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May 23, 2022

Mr. Douglas Parker
Assistant Secretary of Labor for OSHA
Occupational Safety and Health Administration
U.S. Department of Labor - OSHA
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Comments on Occupational Exposure to COVID-19 in Healthcare Settings; Occupational Safety and Health Administration; Docket No. OSHA-2020-0004

Dear Assistant Secretary Parker,

Thank you very much for the opportunity to speak at the Occupational Safety and Health Administration's ("OSHA")'s informal public hearing regarding the COVID-19 healthcare rulemaking. I am pleased to submit the following supplemental comments on OSHA's "Occupational Exposure to COVID-19; Emergency Temporary Standard" ("Healthcare ETS" or "ETS"), Docket No. OSHA-2020-0004, published in the Federal Register of June 21, 2021, on behalf of our coalition – a coalition of companies that have medical clinics embedded within their operations and/or contract with or employ medical personnel, such as nurses or emergency response personnel at their facilities.[1] Our original comments were submitted to the docket on the comment deadline, April 22, 2022.

Introduction

As a reminder, the coalition is composed of a diverse group of national employers and trade associations, representing many industries, including manufacturing, petroleum refining and chemical manufacturing, aerospace defense, shipping/logistics, media and entertainment, and many more, with millions of employees across thousands of workplaces in every state in the Nation. The common thread among our coalition members is that they are responsible employers who care deeply about their employees' health and safety.

As we provided in our original comments, these companies' medical clinics and operations were exempt from OSHA's Healthcare ETS for COVID-19 under the express exemption at 29 C.F.R. Section 1910.502(a)(2)(iii) for "[n]on-hospital ambulatory care settings where all non-

[1] The coalition notes that, while there are many different kinds of clinics for purposes of the Healthcare ETS, the coalition's comments provided herein are narrowly tailored to clinics and emergency services that service employees.

employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings" ("screening exemption").

We understand that OSHA has reopened the comment period in part to solicit comments on the removal of scope exemptions, including the screening exemption. *See* 87 FR 16426, 16427 (March 23, 2022). Under its "Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID–19 patients are screened out; home healthcare)" section, OSHA states:

> A final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of significant risk from exposure to COVID–19, rather than the finding of grave danger OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible. In view of this different risk finding, OSHA is considering whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk. OSHA seeks comment on this approach.

See id. As set forth in our original comments, the coalition strongly urges OSHA to preserve the screening exemption. We reiterate this position here.

Post-Hearing Comments

During the public hearing, on Friday, April 29, 2022, one of our coalition members – the American Chemistry Council – provided testimony describing many of the key reasons why the screening exemption should be preserved, as set forth in our original comments. After providing testimony, the OSHA panel, Solicitor's Office ("SOL"), and members of the public asked certain questions and made certain requests of our coalition, to which we responded during the hearing. We understand that, at the conclusion of the informal public hearing on May 2, 2022, OSHA reopened the docket to allow for submission of post-hearing comments and briefs through May 23, 2022. Through this supplemental letter, we would like to more fully address some of the questions asked and requests made by the OSHA panel and Solicitor's Office. We summarize those questions below, and provide our responses thereafter.

OSHA/SOL Questions:

1. You had indicated that the employers are using a range of different measures to screen employees, including self-assessment checklist, temperature screening, COVID-19 testing, signage, and questionnaires. Please provide a sense of the frequency of each of those various methods of assessment.

2. What specific questions are being posed in employers' self-assessment checklist questionnaires?

3. Would individuals be physically turned away from the medical clinic if they had a [one] COVID-19 symptom?

4. How was contact tracing conducted to determine that any cases of COVID-19 among medical clinic staff were not work-related?

Although not necessarily representative of the entire coalition, we did receive responses (respectively, following the numbering convention of the OSHA/SOL questions above) indicating that:

1. Although coalition members use a variety of methods to screen individuals before entering their medical clinics (and, indeed, as set forth in our original comments, before even entering their facilities), it appears that self-assessments, questionnaires, and signage are the most common, with the next most common method being onsite temperature screenings, followed by COVID-19 testing. Some employers use onsite temperature screenings as a screening mechanism for all employees before they enter the facility, whereas others use it as a screening mechanism for any individual who is entering or visiting (as opposed to someone who is quickly in and out of the medical clinic, for example, dropping off paperwork) the medical clinic. Additionally, temperature checks are often incorporated into employers' self-assessments, questionnaires, and signage.

2. Coalition members' self-assessments and/or questionnaires typically include questions about testing positive for, or being diagnosed with, COVID-19, COVID-19 symptoms, and close contacts / exposure sources.

