VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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

September 25, 2020

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

Re: 16VAC25-220, Proposed Permanent Standard, Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, July 24, 2020.

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 Permanent Standard regarding Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 (hereafter referred to as the "permanent regulation"). Since early March, Virginia's hospitals and health systems have been on the frontline treating patients inflicted 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.

As the Commonwealth continues its important work to reopen businesses and jump start our economy, ensuring that workers across the state can return to their normal activities safely is critically important. However, we are concerned that the broadly applicable nature of the permanent regulation, as well as several specific provisions, will have burdensome and costly implications, at the same time as hospitals and health systems continue to care for COVID-19 patients, reopen facilities, and face mounting financial pressures.

We also 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. As proposed, the permanent standard would remain in effect in perpetuity, even when we are able to contain and offer effective treatment for COVID-19. Similarly, in the event of a few cases or a localized outbreak of a highly contagious disease that if more widespread might warrant a public health emergency on a statewide basis, the regulations should not be applicable and enforceable to an employer hundreds of miles away where there are no cases until such time as there is a recognized public health threat in the region.

As noted in our public comment on the emergency 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 G.1 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. Additionally, this subsection should be amended to explicitly state that hospitals and health systems that follow the CDC guidance pertaining to exposed healthcare workers returning to work will not be subject to enforcement actions under the permanent regulation.

Subsection B.6. of § 40 requires employers to ensure that their "sick leave policies are flexible and consistent with public health guidance…" While we have no doubt that this subsection is well-intended, we believe that requiring "flexible" sick leave policies is vague and presents an opportunity for broad interpretation that may expose employers to unnecessary and costly litigation. Furthermore, we believe that determinations regarding required sick leave are best left to employers allowing them to design more comprehensive policies that include sick leave along with other paid leave and child and caregiver support benefits that provide relief when employee absence or assistance for a family member is required due to illness. Even if consideration were made for a revision that requires employers to adhere to applicable federal and state law regarding sick leave, such a clause would be redundant and unnecessary. Therefore, VHHA recommends this subsection be removed in its entirety.

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.8. 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 a 14-day period is unrealistic and could have Health Insurance Portability and Accountability Act (HIPAA) privacy implications.

In addition to our above concerns, we respectfully request clarification as to the definition of "place of employment." "Place of employment" is ambiguous and could mean at the same facility or job site. The Department has clarified this text in its Coronavirus (COVID-19) FAQs to mean "work site." However, the use of "work site" is equally ambiguous and does not present a clear standard by which an employer is able to comply and achieve the intended purpose of this provision. To address this issue, VHHA recommends the Department provide greater clarification as to the parameters in which employers must report outbreaks, such as limiting the

definition of "place of employment" to specific units, floors, or offices as opposed to an entire facility.

Furthermore, we are concerned about the Department's response to reports of an outbreak. We have received a copy of a letter from the Department sent in response to a report of an outbreak indicating that the employer must conduct an internal investigation and report those findings to the Department. However, the provided "Non-Mandatory Investigative Tool" was more applicable to a slip and fall than an outbreak of a communicable disease and does not provide clear guidance as to the scope and extent of the investigation required. Therefore, VHHA recommends the Department adopt a form or specific criteria in the permanent regulations that detail the information required by the Department when an employer conducts an internal investigation of an outbreak. Furthermore, greater flexibility in the timeline for completion of the internal investigation would be helpful. It is critical that, in the event of an outbreak, resources are immediately directed towards mitigating further contraction of the disease and excessive reporting and investigation requirements may detract from these important activities.

Similar to our concerns with the ambiguity of the use of "place of employment," the definition of "Lower" contained within § 30 states that "[e]mployees in this category have minimal occupational contact with employees, other persons, or the general public…" "Minimal occupational contact" is undefined and does not provide clear guidance to employers seeking to comply with the permanent regulations.

Subsections B.1. and B.2. of § 40 include language that appears to permit employers to choose between strategies for determining whether an employee known or suspected to be infected with COVID-19 will be allowed to work, such as a symptom-based, test-based, or time-based strategy. However, the permanent regulations note in these subsections that determination of what test will be used is "depend[ent] on local healthcare and testing circumstances." The permanent regulations do not state who makes the determination whether "local healthcare and testing circumstances" would support the use of one strategy for allowing an employee to return to work over another. Furthermore, testing supply availability and turnaround time have continued to be an ongoing issue for healthcare providers. By requiring employers who lack knowledge regarding "local healthcare and testing circumstances" to choose between the return to work strategies that include a testing-based strategy, the permanent regulations could further strain an already broken supply chain. As such, we recommend that the text "depending on local healthcare and testing circumstances" be removed from the permanent regulations.

Subsection D of § 40 requires employers to ensure that employees observe physical distancing while on the job and during paid breaks on the employer's property. For large employers or for employers with expansive property or multiple staggered shifts, such an obligation may be impractical or impossible to enforce. VHHA recommends that this provision be modified to require that the employer "shall establish policies and procedures designed to ensure that employees observe physical distancing while on the job and during paid breaks on the employer's property." This creates a standard that allows the employer to monitor compliance where feasible, encourages reports of non-compliance, but does not apply "strict liability" to the employer in the event there is non-compliance despite reasonable efforts to prevent it.

Subsection B.6. of § 50 requires "employers use precautions associated with Biosafety Level 3 (BSL-3)…when handling specimens from [patients or persons] known or suspected to be infected with [COVID-19]." The Department's Coronavirus (COVID-19) FAQs provide greater specificity and correctly identify the ambiguity of this Subsection. The net effect of the FAQ is to indicate that the applicable standard for the job tasks identified as "high" and "very high" in performance of laboratory tests and specimen handling is BSL-2. As such, we respectfully request the Department specify that BSL-2 special precautions apply to those job tasks or otherwise incorporate the interpretation contained within the Department's Coronavirus (COVID-19) FAQs as they pertain to the BSL-3 special precautions.

Subsections C.1. of both §§ 50 and 60 require employers, to the extent feasible, to prescreen or survey each covered employee who is not COVID-19 symptomatic prior to each shift. Depending on the size of a hospital, a single shift could involve several hundred, if not more, employees. Some of those employees are clinical and treat COVID-19 patients, some are clinical and do not treat COVID-19 patients, and many others do not serve in clinical roles and are at minimal risk of exposure to infectious disease. Hospitals across the Commonwealth have already deployed numerous policies and protocols for screening health care workers that may be or have been exposed to COVID-19. Expanding those policies and protocols to every worker across a hospital or health system will substantially increase the burden on staff. This section should be amended to clarify that lower risk staff that do not serve in clinical roles and are at minimal risk of exposure to infectious disease are not required to be subject to the same screening requirements applicable to higher risk employees.

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.

We appreciate the intent behind the permanent regulation and believe that the Department should work with industries with less experience in infection control and prevention and fewer resources to help mitigate and prevent further community spread of COVID-19 in the workplace. However, for reasons discussed here, the 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 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.

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,

Sean T. Connaughton
President & CEO