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President and CEO

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James Frederick  
Acting Assistant Secretary of Labor  
Occupational Safety and Health Administration  
200 Constitution Ave NW  
Washington, DC 20210

**Re: Comments on OSHA-2020-0004, Occupational Exposure to COVID-19;  
Emergency Temporary Standard 86 Fed. Reg. 32,376 (June 21, 2021)**

Dear Acting Assistant Secretary Frederick:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. These tax-paying hospitals account for nearly 20% of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients.

The FAH appreciates the opportunity to submit comments on the *Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS)*, published by the Occupational Safety and Health Administration (OSHA) in the *Federal Register* on June 21, 2021.

The FAH also appreciates that one of OSHA's aims in promulgating the ETS is to protect health care workers from COVID-19, and shares in that goal. However, FAH members have

practical concerns regarding certain facets of the ETS, detailed below. Many of these concerns stem from the fact that this ETS was issued approximately 18 months after the onset of the COVID-19 public health emergency (PHE) in the United States. Throughout that period, FAH members have literally been on the front lines of the PHE, have invested heavily in caring for patients and their families *and* in keeping their employees safe. Now mandating near-immediate compliance with the long and complex ETS – which in many cases conflicts with the U.S. Centers for Disease Control and Prevention (CDC) guidance – is duplicative, confusing, and unrealistic. It also undermines the flexibility that FAH members need to pivot with the constantly changing course and science of the PHE. Moreover, the ETS may conflict with state laws in areas where care for COVID-19 patients has evolved and hospitals have already meaningfully turned a corner in treating patients, including through significant vaccinations rates. In these areas, states have modified their requirements to align with that new reality.

With this context in mind, we address three primary areas of concern with the ETS below: (1) timeline for compliance; (2) conflicts with hospitals' existing safety protocols; and (3) lack of clarity and flexibility around certain ETS requirements.

### **Timeline for Compliance with the ETS**

The ETS requires compliance with most provisions by July 6, 2021 – 14 days after its publication in the *Federal Register*. Covered entities had 30 days (until July 21, 2021) to comply with a few other provisions involving physical barriers, HVAC systems, and employee training. *See* 29 C.F.R. 1910.502(s).

Considering the breadth and complexity of the ETS, these compliance dates are unrealistic. Compliance with the ETS requires FAH members to, among other tasks: (a) review and understand the 916-page ETS; (b) identify how the ETS requirements compare to protocols that members have already implemented to protect employees, patients, and visitors from COVID-19; and (c) change or add procedures, policies, and physical elements based on that analysis. This assessment will differ not only by worksite but also by space *within* worksites, given the ETS's varying coverage provisions.

Moreover, as a practical matter, any modifications will require careful planning by numerous stakeholders, potential acquisition of materials and tools, and re-training. Further, consistent with the admonitions in the ETS, such review, analysis and implementation should involve employees who are called upon to meet emergency needs that constantly arise in the health care environment, creating numerous logistical issues as FAH member hospitals remain dedicated to focusing on quality care for patients.

In light of these complexities and the ongoing nature of COVID-19, the FAH urges OSHA to extend the ETS compliance dates for at least an additional six months. This delay will enable FAH members to thoughtfully review and address the ETS requirements, with involvement from

the employees for whom the ETS is aimed to protect but without sacrificing care for patients who may be critically ill and require immediate medical treatment.

### **Conflicts with Hospitals' Already Robust COVID-19 Safety Protocols**

Certain aspects of the ETS introduce conflicts with COVID-19 employee safety strategies that, at this point, over 18 months into the PHE, hospitals have developed and honed with the advice and expertise of virologists, epidemiologists, physicians, employees, health care providers, and other stakeholders.

For example, hospitals have already invested significantly in personal protective equipment (PPE), restructuring for physical distancing and barriers where feasible, maintaining rigorous cleaning and disinfection protocols, and conducting patient and employee screening (discussed further below). In other words, FAH member hospitals have implemented complex and comprehensive strategies and safety programs that already achieve the goals of the ETS.

These strategies and safety programs have been tailored to the unique aspects of the applicable work environment, based on applicable medical and scientific expertise, as well as based on input from employees. At this later stage of the pandemic, requiring hospitals to conform to the ETS's specific, rigid requirements over their more individualized, already-tested approaches creates confusion and redundancy and diverts necessary time and resources away from patient care at a time when the country is now experiencing renewed and increasing infection rates due to the Delta variant.

### **COVID-19 Plan**

The ETS's mandatory COVID-19 plan requirements are illustrative of this redundancy problem and create significant burden for hospitals. FAH member hospitals developed and implemented COVID-19 workplace plans soon after the start of the pandemic. As discussed above, these plans were developed with significant input by multiple hospital experts, including epidemiologists, virologists, clinicians, and non-managerial employees, and the plans have worked well. Yet, at this point, it would be nearly impossible for hospitals to ensure that all ETS requirements were met when the plans were developed long ago.

