Patient Screening and Management (§1910.502(d))

Under the rule, health care facilities will be required to screen and triage all visitors – clients, patients, residents, delivery people, other visitor and non-employees – entering a health care setting to identify individuals who have symptoms that could indicate COVID-19 infections to prevent the spread of infection. (p. 32622). Additionally, these facilities will be required to limit and monitor every point of entry into a building. The regulation states that these requirements are necessary because "symptoms-based screening is a standard component of infection control." (p. 32430). We agree that constant monitoring of infection control is important. Health care facilities are diligent in monitoring employees, patients and visitors for signs and symptoms of all types of infection, including limiting facility entry points. Health care facilities have standard screening protocols in place to educate staff and visitors during times when there is an increased risk for communicable diseases, such as influenza seasons. These protocols have been enhanced and have changed multiple times during the COVID PHE.

The requirement to screen and triage all visitors and clients is unreasonable given the ongoing efforts of facilities to ensure the safety of their patients and employees. Health care facilities follow current CDC guidelines[1] requiring facilities to screen visitors for COVID-19 infection and restrict visitation if visitors are currently infected, show symptoms, or have had recent exposure to someone with a COVID-19 infection. These facilities continue to educate visitors and patients

[1] Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination. Updated April 27, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html Retrieved July 8, 2021.

about infection prevention and control practices as outlined by the CDC. Masking and physical distancing are still required in most health care settings.

As infection rates drop, coupled with increased vaccination rates, the benefits of limited entry and screening disappear. Limited entry and screening of all individuals entering a facility creates bottlenecks at entry points. Further, excess screening of visitors could discourage visitation and negatively impact patients' health and recovery. We believe that requiring individualized screening of each person entering a health care setting would require health care facilities to divert scarce resources to comply with the requirement and may lead them to once again severely restrict visitation. For some smaller health care facilities, that could mean hiring additional staff to fulfill the requirements. Lastly, local health departments manage many of the rules associated with screening of individuals entering a health care facility and we believe they are better able to adapt recommendations based on local epidemiology.

Physical Distancing (§1910.502(h)) and Physical Barriers (§1910.502(i))

Health care facilities will be required to ensure that each employee (even fully vaccinated employees) is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity. While we agree that physical distancing and barriers may be necessary in certain situations, we feel that increased vaccination rates and lower prevalence of COVID-19 cases mean that these requirements should no longer be mandatory for every health care facility. Many hospitals are mandating vaccination and so these rules are not in agreement with current CDC and World Health Organization (WHO) standards.

The ETS standards will force health care facilities to revert to more restrictive standards that the CDC and some local health departments have said are no longer required. Health care facilities that follow CDC and state guidance could inadvertently fall out of compliance with the ETS. We ask that OSHA allow health care facilities to monitor infection rates and adjust the need for physical distancing or the construction of additional physical barriers as they see fit.

Additionally, we believe that the ETS requirements for physical distancing and barriers conflict with CDC and some states' guidance relaxing physical distancing and barrier requirements. As the regulation states, the CDC has updated its guidance to reflect that fully vaccinated health care personnel can dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. Further, CDC states that if unvaccinated health care personnel are present, everyone should wear masks and unvaccinated individuals should physically distance from others.[2]

Further, the requirement that hospitals install physical barriers at each fixed work location outside of direct patient care areas where an employee is not separated from all other people by at least six feet of distance is not necessary. Many hospitals already have physical barriers separating staff from visitors. The need for physical barriers between employees that are within

[2] Ibid.

six feet of each other is unnecessary if employees are fully vaccinated. Additionally, as noted in the rule, remote work options and expansion of telehealth capabilities have served to limit the number of people congregating in any one area of the health care setting.

