Delaware Healthcare Association

Wayne A. Smith
President & CEO

August 20, 2021

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

Re: Docket No. OSHA–2020–0004, Occupational Exposure to COVID–19; Emergency Temporary Standard; Occupational Safety and Health Administration Interim Final Rule and Request for Comments (Vol. 86, No. 116), June 21, 2021.

Dear Mr. Frederick:

On behalf of the members of the Delaware Healthcare Association, I am writing to express concerns with the emergency temporary standard (ETS) that was published on June 21, 2021.

Since the beginning of the COVID-19 pandemic, Delaware hospitals have made significant investments to understand the virus and to implement the best possible prevention and treatment strategies. Our hospitals have worked tirelessly to keep hospital staff safe during this pandemic. We are pleased with the efforts of Delaware hospital leadership to encourage employees to get the COVID-19 vaccine and are proud of the fact that the majority of Delaware hospital staff has been vaccinated -- the best way to prevent illness and the transmission of SARS-CoV-2 to others.

We share your commitment to health care worker safety. However, we are troubled by the emergency temporary standard (ETS) that was published on June 21, 2021. We appreciate this opportunity to discuss how our efforts and steadfast work have protected health care workers from COVID-19 exposure and infection. We are also working to protect staff from stress, burnout and other disorders, as well as to protect our patients and our community.

We do have significant concerns with the ETS, as follows:

- <u>Concern with "grave danger" designation</u> - The ETS begins with a discussion asserting grave danger for health care workers from COVID-19. In the spring of 2020, when some communities had widespread outbreaks of COVID-19 and a growing number of hospitals were overflowing with suspected or confirmed COVID-19 patients, when PPE was in short supply, and when we were still in our infancy of learning how this disease is spread and effectively treated, the situation was serious. Yet, on May 29, 2020, OSHA stated that there was a lack of evidence suggesting that

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infectious diseases, including COVID-19, to which employees may be exposed, constitute a "grave danger" requiring an ETS as an appropriate remedy. On that day, the Centers for Disease Control and Prevention's (CDC) data reflect that there were 44,581 hospitalizations and 1,190 deaths in the U.S. On June 21, 2021, when the ETS was published in the Federal Register, the New York Times reported that there were 16,945 people hospitalized with COVID-19 in the U.S. and just 311 deaths – still a tragic loss, but only a quarter of the number of deaths on May 29 of the previous year. The number of health care worker deaths have also drastically declined. According to federal data, 1,600 health care workers across America have died during this pandemic, but there have only been 11 health care worker deaths since Feb. 13, 2021. If OSHA saw no grave danger warranting an ETS last May or in any of the intervening months during which COVID-19 surged across the U.S., how can it perceive a grave danger now, with many health care workers fully vaccinated, and those vaccines and other protective measures working?

- The ETS is only partly aligned with CDC guidance – The CDC has provided critical scientific information and recommendations based on data gathered throughout the pandemic; its guidance has evolved and will continue to evolve. This is especially true as we learn more about special circumstances required for those who are immunocompromised and the durability of the protective measures that have been put in place, particularly vaccines and how such measures perform against the emergence of new variants. It has been challenging for hospitals and other health care organizations to follow this evolving evidence, yet we view such action as essential and regularly amend our practices to ensure the safety of both staff and patients throughout the pandemic. This OSHA ETS will complicate those efforts because it is at odds with CDC guidance in critical areas such as masking and social distancing. We are also concerned that the OSHA ETS locks in place compliance with some CDC guidance that may soon be out of date, placing the ETS even further out of alignment with the latest science.

- ETS should not impose requirement that staff be allowed to wear own respirator - The ETS would require hospitals to allow staff to wear a respirator when one is not necessary for the job being performed. The requirement is that either the hospital can choose to provide this higher level of protection or the employee can bring in his or her own respirator. There is an underlying assumption in this element of the ETS that assumes an employee's safety lies in having a higher level form of PPE, which is not the case. Safety is the result of coupling the right forms of PPE with programs that assure the right fit and equip staff with the knowledge to appropriately don, doff and care for the equipment. During this pandemic, we have seen many examples of items being sold as if they met the requirements to be N95s when they do not, and people wearing face coverings that are improperly fitted, improperly donned or doffed in a manner that could transmit disease.

- The ETS contradicts the widely accepted definition used by CDC and infectious disease experts of what constitutes an exposure. Rather, the ETS uses an overly broad definition that fails to account for the fact that health care personnel caring for COVID-19-positive patients in hospitals are wearing highly effective forms of PPE, or that they may be vaccinated. Further, it does not take into account the length of

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time during which the infected person and the staff member were together, which is a critical to determining if someone has really been exposed. Failing to take these factors into consideration could lead to many employees being removed from their work station when there is minimal risk of exposure, and in the process exacerbating existing staffing shortages.

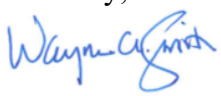
- Requiring respirator use while caring for suspected COVID-19 patients is unnecessary. As Delaware's Healthcare Associated Infection Advisory Committee stated in their July 2021 letter, "Our members' experience suggests this is unnecessary – one example including providing COVID-19 testing (HCP obtaining a nasopharyngeal swab) from nearly 100,000 people (with more than 13,000 testing positive) using contact/droplet precautions only, without a single HCP [health care providers] illness linked to this practice." In addition to being unnecessary, this requirement would be time consuming and costly as each would need to have initial and ongoing fit-testing.

- The ETS would require entrance screenings for employees, visitors and patients. Under the ETS, entrance screenings -- including monitoring temperatures and other related symptoms potentially indicative of COVID-19 – would be required. We oppose this requirement and recommend that each hospital determine whether or not to perform entrance screenings based on their own unique needs and COVID-19 prevalence in the community.

- Physical barrier requirement is unnecessary. According to the ETS, employers must install cleanable or disposable solid barriers outside or patient care areas. Physical barriers are not necessary in environments where both the employee and patients are wearing face masks, thus making this requirement unnecessary and burdensome.

We urge you to withdraw this ETS. If, however, OSHA declines to do so, we recommend that it be allowed to expire at the end of the six months and not be published as a final rule. Protecting our workforce and our community requires that we are able to follow the evolving science and maintain the necessary flexibility, particularly in areas with high vaccination rates and low community transmission of COVID-19.

Sincerely,



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