



August 19, 2021

James Frederick  
Acting Assistant Secretary of Labor for  
Occupational Safety and Health  
Occupational Safety and Health Administration  
200 Constitution Ave NW  
Washington, DC 20210

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

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

Dear Mr. Frederick,

Trinity Health appreciates the opportunity to comment on your Administration's recent COVID-19 emergency temporary standard (ETS) outlined in OSHA-2020-0004. Our comments and recommendations herein reflect a mutual commitment by our health system to the safety of our colleagues (employees) and clinicians who have been caring for the patients we serve throughout the course of this unprecedented, ongoing pandemic of COVID-19.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming, and healing presence in our communities. Trinity Health includes 94 hospitals, as well as 109 continuing care locations that include Program of All-Inclusive Care of the Elderly (PACE) programs, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns \$1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models.

The safety of our colleagues is a top priority and from the start of the COVID-19 pandemic, we have closely followed the guidelines and recommendations from the Centers for Disease Control & Prevention (CDC) and the requirements and recommendations of the federal Occupational Health and Safety Administration (OSHA) (and applicable state plans) on how to protect health care workers and patients. Below are our comments and recommendations on the OSHA ETS.

### **Implementation timeframe (FR pg. 32376)**

Trinity Health's providers, colleagues, member hospitals, large number of ambulatory care locations (e.g. primary care providers), and continuing care (e.g. PACE clinics) had 14 days from publication of the ETS requirements to come into compliance. Given the broad scope and complex requirements, Trinity Health continues to urge OSHA to allow for, or at least ensure OSHA's compliance safety and health officers (CSHOs) are aware, that additional time—up to 3 months—is needed for healthcare facilities and their healthcare personnel to ensure full, detailed, and long-lasting compliance with the ETS, rather than temporary solutions put in place to meet these deadlines. **Trinity Health supports and strongly encourages OSHA to use its enforcement discretion to avoid citing employers who are making a good faith effort to comply with the ETS and urges OSHA to use this discretion for the duration of any additional implementation extension that is granted.**

### **Physical barriers (FR, pg. 32623)**

The ETS states, "...At each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible." This can lead to changes to the environment of care that may disrupt efficient operation of a facility's heating, ventilation and air conditioning (HVAC) systems—in direct conflict with the ventilation section of the ETS. Uncertainty of value of barriers and interaction with HVAC has also been reviewed by Rooney and colleagues (Rooney CM, et al. Infect Prev Pract 2021;vol. 3, issue 2 (June): 100144) who highlight ongoing questions for this strategy. In addition, it is not unusual that patients and colleagues might need to move around barriers to improve communication and understanding during interactions. This circumvents the perceived benefit of barriers to lessen risk of disease transmission.

**Trinity Health recommends OSHA permit flexibility in the wording of this section of the ETS by the employer to avoid unintended consequences like interference with HVAC systems.** Further, we are not aware of evidence that barriers separating employees behind these who interact with the public and who are already wearing facemasks offers substantive additional protection.

### **Employer notification to employees of COVID-19 exposure in the workplace (FR, pg. 32624)**

Section (C) states, "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 portion of a workplace (e.g., a particular floor) in which that person was present, during the potential transmission period." Because the principal mode by which people are infected with COVID-19 is through exposure to respiratory fluids carrying infectious virus by inhalation of very fine respiratory droplets and aerosol particles or deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye, we feel definition of a possible exposure incident during close contact involving an employee should reflect the level of eye and respiratory protection worn by the employee and not necessarily include gowns and gloves as stated in "any other PPE." These elements are rarely worn by employees when in break rooms or shared meeting space. Further, our experience to date in this pandemic has identified few instances of occupational transmission from patient to employee during direct care.

**Trinity Health recommends OSHA narrow the scope for notification of those with possible exposure to emphasize this for instances when eye and respiratory protection was not worn and permit flexibility by employers in determining risk when other elements like gown and gloves are the only ones**

**missing.** Surges of cases in the community needing health care requires adequate staffing and an overly broad definition of exposure involving all elements of PPE often triggers medical removal of a potentially overbroad level of employees. This can, in turn, compromise safe care of patients by creating staffing shortages at a time where this is needed most. **We instead recommend a risk assessment approach that CDC does currently offer when there are possible occupational exposure incidents.**

#### **Medical removal from the workplace (FR, pg. 32624)**

We support and have been following CDC's recommendations to remove employees with confirmed, acute COVID-19 and symptoms of possible infection from the workplace. We also concur with OSHA's requirements for managing employees with close contact – especially for those who are fully vaccinated. Even with a system-wide requirement for vaccination against COVID-19, there will be some employees who have contraindications to the vaccine, approved religious exemptions, or who have not completed their series. The seven-day automatic removal for these employees is challenging as the supply and stability of staffing of employees for care delivery is fragile, especially when case rates in the community are substantial or high.

