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April 22, 2022

Assistant Secretary Douglas Parker
Occupational Safety and Health Administration (OSHA)
Department of Labor
Docket No. OSHA-2020-0004
200 Constitution Ave NW
Washington, DC 20210

RE: OSHA-2020-0004 – Occupational Exposure to COVID-19; Emergency Temporary Standard, published in Vol. 87 No. 56 on March 23, 2022

Submitted electronically via http://www.regulations.gov

Dear Assistant Secretary Parker,

UnityPoint Health appreciates this opportunity to provide comments on the Occupational Safety and Health Administration (OSHA) Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS). UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 8.4 million patient visits.

As a member of the American Hospital Association (AHA), UnityPoint Health supports the AHA comment letter submitted in response to the ETS. In addition, UnityPoint Health respectfully offers the following input.

GENERAL

OSHA is requesting additional information regarding the need for, and impact of the potential provisions and approaches specified in the ETS as well as additional studies, information and data related to the delta and omicron variants since the close of OSHA's initial comment period in August 2021.

Comment: As outlined in our prior ETS comment letter, **UnityPoint Health is concerned about the precedent set by adopting regulations specific to COVID-19 and urges OSHA not to publish this ETS as a final rule.** While the COVID-19 pandemic is a global emergency, it is not the first and will certainly not be the last public health emergency our nation faces. OSHA's response to the H1N1 Influenza pandemic was

consultive by providing proactive tools that were able to be modified quickly, rather than developing fixed regulations.[1]

Furthermore, this does not align with OSHA's response to many other prevalent communicable diseases such as influenza, tuberculosis, and measles. OSHA specifically states the following; "This guidance is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the Occupational Safety and Health Act. Pursuant to the OSHA Act, employers must comply with safety and health standards and regulations issued and enforced either by OSHA or by an OSHA-approved State Plan." [2] In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards that are causing or are likely to cause death or serious physical harm.

- *Influenza*: Influenza is by far the most widely spread communicable disease in our communities, yet OSHA does not provide a specific regulation for Influenza in the workplace. OSHA has instead taken the stance of providing guidance, recommendations to proactively prevent disease. This guidance includes references to the CDC guidance and allows for change. OSHA also makes a stance to defer to The Joint Commission's (TJC) requirement to institute an influenza program[3] and is similar to the CMS regulation requiring a COVID-19 vaccination program. [4]

- *Tuberculosis*: Tuberculosis is highly contagious and can be hazardous to employees. OSHA regulations only dictate what cases to record. The other guidance refers to global standards such as Respiratory Protection Program. [5]

- *Measles*: OSHA only refers to larger global standards such as Respiratory Protections, recordkeeping, eye/face protection, sanitation, etc. [6]

By adopting infection specific regulations for this particular virus, these actions set a precedent for future regulations that potentially burden both the agency as well as health care facilities – ultimately limiting the ability for health care workers to deliver high value and impactful care by instituting operational barriers. As the world continues to learn more about the COVID-19 and its variants, it is even more evident that, having a standard designed for one specific infectious disease and at one point of time, does not allow for the ebb and flow of a disease nor permit health care facilities to be as nimble as they should be.

A. POTENTIAL CHANGES FROM THE ETS

1. ALIGNMENT WITH CDC RECOMMENDATIONS FOR HEALTHCARE

[1] (https://www.osha.gov/news/newsreleases/national/11092009)
[2] (https://www.osha.gov/seasonal-flu/healthcare-employers)
[3] (https://www.osha.gov/sites/default/files/publications/seasonal-flu-factsheet.pdf)
[4] (https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23831.pdf)
[5] (https://www.osha.gov/tuberculosis)
[6] (https://www.osha.gov/measles)

OSHA is considering whether it is appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period.

