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August 20, 2021

Submitted electronically via www.regulations.gov.

James S. Frederick
Acting Assistant Secretary of Labor for Occupational Safety and Health
US Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: Docket No. OSHA-2020-0004-1033, Occupational Exposure to COVID-19; Emergency Temporary Standard

Dear Acting Assistant Secretary Frederick:

The Conference of Boston Teaching Hospitals (COBTH), on behalf of our 12 member hospitals, appreciates the opportunity to comment on the Occupational Safety and Health Administration's Emergency Temporary Standard (ETS) on Occupational Exposure to COVID-19.

By way of background, COBTH is a non-profit organization that supports the full mission of Greater Boston's teaching hospitals, including providing the highest quality patient care, training the next generation of medical professionals, discovering cutting edge medical treatments, and serving our surrounding neighborhoods and communities.

COBTH and its members share OSHA's commitment to protecting our health care workforce from exposure to COVID-19. After making great efforts to protect our workforce through surges in COVID-19 hospitalizations in the City of Boston and throughout our Commonwealth, our hospitals and providers continue to respond to the impacts of the Delta variant on our employees and patients, and we remain committed to taking all necessary steps to protect our workforce, our patients and their families as the challenges of COVID-19 continue to evolve.

We are concerned that the proposed ETS is a "one-size fits all" approach to a pandemic that has created varying conditions throughout Greater Boston, the Commonwealth, and the nation, and fails to allow the flexibility needed to ensure safe and efficient hospital operations and patient care, contradicts prevailing local and national public health guidance, and fails to recognize critical variability in vaccination rates across organizations and localities. To that end, below we express our key concerns with the ETS and its implications for hospital operations and worker and patient safety.

Patient Screening
The ETS requires that health care settings must screen and triage all non-employees entering the setting. This requirement creates an enormous burden on our hospitals, who rely on non-employees

coming in and out of the buildings to keep hospitals stocked and running. This requirement creates unnecessary bottlenecks, administrative burden, and expense and only slows down a return to normal hospital operations.

We believe screening requirements should be decided locally based on infection rates and the use of other public health best practices that effectively prevent viral spread.

PPE and Masking
The ETS requires that employers ensure face masks are worn by all employees at all times. This requirement does not take into account vaccination rates of staff, local infection rates, and the type and location of job being performed by the employee. This requirement is overly broad and does not allow flexibility when safety can be effectively achieved through other means. Additionally, the ETS would require health care settings to allow employees to wear their own respirators instead of a hospital-issued face mask. Hospitals are not able to validate the efficacy of the various masks that may be worn by employees and authorizing the use of PPE that has not been authorized by hospitals could create serious vulnerabilities in the health care setting.

Distancing and Barriers
The ETS mandates that employers ensure employees can be separated by at least six feet unless unfeasible for a specific activity, like providing hands-on medical care. This requirement goes against current guidance that masking and vaccination make it safe for people to be closer together in indoor spaces. Forcing providers to operationalize and enforce a six-foot distance requirement would lead to significant capacity constraints for providing care, attending meetings, as well as for training resident physicians and other allied health professionals. We strongly recommend that distancing requirements should be left to local public health agencies rather forcing the creation of a burdensome "demonstration" requirement to justify health care workers being closer together.

Additionally, the ETS requires the addition of physical barriers outside of direct patient care areas. This requirement is both impractical and unnecessary if employees are complying with the CDC's mask guidance and fails to recognize the key interventions already deployed and in use by hospitals.

Cleaning and Disinfecting
The ETS requires disinfecting all surfaces following an aerosol-generating procedure after the procedure is completed. Typically, this is done not immediately after the procedure is completed, but rather after a patient has left the room or space. We think clarifying this point in the ETS is necessary.

Further, the ETS requires cleaning high-touch surfaces and equipment daily, and following a COVID-19 positive identification, cleaning and disinfecting any areas that have likely been contaminated. Hospitals already abide by cleaning and other facility protocols consistent with federal, state, and accreditation requirements, and this additional proposed requirement by OSHA is extremely burdensome, and goes against what we know about how COVID-19 is spread.

Employee Exposure Protocols and Recordkeeping
The contact tracing and employee notification protocols in the ETS contradicts widely accepted contact tracing protocols and is not practical. Additionally, the protocols ignore widely accepted

masking policies, and do not clearly define what constitutes a contact or an exposure. In Massachusetts, a close contact must be in proximity with a COVID-positive person for more than 15 minutes.

This section of the ETS also requires employers to remove employees from the workplace for 14 days or until the employee can provide a negative COVID-19 test at least five days after exposure. This is not a feasible way to manage COVID-19 exposures and could require hospitals to send entire shifts or units home for many days. Hospital workforces are already struggling to keep up with demand and this requirement will only increase that burden on our workforce, while doing little to mitigate the spread of COVID-19 where there are other effective public health measures in place.

The ETS also requires employers to keep a COVID-19 log to record COVID-19 positive cases and various related datapoints. We are concerned that this requirement will not help track and mitigate the spread of COVID-19 and only duplicates contact tracing efforts that are undertaken at our institutions.

Overall, COBTH shares and appreciates your commitment to protecting workers from the spread of COVID-19 and your efforts to minimize spread of the virus in health care settings. However, we believe existing local and state public health requirements, along with guidance from the CDC, provides adequate direction and allows needed flexibility in our efforts to ensure employee and patient safety as we continue to confront this virus. We urge you to recognize the expertise and experience of local and state public health officials, who are more readily able to take local conditions into account on these matters as appropriate.

Thank you for your consideration of our comments. COBTH's member hospitals are also members of the Association of American Medical Colleges (AAMC) and strongly support the in-depth comments submitted by AAMC on behalf of the nation's academic medical centers and teaching hospitals. Please do not hesitate to be in touch with any questions or if we can provide additional information on these or other matters.

Sincerely,

Patricia McMullin
Executive Director
Conference of Boston Teaching Hospitals