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On behalf of

The Society for Healthcare Epidemiology of America

Occupational Safety and Health Administration – Informal Rulemaking Hearing for Occupational Exposure to COVID–19 in Healthcare Settings

Good morning, Assistant Secretary Parker and other members of OSHA staff:

Thank you for the opportunity to appear before you to share the knowledge and experiences of infection prevention and control experts across the United States. My name is Dr. Sharon Wright, and I serve as an infectious diseases physician and Chief Infection Prevention Officer at Beth Israel Lahey Health in Cambridge, Massachusetts. Today, I am representing the Society for Healthcare Epidemiology of America (SHEA), a professional society that improves public health by establishing infection prevention measures and supporting antibiotic stewardship among healthcare personnel (HCP). SHEA is the premier society representing healthcare epidemiologists at the frontline. Prior to, and during the pandemic, SHEA has provided guidance aimed at ensuring healthcare facilities are safe for HCP, patients, and visitors. SHEA has helped to define best practices in healthcare epidemiology worldwide since the society's founding in 1980.

In the spirit of SHEA's mission, we want to ensure that OSHA's permanent COVID-19 standard results in application of the most up-to-date practices in occupational health and safety to protect HCP.

The national and global scientific community has come together as never before to accelerate our understanding of SARS-CoV-2 and COVID-19. While we now know significantly more about this virus and disease than we did two years ago, we are still learning, as evidenced by the regular updating of public health guidance for our communities, healthcare, and other settings from the Centers for Disease Control and Prevention (CDC) and state and local public health authorities. Public health guidance evolves along with these learnings and changing epidemiology of SARS-CoV-2, and CDC guidance must and continues to evolve with it. Of note, all of CDC's guidance related to infection prevention, occupational health, and vaccination for COVID-19 are considered "interim."[1,2,3] This is because they have and will continue to evolve as science accumulates. In applying these guidance documents over the course of the pandemic, healthcare facilities around the United States have ensured the safety of HCP, patients, and visitors.

For this reason, we encourage OSHA to design a COVID-19 standard that aligns with CDC and directs healthcare facilities to follow the most up-to-date CDC COVID-19 guidance and recommendations. If OSHA instead was to codify public health guidance within a final rule, it would quickly become outdated and could hold healthcare facilities to obsolete and potentially unsafe protocols. As an example, the OSHA ETS provides a detailed list of procedures that are considered aerosol-generating, however, it is possible that the CDC, which currently bases the list on data generated from a prior coronavirus outbreak (SARS-CoV-1 in 2003-4), will refine the list of such procedures or considering a different framework altogether, based on evolving science in this area.[4] If/when this happens, the OSHA ETS, having defined a circumscribed list of procedures (1910.502(b)) will require application of an obsolete definition. It is imperative that the new OSHA standard defer to CDC guidance in order to maintain relevance and, most importantly, to ensure healthcare facilities are applying the most current safety protocols for the protection of HCP.

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[1] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

[2] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

[3] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

[4] Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE

Local epidemiology and circumstances, may necessitate modifications to CDC guidance, as they have throughout the pandemic. Thus, where COVID-19 guidance from local public health departments differs from CDC guidance, the OSHA final rule should allow for healthcare facilities to establish compliance with the standard through compliance with local public health department guidance, as they currently do for all other infection prevention and control requirements.

We urge OSHA to align with CDC on matters regarding the scope of the standard, specifically on COVID-19-related infection prevention measures, future strains, vaccination, and exposures. OSHA should not create clinical definitions for occupational exposure or other similar terms for the purpose of establishing compliance with the standard. These responsibilities and expertise lie with the country's leading public health and infection prevention experts at CDC, and the language in the standard should refer to CDC-created definitions.

For example, the ETS suggests that universal masking may be perpetual in any setting in which healthcare is delivered. However, based on current CDC guidance, requirements for masking should be based on community-level transmission rates. OSHA must also recognize that CDC's established recommendations could evolve even further as knowledge about transmission of SARS-CoV-2 and effective prevention measures continue to grow over time. Therefore, masking requirements in healthcare settings should be based on CDC guidance and local prevalence and trends data.