Further, the ETS's COVID-19 plan requirements seem to be applicable to a single hospital and are less scalable across a hospital system. The ETS requires plans to include site-specific information and that employers consider each employee's potential exposure to COVID-19 in developing a COVID-19 plan, to exchange COVID-19 plans with employers sharing a physical location, and to adjust their own plans to address hazards presented by such other employers' employees. See 29 C.F.R. § 1910.502(c)(7)(i), (ii). This level of coordination is extremely burdensome and could place a hospital at risk of non-compliance based on the failure of another employer to coordinate and cooperate. For example, it is common for some clinicians to be credentialed to treat patients in multiple hospitals – each owned by a different employer – and it

would be near impossible to track that clinician's movements in separate hospitals, especially if clinician is not primarily based out of a particular employer's hospital. In addition, for a hospital system, it is more efficient to have a standardized plan and site-specific information would be cumbersome and unnecessary.

Finally, it is critical to note that in implementing COVID-19 plans, hospitals need flexibility and discretion to implement medical protocols based on CDC guidance and advice from appropriate experts and stakeholders, such as epidemiologists and virologists, as well as non-managerial employees and their representatives, but in the latter case, when appropriate based on their areas of expertise.

### Mini Respiratory Protection Program

The Mini Respiratory Protection Program is another example of the ETS adding burden without benefit. In fact, this Program actually counteracts hospitals' efforts to keep employees safe through use of appropriate PPE. For example, this Program permits employees to use their own respirators in place of a facemask in certain instances where a respirator is not otherwise required, so long as the employer provides a basic disclaimer. *See* 29 C.F.R. § 1910.504(c). However, hospitals need to be able to limit which types of respirators are used in order to ensure standardized quality. If an employee selects their own respirator but it is not of appropriate quality, is not fit tested, or is otherwise being used improperly, the employee may be at greater risk of exposure to COVID-19 or other contractible diseases than they would have been wearing a proper facemask. That result is contrary to the purposes of the ETS and creates liability for hospitals. Accordingly, the FAH recommends that the ETS be clarified to expressly permit employers to implement requirements on the types of respirators that employees may use in place of facemasks where a respirator is not otherwise required.

### Inconsistency with CDC Guidelines

Throughout the COVID-19 pandemic, FAH members have adhered to the ever-evolving CDC guidance applicable to their workplaces. OSHA expressly sanctioned this approach. However, the ETS appears to incorporate by reference certain CDC guidance as of a fixed date. *See, e.g.*, 29 C.F.R. § 1910.502(d)(3), (e), (f)(5). Because CDC guidance evolves as needed to address changes in the known science, PHE effects, and the virus itself (*e.g.*, now recommending mask wearing even for the fully vaccinated due to the Delta variant's highly contagious and transmissible nature over earlier forms of the virus), the ETS will ultimately require compliance with outdated (and, possibly, inappropriate) CDC guidance. We recommend clarifying that the ETS incorporates by reference the specific areas of CDC guidance, as that guidance may be amended from time to time.

In addition, in several places, the ETS conflicts with current CDC guidance, which leads to confusion, inconsistency, and inefficiency. For example, the ETS defines a COVID-19 exposure (which triggers removal from the workplace) differently from the CDC's definition of

COVID-19 exposure.<sup>1</sup> As another example, the ETS appears to require cleaning and disinfectant “after the [aerosol-generating procedure] is completed” – even if the patient is still there – while the CDC more realistically calls for “routine cleaning and disinfection procedures” where aerosol-generating procedures are performed.<sup>2</sup>

As yet another example, the ETS requires PCR testing for employees (*see* 29 C.F.R. § 1910.502(l)(4)(ii)(B)), which often are processed through an outside laboratory as many hospitals do not have a laboratory with PCR processing capacity on site. However, our hospitals report being able to use alternative COVID-19 tests that are more sensitive, valid, and cost-effective, and are less time-consuming because they can be processed through the hospital’s laboratory. The CDC has expressly encouraged prompt, 24-hour turnaround time testing and allows for viral antigen testing<sup>3</sup> and should suffice for any hospital employee testing.

To build upon the efficiencies and validity of the processes that hospitals have already established, in conjunction with CDC guidance, we urge that the ETS be clarified to adhere to relevant CDC guidance where applicable.