Health Screening and Medical Management (§1910.502(l))

Under the health screening and medical management provisions, health care facilities will be required to screen all employees before each work day or each shift, which may include COVID-19 testing. (p. 32624). The ETS requirement that all employees must be screened conflicts with the CDC guidance. The CDC has recognized that screening of asymptomatic health care personnel can be scaled back. Vaccinated individuals can be excluded from expanded screening testing for asymptomatic health care personnel without a known exposure.[3] Many health care facilities currently have in place employee screening and reporting protocols. As more employees get vaccinated and infection prevalence declines in the community, daily screening requirements should be lessened. The ETS requirements should be modified to reflect when the workforce, except those individuals with religious or medical exemptions, is fully vaccinated.

The ETS states that "the employer must require each employee to promptly notify the employer" if the employee has a positive COVID-19 test, are suspected to have COVID-19 or are experiencing recent loss of smell and/or taste. (p. 32624). Health care facilities encourage their employees to monitor themselves for sign and symptoms of COVID-19 infection and remain home when they are feeling unwell. However, health care facilities should be held harmless if an employee does not report this information. While some health care facilities ask employees to attest to being symptom free and not knowingly been exposed to infected individuals, they should not be required to compel employees to disclose this information.

Employers will also be required to inform other employees, visitors, patients and other non-employees who are not wearing a respirator that they may have been in close contact with an employee who has been diagnosed with COVID. Health care facilities currently have contact tracing protocols in place and are sensitive to ensuring that employees' and visitors' personal information is not compromised when performing contact tracing. We believe that current contact tracing protocols utilized by health care facilities and guided by CDC and state criteria are sufficient to inform individuals of a potential exposure while maintaining the confidentiality of the infected employee.

Paid Leave: Medical Removal Protections (§1910.502(l)(5)(iii)(B))

Under the rule, when an employee is removed from the workplace due to confirmed or suspected COVID-19 infection, the employer must continue to pay the employee's normal earnings, as though the employee were still at their regular job, up to $1400 a week for the first two weeks. Pay during removal can be offset with any employer or public benefits, such as paid leave or workers compensation until the employee meets return to work criteria. Further clarification is needed regarding the meaning of "normal earnings" and the definition of "paid sick leave."

[3] Ibid.

Mini Respiratory Protection Program (§1910.504)

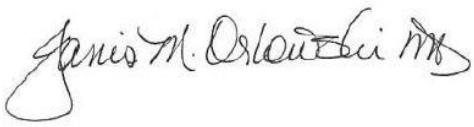
OSHA establishes the mini respiratory protection program to strengthen employee protections with a small set of provisions for the safe use of respirators designed to be easier and faster to implement than the more comprehensive respiratory protection program. The program is primarily intended to be used for addressing circumstances where employees are not exposed to suspected or confirmed sources of COVID-19 but where respirator use could offer enhanced protection to employees. The requirements for use of employer provided respirators are more expansive under the mini respirator program than the requirements for employee provided respirators. Under the ETS, where employees provide and use their own respirators, the employer must provide each employee with a notice detailing proper protocols and warnings. Where employers provide respirators to their own employees, the employer must ensure that the employees receive specified training, ensure employees perform user seal checks, and follow requirements related to reuse of respirators, or discontinuing use of respirators.

It will be difficult for employers to determine the quality of respirators that employees bring to work, and to ensure that they are appropriately maintained, fitted, and safely worn. We are concerned that these standards, which contradict OSHA's existing personal protective equipment and respiratory protection standards, may expose employers to liability and put employees at additional risk.

CONCLUSION

Thank you for consideration of these comments. Health care worker safety is a priority; however, the ETS regulations are not in concert with current CDC and WHO recommendations. Hospitals and health systems must have the ability to remain flexible as they continue to learn about the disease and its variants, increase and/or mandate vaccination of health care workers, and monitor the local disease prevalence. If you have questions regarding our comments, please feel free to contact Gayle Lee at galee@aamc.org and Mary Mullaney at mmullaney@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer, AAMC

cc: Mary Mullaney
Gayle Lee