August 12, 2021

James Frederick
Principal Deputy Assistant Secretary
for Occupational Safety and Health
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

Submitted electronically at regulations.gov

Re: Occupational Exposure to COVID-19, Emergency Temporary Standard; Docket No. OSHA-2020-0004; RIN 1218-AD36

Dear Deputy Assistant Secretary Frederick:

The American Nurses Association (ANA) is pleased to provide comments on the Occupational Safety and Health Administration's (OSHA's) interim final rule, Occupational Exposure to COVID-19, Emergency Temporary Standard (ETS). ANA supports OSHA's use of all its authorities to protect the health and safety of nurses and other healthcare personnel, especially during the COVID-19 pandemic. We strongly support OSHA in holding healthcare employers accountable for meeting the ETS requirements and otherwise fulfilling their duty to prevent illness and injury to their staff.

While supporting the ETS overall, ANA urges additional steps to ensure the safety of the healthcare workforce in this pandemic and similar public health emergencies in the future. As discussed more fully in the comments below, ANA:

1. **Urges Prompt Revisions to the ETS to Ensure Safety for All Healthcare Personnel Providing Care During the Coronavirus Pandemic;**
2. **Supports and Urges OSHA to Provide Robust Guidance on the ETS to Support Meaningful Compliance, Strong Oversight, and Timely Enforcement; and**
3. **Supports Development of a Permanent OSHA Standard to Protect Healthcare Personnel from Airborne and Other Infectious Diseases.**

Overall, ANA Supports the ETS. We applaud OSHA for recognizing that COVID-19 continues to place healthcare personnel in grave danger. As of July 23, 2021, more than a half million healthcare personnel have contracted COVID-19, and 1,657 have died as a result.[1] Issuance and enforcement of an ETS pursuant to OSHA's authority is appropriate under current circumstances. "Grave danger," a statutory criterion, continues as the coronavirus mutates and spreads more easily. Between July 4 and July 17, 2021, 83.2 percent of COVID-19 cases were reported as the Delta (B.1.617.2) variant, a substantial increase from 39.1 percent two weeks prior.[2] Further, vaccination rates in the United States have slowed. With only about half of Americans fully vaccinated against COVID-19, new variants will emerge,

[1] Centers for Disease Control and Prevention (CDC). CDC COVID Data Tracker. U.S. Department of Health and Human Services. Retrieved July 22, 2021, from https://covid.cdc.gov/covid-data-tracker/#health-care-personnel
[2] CDC COVID Data Tracker. Retrieved July 22, 2021.

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and those variants have the potential to be more contagious and deadly than the original virus,[3] leading to the expectation of increasing hospitalizations and medical interventions.

Given the highly infectious nature of the virus, it is critical for healthcare personnel to be protected from infection at their workplaces. With the ETS, OSHA has appropriately adopted a multi-layer approach to protect healthcare workers from COVID-19, including a planning component involving staff, physical distancing, specified respiratory protections, medical management, and vaccine promotion.

However, we believe substantive improvements to the ETS are needed to protect healthcare personnel and urge OSHA to revise the ETS as soon as possible. ANA further urges OSHA to vigorously enforce the ETS, while moving forward to adopt a permanent standard for infection protection.

1. **ANA Urges Prompt Revisions to the ETS to Ensure Safety for All Healthcare Personnel Providing Care During the Coronavirus Pandemic.**

(a) OSHA should revise the ETS definition of "fully vaccinated" to account for authorized boosters and additional doses that may be recommended in the future. Section 1910.502(b).

The current definition of fully vaccinated in 29 CFR 1910.502(b) reflects the state of the science as of June 2021 when the Interim Final was first publicly released. The definition is key to the effectiveness of the ETS, as the ETS' scope and applicability limit employer responsibility, e.g., in areas where people are fully vaccinated. (See Section 1910.502(a)(2)(iv)).