   For example, one employer developed two different versions of its screening form. If an individual calls the clinic and gets a nurse on the phone, the nurse uses one version of the form as part of their typical case management process. If the individual calls the clinic and speaks to an administrator, the administrator can send them a link to the other version of the form to complete online, and a nurse will call to follow up based on how busy the clinic is at the time. Both versions of the form are robust and extensive. For the version that the individual completes themself (i.e., a nurse is not available to help them complete the form), questions include, but are not limited to:

   - Do you have any symptoms (listing fever, cough, shortness of breath or difficulty in breathing, fatigue, muscle pain or body aches, headache, new loss of sense of smell or taste, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, any other symptoms)? If yes:

     - When did you start feeling these symptoms?
     - Have you consulted any healthcare providers for your current symptoms?
     - What is the diagnosis?
     - Did you have close contact (less than six feet and greater than 15 minutes) with any employees or contractors within two days prior to the onset of your symptoms?
     - Did contact occur at worksite?

    - When did the contact occur?

  - Have you been tested for COVID-19? If yes:

    - Test result
    - Type of test
    - Date of test

  - Did you have contact (less than six feet and greater than 15 minutes) with someone diagnosed with COVID-19 recently? If yes:

    - Does the person live with you?
    - When was the last contact with the person?
    - When did the person develop symptoms?

  - Have you traveled recently? If yes:

    - Where did you travel?
    - Departure date(s)
    - Arrival date(s)
    - Mode of travel
    - Reason for travel
    - Did any co-workers travel with you?

  - Have you already quarantined or isolated yourself? If yes:

    - When did you start quarantine or isolation?

  - When was your last day at the worksite?

  - When is your next scheduled work shift?

  - Do you practice social distancing and other recommended best practices for COVID-19 (face coverings, eye protection, hand hygiene)?

Similarly, another employer's self-assessment includes questions about, for example:

- COVID-19 symptoms (e.g., coughing; sneezing; fever; shortness of breath; difficulty breathing; early symptoms of acute respiratory illness such as chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, runny nose, muscle pain; new loss of taste or smell).

- Close contacts (within six feet for more than 15 minutes) with anyone who is either confirmed or suspected of having COVID-19, including anyone who is experiencing or displaying any of the symptoms of COVID-19.

- Testing positive or having been tested and awaiting results for COVID-19.

Additionally, as described in our original comments, many facilities in general industry implement "double screening" – that is, all employees are subject to a first screening before they enter the building, and a second screening if they wish to visit the embedded medical clinic.

For example, one national employer reports that, for purposes of the first screening – that is, before anyone (e.g., employee, visitor) can enter any facility, regardless of whether the facility even has a medical clinic – a daily checklist must be completed. This checklist includes numerous statements, ***all*** of which must be answered in the affirmative for an individual to be able to enter the facility. If an individual does not answer all statements in the affirmative, they are prohibited from entering the facility, and, if the individual is an employee, they are also directed to immediately notify their manager. These statements include, but are not limited to:

- I do not currently have a temperature of 100.4 degrees Fahrenheit or higher, checked daily.

- I am not currently experiencing any of the following symptoms potentially associated with COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea; OR, if I am currently experiencing any of the above symptoms, I meet the applicable return–to-work criteria or have consulted with a health care provider, who has confirmed that my symptoms are related to a previously diagnosed chronic illness or condition (such as asthma, allergies, etc.) and are not related to COVID-19.

- If I previously experienced any of the above COVID-19 symptoms, tested positive for COVID-19 and/or was advised by a medical professional to get tested for COVID-19, I have met applicable return-to-work criteria.

- During the past 10 days, I have not been in close contact with anyone who has been diagnosed with COVID-19 or is showing any of the above COVID-19 symptoms (including during the 48-hour period prior to symptoms showing); OR, if I have been in close contact, I meet applicable criteria for ending quarantine.

- If I have traveled internationally or to any location where I am required to self-isolate after travel, I have self-isolated for the required length of time.

This employer also reports that, to the extent an employee passes their first screening (as set forth above), if that employee wishes to visit the employer's embedded medical clinic, the employee is required to go through a second screening. For purposes of the second screening, the medical clinic requires employees to complete a health pre-

screening form before entry into the clinic. This health pre-screening form includes numerous questions, including, but not limited to:

- Temporal temperature
- Do you feel physically well today?
- Are you experiencing or have you experienced in the last 10 days any of the following COVID-19 symptoms: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?
- I have been told by a health care provider that I have COVID-19 or have received a positive COVID-19 test result?
- I have been tested for COVID-19 and test results are currently pending?
- During the past 10 days, have you been in close contact with anyone who has been diagnosed with COVID-19 or is showing COVID-19-like symptoms (including the 48-hour period prior to symptoms showing)?
- Have you returned from either international or domestic travel within the past 5 days? If yes, indicate location.
- Are you up to date on your COVID-19 vaccination (defined as having had a COVID-19 booster, or completed the primary series of the COVID-19 vaccine and are not yet eligible for a booster).

