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The Society for Healthcare
Epidemiology of America

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Mr. James Frederick

Acting Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety and Health Administration

U.S. Department of Labor

200 Constitution Ave. NW

Washington, D.C. 20210

Submitted via <http://www.regulations.gov>

RE: Occupational Exposure to COVID-19; Emergency Temporary Standard

Dear Acting Assistant Secretary Frederick:

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to submit comments on the U.S. Occupational Safety and Health Administration's COVID-19 emergency temporary standard (ETS).

SHEA represents more than 2,000 physicians and other healthcare professionals globally with expertise in healthcare epidemiology, infection prevention and antibiotic stewardship. SHEA is dedicated to advancing the science and practice of healthcare epidemiology and preventing and controlling morbidity, mortality and the cost of care linked to healthcare-associated infections (HAIs) and antibiotic resistance.

SHEA respectfully submits comments on the following provisions of the ETS:

- 1910.502 – Healthcare
- 1910.509 – Incorporation by Reference

Thank you in advance for your consideration of our comments. Please do not hesitate to reach out with questions to Lynne Batshon, Director of Policy and Practice, at (703) 684-0761 or lbatshon@shea-online.org.

Sincerely,

Mary K. Hayden MD, FIDSA, FSHEA
President, SHEA

SHEA supports provisions of the ETS that align with guidance issued by the U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) to ensure our shared goal of safety of all healthcare workers. Throughout our comments, we raise concerns with aspects of provisions that conflict with the most current public health guidance and, as a result, may undermine healthcare personnel's (HCP) confidence in such guidance and create unnecessary burden for all HCP and healthcare facilities.

1. Vaccination

§ 1910.502(m) *Vaccination*. The employer must support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave, administrative leave) to each employee for vaccination and any side effects experienced following vaccination.

SHEA supports the requirement for employers to provide employees with reasonable paid time off to receive the COVID-19 vaccine and to recover from associated side effects. To further increase vaccine uptake, SHEA strongly recommends OSHA require employers institute a policy that makes COVID-19 vaccination a condition of employment (CoE) for HCP, with exemptions for medical contraindications and other exemptions as specified by federal or state law. In a new consensus statement, SHEA and six other leading healthcare organizations explains what to consider in developing a policy of COVID-19 vaccination as a CoE, including a thorough overview of current vaccines' safety and efficacy, legal considerations, ways to engage stakeholders and improve vaccination rates before implementing a policy of vaccination as a CoE, and advantages to having a fully vaccinated workforce.¹

The consensus statement was authored by a panel of multisociety, multidisciplinary experts working in healthcare epidemiology, infection prevention, infectious diseases, pharmacy, public health, law, and human resources. It included representatives from the SHEA Board of Trustees, the SHEA Guidelines Committee, and other SHEA leaders, as well as organizational representatives from The Society for Post-Acute and Long-Term Care Medicine (AMDA), The Association for Professionals in Epidemiology and Infection Control (APIC), the HIV Medicine Association (HIVMA), the Infectious Diseases Society of America (IDSA), the Pediatric Infectious Diseases Society (PIDS), and the Society of Infectious Diseases Pharmacists (SIDP).

Some healthcare facilities have achieved high rates of HCP compliance with routinely recommended vaccines in the absence of vaccination as a CoE, particularly through a combination of strategies, such as incentives. However, most programs reporting immunization rates of 90% or higher used one or more soft mandates, including mandatory declination forms.²

Compliance among those who were required by their employer to receive the vaccination was 94.4%, compared to 69.6% among those without vaccination as a CoE.³ While vaccinations represent one of the most effective strategies to mitigate risk of transmission of communicable diseases, vaccination of HCP with vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) prior to the COVID-19 pandemic has been suboptimal, with approximately 50% of surveyed HCP in March 2021 remaining unvaccinated.⁴ The National Vaccine Advisory Committee has recommended that employers

¹ <https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/multisociety-statement-on-covid19-vaccination-as-a-condition-of-employment-for-healthcare-personnel/690D1804B72FFF89C5FC0AED0043AD62>

² Lindley MC, Mu Y, Hoss A, Pepin D, Kalayil EJ, van Santen KL, et al. Association of State Laws With Influenza Vaccination of Hospital Personnel. *Am J Prev Med*. 2019;56(6):e177- e83. Epub 2019/04/17. doi: 10.1016/j.amepre.2019.01.011. PubMed PMID: 31003802; PubMed Central PMCID: PMC6527478

³ Acero C, Razzaghi H, Black C, Wesley M, Jeddy Z, Lindley M, et al. Influenza Vaccination Coverage Among Healthcare Personnel -- United States, 2019-20 Influenza Season. In: NCIRD, editor.: CDC.gov; 2020

⁴ Kirzinger A, Kearney A, Hamel L, Brodie M. KFF/The Washington Post Frontline

consider requirements if their facilities are unable to achieve the Healthy People goal of at least 90% of HCP vaccinated for influenza.⁵

While requiring paid time off for employees to receive the vaccine and recuperate from any side effects will ease logistical concerns, a sufficient vaccination rate is unlikely to be achieved without making COVID-19 vaccination a CoE. This policy is essential to unlocking the benefits of a fully vaccinated workforce: 1) reducing the risk of transmission within healthcare facilities among HCP and patients, and from the community to healthcare facilities and from healthcare facilities to the community; 2) maintaining a healthy workforce and supporting HCP wellness; 3) maintaining the trustworthiness of HCP and healthcare institutions.

2. Employee Screening Requirement

§ 1910.502(l)(1) *Screening.*

§ 1910.502(l)(1)(i) The employer must screen each employee before each work day and each shift. Screening may be conducted by asking employees to self-monitor before reporting to work or may be conducted in-person by the employer.