As of the date of this comment letter, the definition of fully vaccinated in Section 1910.502(b) is current. Fully vaccinated means two weeks have elapsed since a person's second dose in a two-dose series or since a single dose in a one-dose vaccine.[4] However, the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) have acknowledged that vaccine boosters or additional doses could be recommended "when the science demonstrates that they are needed."[5] ANA appreciates the important level of detail and science basis embodied in the ETS at the time of its issuance. To clarify for employers their obligations as the science changes, we recommend revising the definition of fully vaccinated to anticipate and account for changes in federal guidelines.

(b) The ETS should require employers to institute mandatory COVID-19 vaccination programs, subject to reasonable exceptions consistent with CDC recommendations.

Subject to recommendations discussed below in section 1(h) of this letter, ANA supports the provisions in the ETS requiring most employers to facilitate vaccinations for healthcare personnel. However, these requirements do not go far enough. In July 2021, as COVID-19 cases and infection rates were increasing

[3]CDC. COVID-19 Vaccinations in the United States. Retrieved July 26, 2021, from https://covid.cdc.gov/covid-data-tracker/#vaccinations

[4] CDC. When You've Been Fully Vaccinated. Updated July 27, 2021. Accessed online August 4, 2021, at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html

[5] CDC and the Food and Drug Administration (FDA). Joint Statement on Vaccine Boosters. July 8, 2021. Accessible online at https://www.hhs.gov/about/news/2021/07/08/joint-cdc-and-fda-statement-vaccine-boosters.html. See also, CDC Advisory Committee on Immunization Practices. July 22, 2021, Meeting.

in most areas of the country, ANA joined dozens of healthcare leaders calling for all healthcare personnel to be vaccinated, as a core strategy to stop the spread of COVID-19 in the community and in health care delivery settings.[6] ANA's updated Position Statement approved on June 29, 2021, aligns with this stance, stating that all healthcare professionals should be vaccinated according to current recommendations, and that nurses have an ethical obligation to model the health care standards they prescribe to their patients.[7]

To underscore the critical importance of COVID-19 immunization to the protection of all healthcare personnel, ANA urges OSHA to amend the ETS to require healthcare employers to mandate COVID-19 vaccination, subject to reasonable exceptions as outlined by CDC, and to support access to vaccines recommended by CDC.

(c) *The ETS should clarify in definitions and throughout that the phrase "confirmed and suspected COVID-19" is intended in the broadest sense to mean confirmation and suspicion according to current science-based recommendations for testing and screening. See sections 1910.502(b), 1910.502(l).*

In numerous places in the ETS, OSHA refers to protections for healthcare personnel who care for, or have contact with, cases of "confirmed and suspected COVID-19." The ETS also, in several places, includes health-related terms describing certain COVID-19 symptoms, e.g., fever, or loss of taste or smell. (See Section 1910.502(l)(2)). This health-related language is critical to determining application of safety requirements such as medical screening. Again, ANA appreciates and fully supports OSHA's attention to a detailed scientific basis for ETS requirements. However, we are concerned that important health-related factors may become outdated or less significant, as COVID-19 mutates. New onset symptoms may emerge with new variants, as some reports have indicated. In addition, as testing becomes widespread, employers and healthcare personnel may have access to different tests and methods of identifying COVID-19 infection. For clarification, ANA recommends OSHA clarify in the ETS that procedures related to COVID-19 screening and detection should be based on the most current science-based recommendations.

(d) *OSHA should require all COVID-19 plans to be written and available to employees within a reasonable timeframe upon request. 1910.502(c)(2).*

The ETS currently exempts providers of a certain size from the written plan requirement. OSHA notes in the preamble to the ETS that an effective plan is a core component of safety, reflecting a "systematic approach to reduce injuries and illnesses in the workplace."[8] A written plan provides a shared point of reference for employees and supervisors, particularly new hires. A written plan can also document the date on which the plan was finalized, and memorialize the engagement of staff, as required by the ETS (Section 1910.502(c)(5)). In this way, a written plan more easily facilitates communication, assessment,

[6] American Nurses Association (ANA). ANA Supports Mandated COVID-19 Vaccinations for Nurses and All Health Care Personnel. Press Release. July 2021. Accessible online at https://www.nursingworld.org/news/news-releases/2021/ana-supports-mandated-covid-19-vaccinations-for-nurses-and-all-health-care-professionals/
[7] ANA. Immunizations. Position Statement. July 22, 2020, updated June 29, 2021. Accessible online at https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/immunizations/
[8] 86 F.R. 32376, 32428. June 21, 2021.

and revision, compared to plans that are orally made and maintained. ANA believes that all healthcare employers, regardless of size, should be expected to provide this core safety tool to employees, in writing and available upon request. We urge OSHA to amend the ETS accordingly.