### **Lack of Clarity and Flexibility**

#### **Fully Vaccinated and Previously Diagnosed/Recovered Employees**

The ETS does not appropriately account for the fact that fully vaccinated employees, as well as those who have been diagnosed with and recovered from COVID-19 in the prior 90 days, are at significantly lower risk of contracting COVID-19 or of experiencing severe symptoms of COVID-19, if contracted. Considering that OSHA’s authority to implement the ETS stems from its conclusion that health care workers are exposed to “grave danger” in the form of COVID-19, the ETS should allow for greater flexibility for these groups of employees for whom that rationale is not supported.

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<sup>1</sup> Compare OSHA’s 29 C.F.R. § 1910.502(l)(3) and its subparagraphs (defining exposure to occur where, among other things, an employee was not wearing a respirator) with the CDC’s Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 (defining exposure to occur where, among other things, an employee was not wearing a facemask or a respirator), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

<sup>2</sup> Compare 29 C.F.R. § 1910.502(g)(3) with Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>.

<sup>3</sup> See Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>. Of note, recently, on June 2, 2021, the CDC updated its “Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)” to recommend a lab-based Nucleic Acid Amplification Test in the return-to-work context, available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>. Thus, already, the version of CDC guidance incorporated by reference in the ETS as of a specific, fixed date has become outdated.

### Patient and Employee Screening

Patient and employee screening is another critical safety protocol that FAH members have already implemented at the beginning of the PHE in early 2020. Hospitals have designed screening protocols that are commensurate with the layout and nature of their work environments, level of community spread of COVID-19, and community and individual workplace vaccination rates. For example, some hospitals may post an employee at an entrance to conduct screening; others may use signage documenting screening questions for COVID-19 symptoms and indicating that further entry affirms that the visitor/employee passed the screening; and others may ask employees to complete self-attestations at home or they may educate employees that clocking in or entering the hospital premises constitutes a self-attestation that the employee satisfactorily answers the screening questions.

The ETS definition of “screen” leaves it unclear whether a self-attestation to screening questions suffices. *See* 29 C.F.R. § 1910.502(b) (defining screen as “asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19”). However, the ETS preamble refers to “verbal questions and answers” in the context of the cost analysis applicable to *patient* screening – while it appears to contemplate “self-screening” for employees, and for patients/family members in the home health care space.

The FAH urges OSHA to clarify that the definition of “screen” expressly encompasses varying levels of self-attestation to screening questions in both the employee and patient contexts. This approach has several benefits. It clarifies internal inconsistencies within the ETS between employee and patient screening; achieves needed efficiencies; and allows the flexibility needed to address the evolving (and in some places waning) state of the COVID-19 PHE.

### COVID-19 Exposure Notification Periods

The FAH agrees that prompt notification of exposure to COVID-19 is important to mitigating the spread of COVID-19, and again, our members have long developed protocols for efficiently executing this process. However, the ETS gives employers only 24 hours to notify certain employees exposed to persons with COVID-19 in the workplace (except for exposure to COVID-19 patients where treatment services are normally provided to such patients). To comply with this requirement, the ETS requires employers to investigate and determine multiple, often difficult-to-discern facts within three different categories, including the status of *other* employers’ employees.<sup>4</sup>

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<sup>4</sup> First, employers must determine (a) which employees were in “close contact” with the COVID-19 positive person; (b) whether those employees were wearing respirators and any other required personal protective equipment; and (c) the dates of the contact. Second, employers must determine: (a) all other employees present in a well-defined portion of the workplace (e.g., a particular floor) in which the COVID-19 positive person was also present during the potential transmission period; (b) whether those employees were wearing respirators or any other required PPE; and (c) the dates on which the employee was present. Third, employers must determine if employees of *other* employers were (a) in close contact with the COVID-19 positive person; (b) worked in a well-defined portion of a workplace in which

It is not feasible for hospitals to make all of these factual determinations and execute the required notification within 24 hours of learning of a positive COVID-19 individual, especially in the case of large exposure. Moreover, this bright-line requirement does not account for inevitable variations in the size of well-defined work areas and of potentially exposed groups. Given the problems posed by this unrealistic and inflexible timeline, the FAH urges that the phrase “within 24 hours” in 29 C.F.R. § 1910.502(l)(3)(i) be replaced with “as soon as feasible,” or, alternatively, require that the factual investigation and notification process begin within 24 hours.

### **Conclusion**

The FAH appreciates OSHA’s mission of keeping employees safe from COVID-19. Respectfully, our members have done so throughout the PHE with the same expertise and dedication that they have brought to patient care. Thus, hospitals already have effective processes in place to protect employees while treating patients; yet the ETS now places undue burden on hospitals and undermines the flexibility they need to address the changing demands of COVID-19 on an ongoing basis.

Thank you for your consideration of these comments. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,



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that person was present during the transmission period; and (c) whether they were wearing respirators or other required PPE. *See* 29 C.F.R. § 1910.502(l)(3)(i).