Additionally, we advise OSHA to align with up-to-date CDC guidance on future variants and strains of SARS-CoV-2. Clinical guidance and standards for previous infectious disease outbreaks do not always apply to future emerging infectious diseases. The COVID-19 standard should not apply to any future, novel strains of the virus until it can be established that the standard is effective in protecting HCP from novel strains. We also note that there already exist four other endemic coronaviruses (229E, NL63, OC43, and HKU), for which CDC does not recommend the same infection prevention measures as with SARS-CoV-2.[5] These endemic coronaviruses cause mild upper respiratory tract illnesses such as the common cold. They are less transmissible and cause less severe disease than SARS-CoV-2 and thus do not warrant the same infection prevention measures. We are concerned that applying the standard to future strains may be interpreted to unnecessarily apply to these endemic coronaviruses, imposing burden on HCP and healthcare facilities, without improving safety.

SHEA appreciates OSHA's support for vaccination of HCP and urges OSHA to continue to encourage vaccination and boosters for HCP. Data clearly show that vaccination reduces the burden of infection in communities, and among HCP and patients. SHEA, prior to the COVID-19 pandemic, urged all HCP receive all vaccinations based on recommendations from the CDC Advisory Committee on Immunization Practices (ACIP),[6] and during the pandemic issued a comprehensive guidance describing the rationale for ensuring COVID-19 vaccination as a Condition of Employment.[7] However, OSHA should not create definitions for being fully vaccinated or similar terms for the purpose of establishing compliance with the standard and instead point employers to CDC recommendations and definitions for being "up-to-date with COVID-19 vaccination".[8] The standard should also be consistent with existing vaccination requirements for HCP, such as CMS' interim final rule requiring COVID-19 vaccination for all staff defined as HCP who

[5] https://www.cdc.gov/coronavirus/general-information.html

[6] Weber DJ, Talbot TR, Weinmann A, et al. Policy statement from the Society for Healthcare Epidemiology of America (SHEA): Only medical contraindications should be accepted as a reason for not receiving all routine immunizations as recommended by the Centers for Disease Control and Prevention. Infection Control & Hospital Epidemiology. 2021;42(1):1-5. doi:10.1017/ice.2020.342

[7] Weber DJ, Al-Tawfiq JA, Babcock HM, et al. Multisociety statement on coronavirus disease 2019 (COVID-19) vaccination as a condition of employment for healthcare personnel. Infection Control & Hospital Epidemiology. 2022;43(1):3-11. doi:10.1017/ice.2021.322

[8] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

enter health care facilities that participate in Medicare or Medicaid,[9] and avoid being overly prescriptive on how employers must establish compliance.

Finally, SHEA believes COVID-19 data reporting should be held to the established standards of infectious diseases reporting to state and federal authorities and align with CDC guidance and existing standards for recordkeeping and exposure evaluation and management for other infectious diseases in healthcare settings. CDC has issued and updated guidance both for defining exposure to SARS-CoV-2, and for managing HCP with such exposures, with different recommendations based on the level of risk of the exposure.[10]

The proposed requirements for maintaining a COVID-19 log of employees who test positive for COVID-19 create an additional paperwork burden on employee and occupational health staff. COVID-19 is a reportable disease to local health departments, and so requiring healthcare facilities to maintain a separate log is redundant and unnecessary. The log is also misleading as it requires a recording of all personnel testing COVID-19 positive, whether or not other HCP are exposed as defined by the CDC, and may heighten anxiety for staff without clear benefit. SHEA encourages that the permanent OSHA standard defer to CDC guidance on the definition of a COVID-19 exposure and any recommended follow-up.

We are also concerned about the potential release of protected health information associated with the requirement to provide a version of the COVID-19 log upon an employee's request. While the ETS specifies that the version of the log provided should not include names or occupations to attempt to de-identify the released data, the version is still required to include the employee work location and last day that the employee was at the workplace, among other items. Thus, it can never be truly deidentified, especially in small practices.

SHEA and OSHA share a common mission to prevent infections among HCP. On behalf of SHEA's board and members, we thank you for your focus on creating safe healthcare environments. In summary, SHEA recommends that OSHA refer to CDC guidance, whenever possible, for definitions and evaluation of exposure to SARS-CoV-2, surveillance and reporting, and necessary personal protective equipment to ensure the most evidence-based, up-to-date protection for HCP.

Thank you for this opportunity to share SHEA's expertise, and I look forward to answering your questions and discussing these issues further.

[9] https://www.federalregister.gov/documents/2021/11/05/2021-23831/medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-vaccination

[10] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html