



SENT VIA EMAIL (Ray.Davenport@doli.virginia.gov) AND ONLINE (townhall.virginia.gov)

July 29, 2021

C. Ray Davenport Commissioner
Department of Labor and Industry Main Street Center
600 East Main Street
Suite 207
Richmond, Virginia 23219

Re: Proposed Amendments to the Final Permanent Standard, Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, as Adopted by the Virginia Safety and Health Codes Board on June 29, 2021.

Dear Commissioner Davenport:

On behalf of the Virginia Hospital & Healthcare Association's ("VHHA") 26 member health systems, with more than 125,000 employees, thank you for the opportunity to comment on the Department of Labor and Industry's (the "Department") proposed amendments to the Final Standard regarding Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 (hereafter referred to as the "Amended Regulations"). Since March 2020, Virginia's hospitals and health systems have been on the frontline treating patients infected with the COVID-19 virus and playing a leading role in the Commonwealth's response to the pandemic. Throughout these efforts, Virginia hospitals have remained steadfastly committed to our top priority – the safety of our patients, visitors, employees, and the communities we serve.

We continue to question whether adopting a permanent regulation specific to COVID-19 is necessary or appropriate. The Commonwealth will undoubtedly face other pandemics or public health threats from communicable disease that involve different safety precautions than those indicated for COVID-19. Accordingly, we believe that a more general standard that sets forth a high-level framework rather than disease-specific criteria should be considered for permanent regulations. For example, the permanent regulations could be simplified in a manner that recognizes the threat posed by COVID-19, but more generally provides a basic series of steps employers would undertake for any pandemic or communicable disease of public health threat (e.g., risk assessment, environmental and administrative controls, infection control plans). That is, the regulations need not be disease specific and could simply require best practices for disease infection and control that apply generally.

Additionally, regardless of whether a permanent standard is specific to COVID-19 or communicable disease more generally, its applicability and enforcement should be tied to an executive order or an order of public health emergency declaring a state of emergency due to a communicable disease of public health threat. Similarly, in the event of a few cases or a localized outbreak of a highly contagious disease that does not amount to public health emergency on a statewide basis, the regulations should not be applicable to an employer located in an area where there are no cases and where there is not a recognized public health threat in the region.

Any regulations such as these should be limited in duration. As proposed, the Amended Regulations would remain in effect in perpetuity with no clear objective or measures by which they will be rescinded or revoked. The lack of a clear objective or measure for rescission of the Amended Regulations would lead to protracted uncertainty for employers making good faith efforts to comply with the Amended Regulations despite a foreseeable future with zero or minimal positive COVID-19 cases in the Commonwealth or only localized outbreaks.

While we applaud the Amended Regulations' deference to and conformity with the Occupational Safety and Health Administration's COVID-19 Emergency Temporary Standard (29 C.F.R. 1910.502 *et seq.*) (the "OSHA ETS"), we have concerns about the application of two different sets of COVID-19 workplace regulations to hospitals and health systems. The Amended Regulations at 16VAC25-220-10.B.1-4 provide that applications of nearly all of the Amended Regulations' requirements are suspended "where any employee provides healthcare services or healthcare support services" absent an intervening suspension, stay, invalidation by a state or federal court, revocation, repeal, declaration of unenforceability, or expiration of the OSHA ETS. 16VAC25-220-30 defines "healthcare support services" to mean "services that facilitate the provisions of healthcare services. Healthcare support services include [but are not limited to] patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/processing services." 16VAC25-220-50.A.6.f states that "[t]his section does not apply to the following... healthcare support services not performed in a healthcare setting (.e.g., off-site laundry, off-site medical billing)..."

Presumably, the intent of the Amended Regulations was to have the Amended Regulations apply to "off-site" healthcare support services and the OSHA ETS apply to "on-site" healthcare support services. This result would require hospitals, health systems, and other healthcare employers to implement two different regulatory schemes by attempting to determine what it means to be an "off-site" healthcare support service. Furthermore, employees providing "off-site" services who enter a facility that would be considered "on-site" would be required to follow different procedures than in their usual workplace and would also be subject to the training requirements within the Amended Regulations *and* the OSHA ETS – among other duplicative or conflicting requirements making implementation of the Amended Regulations onerous and complex.

Similar to "off-site" healthcare support services, employees in "well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior

to entry and people with suspected or confirmed COVID-19 are not present” (16VAC25-220-50.A.6.d.) are not subject to 16VAC25-220.50. As a result, employees within the same facility could find themselves subject to the Amended Regulations in one workspace but would be subject to the OSHA ETS by simply walking to another section of the same facility.

We respectfully request that the Amended Regulations eliminate the confusion this would cause employers and employees by amending 16VAC25-220-10.B.1-3 and 16VAC25-220-50.A.1-3. to state that the Amended Regulations do not apply to hospitals or health systems rather than adopting the OSHA ETS definitions of “healthcare services” and “healthcare support services.” This would enable hospitals and health systems to develop employer-wide policies that are consistent among its work force and in compliance with the OSHA ETS in certain settings while adhering to the obligations placed on employers by the General Duty Clause of the OSH Act (29 U.S.C. § 654, 5(a)1) in settings not covered by the OSHA ETS. Hospital and health system employees would also have clear standards by which they are required to operate regardless of whether they happen to be “on-site,” “off-site,” or in a “well-defined hospital ambulatory care setting where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings” throughout the workday.