3. Many coalition members do indeed bar entry into their medical clinics if an individual indicates that they have even one symptom of COVID-19 during the screening process. One employer reported that even one symptom is enough to send employees home – they then must get tested and follow up with an external health provider before returning to work. Another employer reported that anyone with one symptom of COVID-19 is turned away and told they must leave the site and notify their manager.

4. As provided in our original comments, while there were instances of coalition members' medical staff contracting COVID-19, those cases were ***all*** determined to be non-work-related (e.g., contracted during personal travel or from children at home). Although coalition members use a variety of methods to conduct contact tracing for purposes of determining work-relatedness, the process typically involves an evaluation of the employee's work and outside-of-work activities for potential sources of COVID-19 exposure. One employer reports that it uses tracing questions based on CDC tracing guidance. Another employer reports having an intake process whereby it questions the medical staff member about how they may have contracted COVID-19 and asks for any close contacts in the workplace, among other things.

Additionally, the OSHA panel asked to be provided with the data we shared during the hearing. This data is included in our original comments, and is re-copied/pasted here for ease of access.

> For example, one employer reported that, for one of its sectors, which has about 25,000 employees (of which, there are about 15 total staff in health services), from March 2020 to April 2022, it had approximately 4,000 total positive COVID-19 employee cases (confirmed by test or health care provider), with ***zero*** total medical personnel who contracted COVID-19 from the workplace.[2] This is despite almost 7,000 total number of visits to the medical clinics during this time period. The employer has been screening and barring using a questionnaire that includes questions about COVID-19 symptoms and exposure and has refused entry due to a failed screenings almost twenty times. Outside of this sector, at another site, the site reported that it had between four to seven employees/contractors during the pandemic, with ***zero*** exposure to a COVID-19 case or any positive cases amongst the medical staff.
>
> Additionally, in speaking with one doctor who is a contractor for one of the largest sites of a major manufacturer, the doctor reported that there have been ***zero*** work-related COVID-19 cases among his medical staff in 4,310 encounters at his two embedded medical facilities since OSHA issued the Healthcare ETS in June 2021.[3] Indeed, the doctor reported that he has "stacks and stacks" of completed screening checklists, and that, despite many employee clinical visits, he believes no COVID-19 cases came through his clinic. The site has not had ***any*** health professional have a positive case due to a workplace exposure.
>
> Another employer reported that, at one site, in the last seven months, it too has had ***zero*** work-related cases of COVID-19 among the staff in its medical unit.[4] The employer reports that the rate of COVID-19 cases across its sites has typically been about 25 percent lower than that of the community, with some sites as much as 75 percent lower. Thus, even though some portion of employees were contracting COVID-19, especially during local area surges (albeit at a substantially lower rate than the local community generally), the medical personnel in the facility's clinics were not contracting COVID-19.
>
> In looking plainly at rate of transmission, without regard to work-relatedness, another employer's data reveals that at one of its locations, the rate of transmission among clinic staff was much lower than that of non-clinic employees. Additionally, the rate of transmission among clinic staff at four other locations was ***zero*** percent.
>
> Moreover, one employer who conducted second-level screening (i.e., screening at the door to the clinic, after screening at the door of the facility) via COVID-19 testing found that screening correctly identified and allowed the employer to screen out those employees who were asymptomatic or presymptomatic.

[2] Only two medical team members contracted COVID-19 and both cases were due to personal travel.
[3] Only one employee of the doctor's staff contracted COVID-19, and that employee contracted the virus from the employee's son at home.
[4] Only two medical unit staff members contracted COVID-19, and both had children who contracted the virus first.

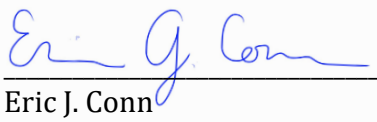
> This experience is corroborated across the board by coalition members, regardless of the geographic region in the country or the type of industry. One employer stated that its medicine and occupational health units were simply not affected – ***at all*** – by COVID-19, even when their manufacturing sites experienced waves of COVID-19 driven by local area surges. The numbers truly speak for themselves as to the effectiveness of OSHA's screening exemption.

As set forth in our original comments, our hearing testimony and comments, and these supplemental comments, the coalition strongly urges OSHA to preserve the screening exemption.

CONCLUSION

On behalf of our coalition members, we respectfully request that OSHA give meaningful consideration to these supplemental comments and recommendations in considering the development of any permanent COVID-19 healthcare standard.

Sincerely,



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