**Trinity Health recommends OSHA permit employers more flexibility in determining medical removal for employees that fall under this situation.** There are some redundant safety strategies that are in place in facilities, including source control by wearing facemasks, screening for symptoms of possible infection prior to each shift, and testing of the employee. We require an initial test as close to the time of the exposure incident, in addition to a repeat test at least 5 days thereafter. These measures mitigate risk, but also permit appropriate staffing to deliver safe patient care.

#### **Mini respiratory protection program (FR, pg. 32626)**

The ETS includes a new mini respiratory protection program (RPP), 910.502, that applies to certain circumstances during which workers are not at risk of exposure to persons under investigation (PUI) or with acute COVID-19, but may wear a respirator in place of a facemask in situations where the employer requires use of a facemask.

The flexibility to allow employees to bring in their own personally owned respirators creates an added layer of complexity in managing an RPP. Employers are still required to ensure colleagues know how to safely wear their personal respirator and such respirators may not align with the current personal protective equipment (PPE) we provide under OSHA's the existing full RPP (29 CFR 1910.134). In addition, employers will still need to inspect an employee's personal respirator to ensure it complies with what is allowed in our facilities. **Trinity Health has a strong preference that colleagues use respirators provided by their employer and recommend OSHA allow employers the option to require colleagues use employer-provided respirators.**

#### **Reporting of COVID-19 Fatalities and Hospitalizations (FR, pg. 32626)**

Healthcare organizations are required to report to OSHA each work-related COVID-19 fatality within 8 hours of learning of the fatality and each work-related COVID-19 in-patient hospitalization within 24 hours. There is no outside window from date of event to outcome in the ETS, which makes recordkeeping difficult. The non-ETS recordkeeping standard (29 CFR 1904) places an outside limit on fatalities as having occurred within 30 days of the event and inpatient hospitalizations as having occurred within 24 hours of the event.

**Trinity Health requests OSHA maintain main recordkeeping requirements and align reporting of COVID-19 fatalities and hospitalizations with the OSHA recordkeeping standard to reduce complexity**

of reporting requirements within different timeframes. In addition, OSHA should release guidance clarifying the definition of a work-related hospitalization specific to COVID-19, as this is not clear in the rule, and the ETS has no definition of hospitalization in relationship to date of exposure or diagnosis.

**Reuse of respirators (FR, pg. 32627)**

Trinity Health recommends OSHA lessen the requirement that PPE supply be at crisis before using conservation strategies like extended use or limited reuse. These strategies have been effective and have not compromised safety of employees to our knowledge when employees are trained in deployment. We understand the requirements under OSHA RPP 1910.134. However, while supply of disposable respirators like N95 respirators is stable, this can quickly become unstable in any region that is experiencing substantial and/or high rates of infection in the community leading to high levels of healthcare needs. There are innumerable examples of the fragility of the supply chain for PPE to date.

CDC has recommended that strategies like extended use and limited reuse be limited to crisis conditions and the OSHA ETS, while citing this, currently does not permit these work practices. Is there evidence that extended use and limited reuse significantly increases risk of exposure to employees? The repeated doffing and donning of a new N95 respirator, especially in units that are occupied by an entire cohort of COVID-19 patients may not offer any better protection of employees than extended use and limited reuse. Is OSHA, NIOSH or CDC's COVID-19 Response Team aware of instances that these practices are associated with occupational transmission? Waiting until a facility is in crisis condition also seems too strict. Better that the ETS permit the employer that is detecting unusual increased demand for PPE to implement conservation strategies more proactively and potentially even preempt a crisis condition.

**Conclusion**

Thank you for your commitment to health care worker safety. If you have any questions on our comments, please feel free to contact me at [jennifer.nading@trinity-health.org](mailto:jennifer.nading@trinity-health.org) or 202-909-0390.

Sincerely,

/s/

Jennifer Nading  
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Trinity Health