In addition to these overarching concerns, there are several technical issues with the regulations that we have previously commented on and that should be considered in this and any future rulemaking:

As noted in our public comment on the permanent regulations, infection prevention and control is a daily, ongoing focus within Virginia hospitals and health systems. Operating under the oversight of the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Virginia Department of Health (VDH), and various other accreditation and regulatory authorities, hospitals and our ancillary facilities are required to consistently demonstrate that their patients and staff receive and provide care in a safe environment. This includes development and implementation of comprehensive infection control plans, quality improvement programs, managing supply chain, training employees and caregivers, ensuring employees have the resources they need, planning for future health emergencies, and working with congregate care settings to institute strong infection control practices, among other activities.

In other words, infection prevention and control and ensuring the safety of our patients and employees are not a new focus for Virginia hospitals and health systems. They are

ingrained components of our daily operations. Imposing new and separate regulatory requirements, many of which duplicate the policies and protocols already in place within our facilities, will unnecessarily result in burdensome new compliance costs without meaningfully improving our ongoing efforts to protect our patients and employees. Consequently, we recommend that Subsection E of § 10 – which states that an employer in compliance with CDC publications regarding COVID-19 will be considered in compliance with the standard/regulation – be amended to acknowledge these requirements and explicitly state that hospitals, health systems, and other facilities under their control that are in compliance with the broader industry standards set forth by state and federal health care regulatory entities are deemed in compliance with the permanent regulation and not subject to enforcement actions for failure to comply with any specific requirement under the permanent regulation that is already addressed in these broader industry standards.

Subsection B.5 of § 40 prohibits employers from permitting known or suspected COVID-19 employees or others to report to or be allowed to remain at work. While the intent of this prohibition is clear, as a practical matter it is problematic to require ongoing monitoring of all employees who may be experiencing symptoms that are not visible without examination or inquiry. Furthermore, it is difficult or impossible to enforce where the employee or other person does not physically report to a facility or building under the surveillance and control of the employer as distinct from a teleworking arrangement. To address this, the prohibition could be limited to not “knowingly” permitting the employee to report to or be allowed to remain at work. Alternatively, the prohibition could be limited to those employees who report COVID-19 to the employer under Subsection B.3 of § 40.

The requirement in Subsection B.7 of § 40 is unnecessary and inappropriate to impose on employers. Those subcontractors and companies that provide contract or temporary employees are presumably subject to these regulations by virtue of being an employer in their own right and an upstream employer should not bear this burden. Furthermore, such encouragement is more appropriate coming from the Department.

Subsection B.7. of § 40 requires employers to notify their employees within 24 hours if an employee, subcontractor, contractor, temporary employee, or other person who was present at the place of employment within the previous 14 days tests positive for COVID-19. This requirement poses a challenge for hospitals. Given the inherently higher risk of exposure in the health care setting, notifying every employee of a hospital or health

system each time an employee tests positive will require an unreasonable level of ongoing notification. Even assuming a blast e-mail or similar broad communication meets the requirement, notifying every employee – clinical or non-clinical – upon a positive test of essentially anyone entering the facility within “2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test)” is unrealistic and could have Health Insurance Portability and Accountability Act (HIPAA) privacy implications.

In addition to our previous comments, several of the changes to the permanent regulations present new technical issues that we believe should be addressed in this and any future rulemakings:

Subsection C. of § 40 requires employers to “immediately remove” employees from a worksite if the employee has suspected or confirmed to have COVID-19. “Immediate removal” of an employee from a worksite may not be feasible in some circumstances. To address this issue, removal could be “immediately or, if circumstances present a danger to the employee or others, as soon as practicable.”

Subsection C.1. of § 50 require employers, to the extent feasible, to prescreen or survey each covered employee to verify the employee does not have signs or symptoms of COVID-19 prior to the commencement of each work shift. However, the Amended Regulations do not clearly define what it means to “prescreen or survey” each employee. The OSHA ETS resolves this ambiguity by defining “screen” to mean “asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19.” (29 C.F.R. 1910(b)) The OSHA ETS further addresses patient screening and management (29 C.F.R. 1910(d)) as well as employee screening (29 C.F.R. 1910(l)). Therefore, we recommend mirroring these sections of the OSHA ETS in the Amended Regulations to avoid any confusion regarding the required processes. Similarly, this recommendation would resolve the ambiguous use of “screen” in 16VAC25-220-50.A.6.c-e.

In closing, while COVID-19 may be the first pandemic in recent years to broadly impact the Commonwealth, Virginia’s hospitals and health systems deal with issues surrounding infection prevention and control, patient and workforce safety, and employee wellness on a daily basis. We have long-established policies and protocols governing these aspects of our operations and work closely with a variety of regulatory authorities to promote a safe care environment for our patients and our employees. Our utmost priority always has been and always will be the safety of our patients, visitors, employees, and the communities we serve.

The potential confusion surrounding whether the Amended Regulations or OSHA ETS apply to a workplace – or even to specific areas within a facility – as well as additional and duplicative requirements are unnecessary for hospitals and health systems and will have numerous burdensome and costly implications for them. Furthermore, the permanent regulations contain ambiguities that open hospitals and health systems to an uncertain and/or inconsistent interpretations by Department officials despite good faith efforts of hospitals and health systems to comply. We also continue to question whether the permanent regulation should be specific to COVID-19 and believe that any such regulation should only be in effect for the duration of the public health emergency or, at a minimum, contain an objective standard by which any such regulation would no longer be in effect.

Thank you again for the opportunity to comment on the permanent regulation. Please do not hesitate to contact Brent Rawlings (brawlings@vhha.com, 804-965-1228) or me at your convenience if we can provide any additional information regarding our suggested modifications.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sean T. Connaughton', with a long horizontal stroke extending to the right.

Sean T. Connaughton
President & CEO