SHEA believes it would be more appropriate for OSHA to base the employee screening requirement on a risk-assessment conducted by the facility. For example, as COVID-19 numbers decline substantially, it is possible that employees may simply “click through” self-reported screenings or ignore symptom screenings altogether. When expecting HCPs to change their routines, there needs to be clear justification of why and how the change is an improvement on the current state. Otherwise, facilities risk losing employee confidence, contributing to poor adherence to other preventive measures, such as mask wearing when indicated.

Affording employers some degree of flexibility to determine the threshold at which to enforce this requirement among employees – e.g., to ensure staff remain attentive to screening during COVID-19 surges – may be more impactful in reducing the spread of COVID-19 transmission. **Further, SHEA suggests that OSHA consider passive screening during times of low COVID-19 transmission, avoiding adding unnecessary screening technology and barriers. SHEA recommends that OSHA clarify what is envisioned by these screening requirements, acknowledging that self-screening ought to fulfill the broader purpose of this measure.**

3. Employer Notification Requirement

§ 1910.502(l)(3) *Employer notification to employees of COVID-19 in the workplace...*when the employer is notified that a person who has been in the workplace(s) (including employees, clients, patients, residents, vendors, contractors, customers, delivery people and other visitors, or other non-employees) is COVID-19 positive, the employer must, within 24 hours: Notify each employee who was not wearing a respirator and any other required PPE and has been in close contact with that person in the workplace...Notify all other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace (e.g., a particular floor) in which that person was present during the potential transmission period...Notify other employers whose employees were not wearing respirators and any other required PPE and have been in close contact with that person, or worked in a well-defined

Health Care Workers Survey. Kaiser Family Foundation [Internet]. 2021. Available from: <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-washington-post-health-careworkers/>.

⁵ Committee NVA. Strategies to achieve the healthy people 2020 annual influenza vaccine coverage goal for health-care personnel: recommendations from the national vaccine advisory committee. *Public Health Rep.* 2013;128(1):7-25. PubMed PMID: 23277655; PubMed Central PMCID: PMC3514716.

portion of a workplace (e.g., a particular floor) in which that person was present, during the potential transmission period.

§ 1910.502(b) *Definitions*. *Close contact* means being within 6 feet of any other person for a cumulative total of 15 minutes or more over a 24-hour period during that person's potential period of transmission. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated.

§ 1910.502(b) *Respirator* means a type of personal protective equipment (PPE) that is certified by NIOSH under 42 CFR part 84 or is authorized under an EUA by the FDA. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators.

The criteria triggering the employer notification requirement, coupled with the 24-hour period allotted to notify employees, conflicts with CDC guidance and is impractical. Imposing the employer notification requirement when an employee in close contact with someone with COVID-19 is “not wearing a respirator and any other required PPE” but is wearing a facemask (i.e., medical procedure mask) conflicts with CDC guidance titled, “Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2,” updated March 11, 2021.⁶ In this interim guidance, CDC recognizes the effectiveness of facemasks in protecting HCP from COVID-19. Additionally, CDC recommends that healthcare facilities determine whether to perform contact tracing and apply work restrictions on “the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing.” **SHEA recommends OSHA reflect the effective level of protection conferred by facemasks by requiring employers to notify employees in close contact with someone with COVID-19 if they are not wearing a respirator or facemask. Additionally, SHEA recommends OSHA refrain from codifying the specific criteria triggering the employer notification requirement and, instead, give facilities the flexibility to manage notification and contact tracing activities that align with their local health authorities’ practice and are appropriate for their local situation.** Notifying individuals with no further instruction is confusing and unproductive.

Furthermore, SHEA recommends that OSHA provide employers with up to 72 hours to notify employees about the exposure to COVID-19. The 24-hour period is not feasible for healthcare facilities, particularly smaller facilities with limited resources dedicated to occupational safety and health.

4. Personal Respirators

§ 1910.502(f)(4)(ii) *Facemasks*. Where the employer provides the employee with a facemask as required by paragraph (f)(1) of this section, the employer must permit the employee to wear their own respirator instead of a facemask. In such circumstances, the employer must also comply with § 1910.504 *Mini Respiratory Protection Program*.

Permitting employees to wear their own respirators instead of an employer-provided facemask introduces multiple issues. Generally, if an HCP insists on wearing a respirator without proper fit testing, the employee must sign a waiver relieving the employer of responsibility for failing to wear a fitted respirator. Allowing HCP to buy and use their own respirators may increase the employee's exposure risk, as they may be more apt to purchasing improper or counterfeit materials and less apt to be aware of proper storage and care. Notably, this provision introduces a loophole to the OSHA's standard on bloodborne pathogens, causing confusion about compliance and enforcement. It states, “Personal protective equipment will be considered ‘appropriate’ only if it does not permit blood or other potentially

⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.”⁷ Furthermore, allowing employees to wear their own respirators discriminates against employees without the resources to purchase their own respirators.

5. Incorporation by Reference

§ 1910.509(a)(1) The material listed in this section is incorporated by reference into this subpart with the approval of the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, OSHA must publish a document in the Federal Register and the material must be available to the public.

SHEA appreciates OSHA’s attempt to incorporate guidance from public health authorities, such as CDC. However, the approach of codifying specific and dated versions of guidance and subsequently publishing such guidance in the Federal Register will be challenging. In order to apply the most current guidelines to ensure the safety of our healthcare personnel, SHEA recommends OSHA reference current applicable guidelines without codifying specific and date guidance to allow facilities to modify in accordance with evolving science and disease prevalence.

⁷ § 1910.1030