(e) The standard should clarify employers' responsibility to maintain a current COVID-19 plan. 1910.502(c)(6).

As discussed above, the future course of the pandemic and potential emergence of multiple variants may lead to revised recommendations for vaccination and other COVID-19 prevention measures. However, the ETS does not explicitly set expectations for employers to keep their COVID-19 plans current. To ensure that safety precautions are up-to-date and fully responsive to changes in the pandemic and COVID-19 variants, section 1910.502 (c)(6) should be amended. ANA recommends OSHA add this requirement: "The employer must monitor each workplace and review the plan at 90-day intervals or more frequently as needs arise, to ensure the ongoing effectiveness of the COVID-19 plan and update it as needed."

(f) Respiratory protections in the ETS should be strengthened to ensure that employers take consistent, meaningful steps to provide adequate and appropriate face coverings to all employees. Section 1910.502(f).

ANA generally supports the ETS' level of specificity and scientific basis for PPE requirements, including respiratory protection. We applaud OSHA for emphasizing recent CDC and FDA assessments that an adequate supply of N95 respirators has been restored, as of June 2021 when the ETS was released.[9] We also concur with OSHA's suggestion that durable respirators such as elastomeric facepieces should be sought if single-use N95s are not available. However, we continue to be concerned about healthcare employers limiting access to respiratory protection, including respirators. To strengthen the ETS and OSHA's basis for enforcing optimal respiratory protection, we urge the following changes to the ETS:

- OSHA should add a note to section 1910.502(f)(1) clarifying required mitigation steps in the event of demonstrable shortages of surgical masks for required use when N95 respirators are not required.
- With regard to the supply of N95 respirators (note to section 1910.502 (f)(2)), the ETS should define "limited supply." Employers should also be required to specify in their COVID-19 plans how PPE supply will be assessed, based on surge forecast as well as availability and past use. In this connection, we note that CDC PPE burn rate calculators are dependent upon past use, and do not prepare for anticipated surges as new waves of COVID-19 arise. Therefore "just in time" inventory management should not be considered sufficient. We also note that healthcare employers may be subject to state requirements regarding PPE inventory. OSHA should offer guidance clarifying application of the ETS in relation to state and local regulation. If state provisions are more stringent, the ETS should be considered a minimum standard.
- Section 1910.502(f)(3) should be revised to require use of respirators and PPE during *all* aerosol-generating procedures, not just with patients who have confirmed or suspected COVID-19. Aerosol-generating procedures carry heightened risks of infection. Given emergence of COVID-

[9] See, e.g., 86 F.R. 32376, 32438.

19 variants that may not be detectable or suspected under current testing and screening protocols, all personnel performing such procedures should be afforded maximum respiratory protection.

- OSHA should state explicitly in the ETS that the annual fit test for respirators (29 CFR 1910.134(f)(2)) is in force and no longer subject to enforcement discretion. Though fit and seal procedures are addressed in the ETS, OSHA has not clearly specified the effect of the ETS on earlier emergency guidance relaxing enforcement of the annual fit test.

(g) ETS provisions on employee health screenings, exposure notification, and medical management should be clarified and strengthened to protect all employees in the event of exposure, including possible exposures to new and emerging COVID-19 variants. Section 1910.502(l).