Comment: The OSHA ETS locks in place standards at a point in time for a pandemic that is dynamic and for which science continues to evolve. Not only is the OSHA ETS out of date, its misaligned with current scientific evidence and contradicts with CDC guidance, including critical areas such as masking and social distancing. As a result, health care facilities across the nation continue to adapt to the fruit basket upset as transmission levels continue to change over time and federal guidance continues to be released and revised. **UnityPoint Health recommends OSHA not implement a specific COVID-19 regulation, but rather focus efforts on updating overall guidance while providing resources to assist health care facilities.**

2. ADDITIONAL FLEXIBILITY FOR EMPLOYERS

OSHA is considering restating various provisions as broader requirements without the level of detail included in the Healthcare ETS and providing a ''safe harbor'' enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue. OSHA seeks comment on this approach.

Comment: UnityPoint Health is supportive of this approach as a guideline, not a standard.

3. REMOVAL OF SCOPE EXEMPTIONS

OSHA is considering whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk.

Comment: **UnityPoint Health believes OSHA should present general guidelines to employers with strategies to keep employees safe from COVID-19.** These guidelines should be broad enough to cover employees in any setting.

4. TAILORING CONTROLS TO ADDRESS INTERACTIONS WITH PEOPLE WITH SUSPECTED OR CONFIRMED COVID-19

OSHA is considering the need for COVID–19-specific infection control measures in areas where healthcare employees are not reasonably expected to encounter people with suspected or confirmed COVID–19.

Comment: UnityPoint Health would agree that OSHA efforts should be placed on the areas of highest risk of exposure to COVID-19.

5. VACCINATION: BOOSTER DOSES, EMPLOYEE VACCINATION & EMPLOYEE REQUIREMENTS

OSHA is considering how the Advisory Committee on Immunization Practices (ACIP) and CDC recommendations might impact the requirements in the ETS that take account of individuals' vaccination status (e.g., fully vaccinated, up to date) and seeks comment on this issue. In addition, the agency seeks comments on a number of employer requirements.

Comment: OSHA implementing a final rule on COVID-19 for health care is unnecessary. CMS has implemented a regulation requiring all health care facilities implement a COVID-19 vaccination program.[7] This regulation requires health care facilities to require all team members (employed and not) to be fully vaccinated for COVID-19 or have an approved exemption. This regulation further requires health care facilities to have contingency plans for unvaccinated workers which may include, but are not limited to, reassignment, masking, physical distancing or testing. Any additional regulation would be duplicative and have a significant risk for contradicting each other. **UnityPoint Health has implemented strategies to protect workers and additional regulations are superfluous.**

6. LIMITED COVERAGE OF CONSTRUCTION ACTIVITIES IN HEALTHCARE SETTINGS

OSHA is considering the same coverage for workers engaged in construction work inside a hospital (e.g., installing new ventilation or new equipment or adding a new wall) as for workers engaged in maintenance work or custodial tasks in the same facility.

Comment: Due to the recommendation of the CDC, health care facilities are one of the only remaining locations to require masking and have longer exposure restrictions and testing requirements. This higher burden to health care, provides an exponentially more conservative work environment than general industry. The impact of this industry variation has been experienced within CMS's COVID-19 vaccine regulation. Due to the CMS regulation, UnityPoint Health is already ensuring all construction personnel are fully vaccinated or have an approved exemption to the COVID-19 vaccination. While collecting this information, UnityPoint Health has experienced many barriers, including vendors unwilling to share their employee vaccination records citing personnel information is confidential. UnityPoint Health believes that it may become more difficult to find partners for construction projects if there are significant increases in requirements via an OSHA standard. If OSHA deems a final COVID-19 ETS is appropriate, **UnityPoint Health recommends OSHA issue a broad enough standard that it can be implemented as a general industry standard as opposed to a health care specific regulation.**

7. RECORDKEEPING AND REPORTING: NEW CAP FOR COVID-19 LOG RETENTION PERIOD

OSHA is focused on whether any adjustments to the log and reporting provisions should be made in light of experiences involving the Delta or Omicron variants. In addition, the agency proposes to cap the record retention period for the COVID–19 log at one year from the date of the last entry in the log, rather than the current approach in which that retention period is tied to the duration of the standard.

