Insert Date

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:

I write to you on behalf of the staff and leadership of __INSERT HOSPITAL/HEALTH SYSTEM NAME____. Since the beginning of the COVID-19 pandemic, we have invested enormous energy and expertise in our work to understand this novel virus, how it is transmitted, and how it can be prevented and treated. This expertise and experience has enabled us to procure appropriate personal protective equipment (PPE) and other protections for our staff.

More recently, we have been actively engaged in efforts to vaccinate our community, starting with our staff and continuing with other front-line workers and the local community population. We are proud that we have ___ INSERT A FACT ABOUT YOUR HOSPITALS' WORK TO PROTECT STAFF AND COMMUNITY, SUCH AS THE PERCENT OF YOUR STAFF WHO ARE VACCINATED OR THE NUMBER OF PEOPLE IN YOUR COMMUNITY VACCINATED BY YOUR HOSPITAL. ___. We know that each of these authorized vaccines are safe, remarkably effective in preventing illness and substantially effective in preventing 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.

Much has been written in the press about the heroic efforts of doctors, nurses, pharmacists and others who provide direct care to patients during the pandemic; they deserve all of the praise and gratitude that has been bestowed to them. However, front-line caregivers are not alone in their efforts. Administrators, infection control officers, hospital engineers, supply managers and others work alongside those front-line caregivers to: provide support; secure needed PPE; build and execute on programs to ensure proper use and care of PPE; reengineer ventilation and make other adjustments

to the physical plant; and to stay abreast of the latest scientific information and guidance.

All across the country, hospitals have done an outstanding job of protecting our staff and the patients in our care even as we learned about this novel virus. The effectiveness of those efforts is emerging in several scholarly articles. In fact, researchers, during a recent study of nearly 25,000 health care workers, concluded that the community prevalence of COVID-19 and known exposure to someone with COVID-19 outside work were more common predictors of health care workers contracting COVID-19 than anything about their work environment.

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, your agency stated that there was a lack of evidence suggesting that 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.

As of Aug. 3, nearly 58% of Americans over the age of 12 have been fully vaccinated, and more are getting vaccinated every day; meanwhile, the vast majority of those who are sick enough to require hospitalization are unvaccinated. Vaccines are readily available to all who want to be vaccinated, including all health care personnel; as such, it is difficult to understand why, at this point, OSHA is asserting there a grave danger, a danger that OSHA contends did not exist last year when there were more deaths and hospitalizations from COVID-19, as well as no vaccines to protect against SARS-CoV-2.

The federal government's own data – the very data OSHA cites in its ETS in noting that 1,600 health care workers across America have died during this pandemic – documents that, since Feb. 13, 2021, 11 deaths of health care workers were recorded. There were 24 weeks between February and the last week of July with fewer than five reported deaths of health care workers; in the period between July 7 and July 31, there were *zero* recorded deaths of health care workers. 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?

Our key concerns follow:

First, we are concerned that the ETS is only partly aligned with CDC guidance. 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.*

Further, as evidence evolves and the coronavirus mutates, we expect there may be more changes to CDC guidance. The OSHA ETS as written 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.

Further, 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, but this is not true.

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.

Second, 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; it also fails to account for the vaccine status of the health care personnel. Further, it does not take into account the length of 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, in the process exacerbating existing staffing shortages.

Third, the ETS would require entrance screenings for employees, visitors and patients. These entrance screenings include monitoring temperatures and other related symptoms potentially indicative of COVID-19. As envisioned by the ETS, this would

require hospitals to place staff at all available entrances and conduct such screenings. These screenings have been recommended previously, and are extremely time consuming; they are also ineffective in identifying individuals who should be denied entrance to the hospital. In our hospital, we have found that an effective alternate strategy is __INSERT BRIEF DESCRIPTION OF THE PROCESS YOU ARE USING__.

At __INSERT NAME OF HOSPITAL ___, we continue to focus on the health and safety of our workforce and our patients. We believe strongly in the effectiveness of the vaccines and the effectiveness of the programs we have put in place to protect our patients and our staff. OSHA should not impede these effective programs by instituting other, unproven strategies.

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,

INSERT SIGNER AND NAME OF HOSPITAL