ANA strongly believes all healthcare personnel should be notified of possible exposures to COVID-19, so that they can take immediate steps to avoid transmitting the virus to co-workers and their families. Specifically, ANA urges OSHA to eliminate section 1910.502(l)(3)(iii) of the ETS, which exempts employers from notifying employees who work in areas where "services are normally provided to suspected or confirmed COVID-19 patients." Staff in these areas may be aware of their risks inherently. However, the exception assumes without basis that appropriate respiratory protection is used at all times in all potentially COVID-19-affected areas. To the extent this is not the case, employees should have the benefit of notification of actual COVID-19 cases in their work areas.

(h) OSHA should require all healthcare employers to extend all benefits specified in 1910.502(l)(ii) to employees who have been removed from the workplace due to medical removal provisions in the ETS. 1910.502(l)(5)(i) and (iii).

ANA supports OSHA's determination that salaries and benefits should be protected during those unfortunate times when healthcare personnel are removed from work following exposure to COVID-19 on the job. Without these protections, employees face economic insecurity at no fault of their own, and therefore may be less likely to self-monitor or undertake appropriate mitigation. Requiring employers to continue salary and benefits to encourage self-monitoring and reporting is sound policy. However, ANA believes the current ETS makes unnecessary distinctions in how it applies these protections, based on employer size. Potential economic hardship due to COVID-19 isolation is a reality for all healthcare personnel, regardless of attributes of their employers. We urge OSHA to remove the disparate requirements of section 1910.502(l) that are based on employer size.

(i) OSHA should refine the ETS Mini Respiratory Protection Program to ensure appropriate respiratory protection. Section 1910.504.

ANA appreciates OSHA's attempt through the Mini Respiratory Protection Program (MRPP) to standardize appropriate respirator use, including those occasions when such use is not required by section 1910.502. The MRPP recognizes that healthcare personnel may make their own decision to use a respirator, even if not required, out of reasonable concern during a pandemic of the highly contagious and variable COVID-19 virus. The MRPP further reflects the principle that maintaining consistency in safe use and handling of all respirators is essential to infection control, promoting a culture of safety in

general. However, ANA recommends the following additional steps to ensure maximum protection under the MRPP:

- The ETS should explicitly discourage use of respirators provided by employees covered by the MRPP. Employers should be expected to maintain adequate supply of respirators to meet the needs of all employees, including those opting for respirator use under the MRPP. We recommend that OSHA add a note to this effect to section 1910.504(c).
- The ETS should clarify employer roles and responsibilities regarding re-use of N95 respirators under the MRPP. Instead of the note to section 1910.504(d)(3)(i), which discourages reuse of single-use respirators, the regulatory text of section 1910.504(d)(3) should explicitly prohibit re-use of single-use respirators unless the employer demonstrates a need to resort to CDC's optimization standards.
- For those times when reuse of single-use respirators is proven to be necessary, the MRPP should specify a process by which employers must implement the 5-day storage requirement. Section 1910.504(d)(3)(i), for instance, should require respirators to be stored in a safe, central location at the worksite, under facility supervision. Single-use respirators subject to the storage requirement should not be placed in employee or lockers or removed from the premises.

2. ANA Supports and Urges OSHA to Provide Robust Guidance on the ETS to Support Meaningful Compliance, Strong Oversight, and Timely Enforcement

The pandemic is far from over. The COVID-19 public health emergency (PHE) has been extended without pause every 90 days since the initial declaration in early 2020. The PHE will likely be extended well into 2022. As new variants emerge and communities experience additional waves and surges, it is critical for OSHA to vigorously use its enforcement authority under the ETS to protect healthcare personnel and save lives. ANA appreciates the guidance and other tools OSHA has made available to the public to implement the ETS. We urge continued release of guidance to support meaningful compliance, strong oversight, and timely enforcement. Items of particular concern are noted as follows:

- Employers should be expected to document how they designate "well-defined settings," and state how such designations are reviewed for continued appropriateness. Section 1920.502(a)(2) creates certain exceptions from ETS requirements in "well-defined settings" where risks of COVID-19 exposure are presumably low. However, the course of the pandemic may be such that areas of a given facility cannot be effectively separated as "well-defined." In such a case, ETS provisions should apply, including requirements for face coverings and PPE.
- OSHA guidance should educate employers about key components of effective COVID-19 plans, and communicate the following expectations:
    - Plans must be reviewed and revised as needed to account for changes in COVID-19 or its variants, i.e., nature of onset symptoms, reliability of available tests, severity of disease, and degree of contagiousness.
    - Plans should address how employers will meet requirements for airborne infection isolation rooms (AIIRs), based on reasonable forecasts of need.
    - Employers should document planning activities and record the involvement of non-managerial employees and representatives in planning processes.