Comment: UnityPoint Health appreciates the reduction of administrative burden. The additional contract tracing burden required by the ETS has fallen to clinical leads within hospital units (e.g., nurse managers), taking time away from patient care. Since the beginning of February 2022, only 1% of COVID-19 contractions in UnityPoint Health's workforce have been related to work. Our data shows, the community has the same, if not, greater risk to COVID-19. A 1% work related

[7] (https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23831.pdf)

transmission level demonstrates adequate procedures and policies are in place within the health care system. With a shrinking and exhausted labor force, less administrative burden is greatly preferred.

8. TRIGGERING REQUIREMENTS BASED ON THE LEVEL OF COMMUNITY TRANSMISSION

OSHA is considering linking regulatory requirements to measures of local risk, such as CDC's community transmission used in CDC's guidance for healthcare settings or the CDC's COVID–19 Community Levels used in CDC's guidance for prevention measures in community settings.

Comment: **UnityPoint Health agrees, local risk and community transmission levels should be used in assessing mitigation efforts.** However, it should be noted, this guidance exists today from the CDC and therefore additional guidance would be duplicative. Furthermore, the CDC recently began providing COVID-19 Community Levels for communities to use in determining the impact of COVID-19 and to act upon. Additionally, the CDC continues to provide Community Transmission levels for health care facility use. The two transmission levels provided by the CDC use different metrics and already provide a layer of complexity and confusion in assessing mitigation efforts. Adding another level of permanent regulation will only add to the growing complication and confusion that currently exists today.

9. EVOLUTION OF SARS-CoV-2 INTO A SECOND NOVEL STRAIN

OSHA is considering specifying that this final standard would apply not only to COVID–19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects.

Comment: UnityPoint Health does not recommend an ETS with disease specific requirements. Related strains of the virus will develop over time. Information gathered from the Omicron and Delta variant has proven each mutating strain will present different levels of infection rates, severity, and risk. It is unreasonable to set an all-encompassing standard.

ADDITIONAL CONSIDERATIONS

MEDICAL REMOVAL

Per OSHA when an employer removes an employee due to COVID-19 exposure, the employer must continue to provide the benefits to which the employee is normally entitled and must also pay them the same regular pay they would have received had they not been absent from work until the employee meets the return-to-work criteria.

Comment: UnityPoint Health believes medical removal benefit requirements are out of scope for OSHA standards and should be removed from the final ETS. The medical removal protection benefits are the most overreaching portion of the ETS. In no other circumstances do OSHA policies dictate paid personnel benefits. Historically this has been handled by the state's workers compensation benefits and the employer's personal leave benefits. As written, the medical removal benefit standard is extremely difficult to interpret and overly burdensome to administer. This will undoubtably lead to a significant overpayment of benefits to ensure standard compliance. As interpreted, this requirement dictates benefit payment to personnel who are off

work for nonwork related conditions, an area out of scope for OSHA standards.

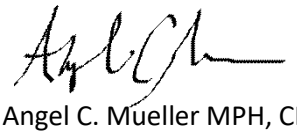
PHYSICAL BARRIERS

OSHA states each fixed work location outside of direct patient care areas (e.g., entryway, check-in desk, nurse station, triage) where an employee is not separated from all other people by at least 6 feet must have installed a cleanable or disposable solid barrier to block face-to-face pathways between individuals where persons would normally sit or stand.

Comment: UnityPoint Health recommends the physical barrier requirements be removed from the final ETS. Science continues to evolve on the impact of physical barriers on preventing the transmission of COVID-19 within a space. The CDC notes that when not carefully installed or without appropriate testing, physical barriers may hinder good ventilation and airflow distribution within a space, creating higher concentrations of infectious aerosols and increased exposure risk.[8] By including this very specific requirement in the final ETS, health care facilities ability to adapt to updated scientific evidence and CDC guidance will be severely hampered.

We are pleased to provide input on this ETS and its impact on our health system, our patients and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government & External Affairs at cathy.simmons@unitypoint.org or 319-361-2336.

Sincerely,



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[8] (https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html)