MISSOURI HOSPITAL ASSOCIATION

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July 8, 2021

Edmund C. Baird
Associate Solicitor of Labor for Occupational Safety and Health
Office of the Solicitor
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Comments on OSHA-2020-0004, Occupational Exposure to COVID-19; Emergency Temporary Standard

Dear Mr. Baird:

On behalf of its 141 member hospitals, the Missouri Hospital Association expresses concern with the Occupational Safety and Health Administration's interim final rule establishing emergency temporary standards related to the occupational exposure to COVID-19. MHA has provided support to Missouri hospitals throughout the pandemic response on how best to protect the health care workforce, patients, visitors and our communities. This includes the new and existing standards related to infection prevention and controls issued by OSHA, the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. Missouri hospitals have worked tirelessly for more than a year to treat infected individuals and prevent the infection of health care workers, while complying with evolving guidance.

OSHA issued the ETS based on a determination that COVID-19 poses a "grave danger" to workers in all health care settings where people with COVID-19 can reasonably be expected to be present; and that its current guidance fell short of establishing needed protections. Existing hospital infection prevention programs, aimed at keeping patients and workers safe, already have adopted most of the principles outlined in the ETS based upon the guidance offered by the CDC and CMS. In areas where infection rates are low, hospitals have begun to phase out certain guidelines deemed no longer necessary based upon CDC guidance, infection and vaccination rates. The timing of the ETS appears misplaced and misaligned with evolving standards issued by agencies that guided health systems through the peak of the pandemic.

It is uncertain how hospitals will be able to resolve the discrepancies between CDC/CMS guidance and the ETS. This particularly is true in the areas of barrier requirements, masking, cleaning procedures following aerosolizing treatments or procedures, and the creation of a mini respirator program in which employees who have never worn a respirator throughout the pandemic now are required to do so. In addition, they have never received fit testing or education. Substantial resources will be needed to implement this requirement alone. One of our health systems, having more than 40 locations, has not identified a work-related case of COVID-19 since October 2020. Its current protocol is to use droplet masks in moderate exposure

areas (COVID-19, Persons Under Investigation in non-ICU and no aerosol generating procedures) and N95 respirators in high exposure areas (COVID-19, PUI in ICU and AGP). Prior to October 2020 when work-related cases were identified, the N95 respirators and droplet masks were evenly distributed. Lack of eye protection was identified as the primary source of transmission and adjustments were made resulting in no further identifiable work-related cases. Despite their proven success, this health care system now is scrambling to comply with standards that are leaving infection preventionist and safety staff in our hospitals scratching their heads.

Our hospital members have expressed concern with workforce shortages given the reluctance of young health care workers to be vaccinated despite validation of vaccine safety. Health care workers are voicing strong dissatisfaction with being forced to comply with vaccine mandates. However, a vaccination mandate seems to be the only way to avoid many of the strict requirements included in the ETS. Hospitals support vaccination and have led the effort to ensure vaccination opportunities are available across the state. In time, the reluctance likely will diminish, and we will see vaccination rates similar to or greater than that of other illnesses such as seasonal influenza. However, it is unlikely hospitals will ever reach 100% compliance and the burden of complying with the ETS will indefinitely loom.

As states are implementing new CDC guidance on masking and attempting to return to a new normal, hospitals have voiced concerns with onerous and unproductive workplace safety requirements as their patients and the public are growing intolerant of visitor limitations, screening, masking requirements and other restrictions. Before COVID-19, hospitals were and continue to be, high among the settings most susceptible to incidents of workplace violence. The lack of alignment between different federal agencies regarding workplace violence standards has already placed hospital workers at higher risk of being subject to acts of violence. Consistent guidance between federal agencies is essential regarding infection prevention and control standards. Hospitals are reporting increased incidences of unrest and violence related to enforcement of COVID-19 infection control and safety practices given the growing intolerance of what is perceived as overly restrictive practices. For example, staff who are vaccinated voice dissatisfaction with continuing to wear masks let alone being required to wear a respirator when in an areas where there are no aerosolizing treatments. The public are refusing to answer screening questions and wear masks leaving volunteers and paid workers to try to enforce such standards. Inconsistent standards for hospitals on COVID-19 worker protections could contribute to increased incidents of unrest and violence as seemingly contradictory standards are enforced. Additionally, the ETS limits its requirements to settings where employees provide health care and health care support services to protect employees at the highest risk of exposure. Hospital workers in general, given existing regulatory requirements for mitigating risk of exposures, do not appear to be the sector at highest risk of transmission, yet may be the group at highest risk of workplace violence when implementing policies and procedures that appear to be overly restrictive.

Hospitals now are faced with diverting resources to quickly implement new policies and in some cases resurrect outdated policies, like barrier installation. Hospitals have been working under infection prevention and control standards established by OSHA, CDC and CMS that incorporate

best-practice guidance. The "grave danger" period came, was addressed and has largely gone. We have much work to do to continue to encourage vaccination and refine those best practices as they relate to the threat of COVID-19 and other life-threatening diseases. MHA encourages OSHA to suspend the implementation of the ETS and extend the comment period allowing those actively caring for patients the time to consider the impact of the changes and offer additional recommendations. OSHA should solicit the input of those who had front-line experience throughout the worst of the pandemic and thoughtfully consider changes to existing standards that incorporate evidence, allow for flexibility as the disease and science evolves and create alignment with other regulatory and guiding agencies.

Please contact me with any questions at 573-893-3700, 1332, or hkuhn@mhanet.com.

Sincerely,

Herb B. Kuhn
President and CEO

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