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Douglas L. Parker
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Health and Safety Administration
200 Constitution Avenue, NW
Washington, D.C. 20210

Subject: Occupational Exposure to COVID-19 in Healthcare Settings

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OSHA Docket Number: OSHA-2020-0004
RIN: 1218-AD36

Dear Assistant Secretary Parker:

On behalf of the American Public Health Association, a diverse community of public health professionals that champions the health of all people and communities, I write to submit comments in support of the Occupational Safety and Health Administration efforts to develop a permanent rule to protect workers in health care settings from aerosol transmissible infectious diseases. These comments were developed in collaboration with members of the and Safety Section. As the leading and largest public health organization in the United States, we are in a unique position to clarify the importance of a regulation to protect workers that augments and strengthens guidance provided by the Centers for Disease Control and Prevention. Local, state and federal public health agencies are essential for understanding the risk factors for transmission of infectious diseases and the community controls that are needed.

However, special considerations and measures must be in place and enforced by the designated agency assigned to ensure workplaces are safe and healthy environments. That A permanent standard is urgently needed as workers in health care remain at serious risk of infections. It is important and necessary to have a comprehensive and consistent approach in health care settings, nationally.

Both the proposed deference to CDC guidelines and references throughout the Federal

To that end, the National Institute for Occupational Safety and Health must be included in providing assistance to OSHA and state plans - as the key CDC branch responsible for worker health and safety.

An example that demonstrates this gap in public health measures for the community versus workplace health and safety is the fact that 26 states have passed laws stripping state and local public health officials of the power to enforce public health mandates such as vaccination, quarantine, and masking.[1] This puts public health decision making into the hands of elected officials instead of qualified, independent, science trained public health officials. This makes the need for a uniform national standard from OSHA even more urgent. Guidance alone does not carry the weight and strength of a regulation. Additionally, local and

state health departments differ in their expertise regarding worker protections and have given varying advice to employers for workplace protection.

There is much research that worker safety improves patient safety.[2,3,4] In addition, our workforce capacity has been impacted by the morbidity and mortality among health care workers along with the low morale and burnout due to working conditions and decreased staffing.[5] It is imperative that these trends be reversed. , a publication of APHA, reported in April 2021 on
Guardian.[6] The project has documented more than 3,500 deaths among health care workers from COVID-19 as of April 2021, with 67% from minority populations. Personal stories of these tragic losses have also been documented by the project.

OSHA should not consider a permanent standard that is weaker than the Emergency Temporary Standard; it must be stronger. The standard must fully recognize and address aerosol transmission and require measures to control transmission and exposure including ventilation, filtration, and appropriate respiratory protection. It is critical that the standard protect all workers at risk of exposure and infection; not just those at the highest risk.

In addition, this effort provides an important foundation for a future comprehensive standard that addresses the needed preparation for all future novel aerosol transmissible infectious pathogens. The development of the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard in 2009 is a prime example of a regulation that struck a balance between regulatory mandates and public health science.[7]

APHA has been committed to the protection of the health care workforce, patients and community health, and has a long history of adopting policy statements that focus on worker protections as well as preparedness for novel and emerging infectious diseases, including:

APHA Policy Statement 20158:

APHA has worked closely over the years with CDC and has supported its role as the primary national public health agency. As public health professionals, we rely on the knowledge and resources of CDC.

However, over 50 years ago, the recognition that protecting worker health and safety required an enforceable system of standards resulted in the Occupational Safety and Health Act. Of course, OSHA regulations are based on science and engineering, and the CDC, particularly NIOSH, provide important leadership in standards development. OSHA uses robust stakeholder involvement to develop regulations which then become legal mandates for minimum protections in the workplace. CDC guidance cannot create this kind of stable mandate, since, as we have seen during the COVID-19 pandemic, it has not provided a stable platform for regulatory enforcement.

In creating OSHA, Congress recognized that employers control working conditions, and therefore must have the primary responsibility to provide a safe and healthful workplace and institute protective measures for recognized hazards. In analyzing the difference between public health recommendations and workplace health and safety regulations we see several key issues:

1. In health care, exposures to infectious diseases and other hazards cannot be avoided through exclusion of infected patients, or instructions to stay home. The health care

Beltrami et al (2000) provide data demonstrating the dramatic decrease in the incidence of Hepatitis B among health care workers.[13,14]

The experience of the California OSHA State Plan, Cal/OSHA, also illustrates how independent OSHA mandates work to both improve worker health and safety and support strong public health guidance. In 2009 California adopted the Aerosol Transmissible Diseases Standard to protect health care workers, and other workers in higher risk environments. The ATD Standard came into effect during the 2009 H1N1 influenza pandemic and was used to enforce certain protective measures in health care. During the decade since adoption of the standard, inspections were conducted regarding exposures to

Ebola.

In February 2020, Cal/OSHA issued guidance regarding how the ATD Standard applied to COVID-19 under what the s
of respiratory protection and, unless infeasible, the placement of COVID-19 cases and suspected cases in aerosol transmissible infection isolation rooms or areas with other engineering controls. Although there remained significant pressure to eliminate or reduce requirements for respirators (for example, only for high hazard procedures), particularly due to failures in private and public stockpiles, the s
the California Department of Public Health in supporting respirator use with confirmed and suspected COVID-19 cases. California also sought to expand the supply of N95 respirators

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