  - Plans should document reasonable approaches to determining if PPE supply is limited, for the purposes of employing optimization strategies as permitted by the ETS.
- Implementation guidance and enforcement of 1910.502(f)(ii), regarding sufficient supply of face masks to employees, should consider ease of employee access to supplies as well as other indicators of compliance.
- Implementation guidance and enforcement of 1910.502(j), regarding cleaning and disinfection, should consider ease of employee access to cleaning and disinfection supplies as well as other indicators of compliance.
- Training must be sufficiently frequent to ensure that all employees are up to date on emerging COVID-19 risks and protections, as outlined in 1910.502(m).

3. Supports Development of a Permanent OSHA Standard to Protect Healthcare Personnel from Airborne and Other Infectious Diseases.

In issuing the ETS, OSHA invited comments on whether the ETS should be adopted as a permanent standard. The COVID-19 public health emergency has demonstrated, as did the H1N1 and other pandemics, a need for safety standards that provide for the highest level of respiratory protection from infectious disease, however transmitted. Despite the 2009 release of *Guidance on Preparing Workplaces for an Influenza Pandemic*,[10] many healthcare employers clearly failed to prioritize safety of healthcare personnel on a voluntary basis. Consequently, the failure to promulgate enforceable standards has contributed to the deadly impact of COVID-19 thus far on nurses and other health care workers.

ANA continues to believe that healthcare personnel, in particular, need a comprehensive federal safety standard that protects them from contracting infectious diseases on the job. The ETS is a good first step toward such a standard. In broad outline, the ETS is foundational in that it incorporates a multi-layer approach to infection control in healthcare settings, including respiratory protections and other mitigating measures that can be taken, such as medical screening and management, cleaning and disinfection, and access to vaccines. We are encouraged by the requirement for staff engagement in planning, which we believe is indispensable to effective prevention. Revisions based on our recommendations outlined above would strengthen this foundation.

There is precedent for prioritizing a permanent standard when new or increased infection risks are identified. In 1991, OSHA created the Bloodborne Pathogens Standard (29 CFR 1910.1030). This standard responded to the emerging risks seen as resulting from occupational exposures to blood and other potentially infectious materials including hepatitis B, hepatitis C, and the human immunodeficiency virus (HIV). As more data became available, this standard was later revised to include requirements to prevent needlestick and sharps injuries to protect healthcare workers.

More work must be done expeditiously to promulgate a permanent standard for infection control. This work must be a priority to save lives and safeguard the capacity of healthcare systems to provide care

[10] Occupational Health and Safety Administration. (2009). *Guidance on preparing workplaces for influenza pandemic.* U.S. Department of Labor. https://www.osha.gov/sites/default/files/publications/OSHA3327pandemic.pdf

without resort to contingency or crisis care standards. In addition to anticipating future pandemics, a permanent standard has the potential to improve workplace safety for healthcare personnel on an ongoing basis. Improved infection control in health care could contribute to reductions in severe seasonal flu cases and resulting lost days of work. Protecting healthcare workers, patients and family members with chronic health conditions could also play a part in promoting health equity in all our communities. Standards targeting safe practices in health care settings would promote safety and certainty for patients and family.

We urge OSHA to prioritize creation of a permanent standard, and at a minimum to take a final action that would allow a version of this ETS to apply without delay, as practicable, in future pandemics.

If you have any questions, please do not hesitate to contact Ingrida Lusis, Vice-President, Policy and Government Affairs, at Ingrid.Lusis@ana.org or (301) 628-5081.

Sincerely,

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