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INSIDE

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OSHA's COVID-19 Regulation: Better Late Than Never

Lagging facilities must comply with codified CDC guidelines

By Gary Evans, Medical Writer

The Occupational Safety and Health Administration's (OSHA) emergency temporary standard (ETS)[1] to protect healthcare workers from COVID-19 is drawing mixed reviews. There certainly is a broad appreciation of OSHA's effort to protect healthcare workers, but the benefits of the ETS are somewhat mitigated by the fact that it comes 18 months into the pandemic. Many employees are now vaccinated.

"Unfortunately, the ETS is very late in the pandemic, to the point where many negative outcomes have already been experienced," says **Cory Worden**, PhD (ABD), MS, CSHM, safety advisor at the City of Houston Department of Health. "We will never know how many exposures could have been prevented had exposure prevention controls been implemented and enforced earlier in the pandemic."

Regarding enforcement, the ETS puts regulatory teeth into the CDC's recommended practices, some of which were politicized and undermined during the pandemic.

"Because this is an OSHA regulation, it mitigates the subjective risk assessments of some organizations that did not implement exposure prevention controls because they did not believe the pandemic to be a threat based on political opinions," says Worden, Region 2 Director for the Association of Occupational Health Professionals in Healthcare (AOHP).

> "UNFORTUNATELY, THE ETS IS VERY LATE IN THE PANDEMIC, TO THE POINT WHERE MANY NEGATIVE OUTCOMES HAVE ALREADY BEEN EXPERIENCED."

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OSHA's delay in issuing regulatory protections against COVID-19 is partly explained by the fact that it essentially required a change in presidential administrations. President Joe Biden issued an executive order on Jan. 21, calling for OSHA to take action to protect workers.

"Consider whether any emergency temporary standards on COVID-19, including with respect to masks in the workplace, are necessary, and if such standards are determined to be necessary, issue them by March 15, 2021," according to the executive order.[2]

However, OSHA did not issue the ETS until June 10. At a press conference, **Jim Frederick**, Acting Assistant Secretary of Labor for Occupational Safety and Health, said, "OSHA has determined the most impactful action we can take at this time is to issue an emergency temporary standard that is focused on healthcare settings where workers are most likely to come into contact with someone carrying the virus. This includes workers in hospitals, nursing homes, and other high-risk areas in healthcare settings."

OSHA determined healthcare workers are in "grave danger" from COVID-19 — a requirement for an ETS — but did not broach the controversial subject of vaccine mandates some hospitals are adopting. *(For more information, see related story in this issue.)* Hospitals and other facilities under the regulation are required to "provide reasonable time and paid leave for vaccinations and vaccine side effects."

In addition to hospitals and nursing homes, the standard applies to emergency responders, home healthcare workers, and ambulatory care facilities where suspected or confirmed COVID-19 patients are treated, according to an OSHA fact sheet on the standard.[3]

"The ETS exempts fully vaccinated workers from masking, distancing, and barrier requirements when in well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present," OSHA stated, in keeping with CDC guidelines.

However, in most situations involving patient care, it appears personal protective equipment (PPE) still is required even if healthcare workers are vaccinated.

Healthcare Workers Called OSHA

While essentially codifying CDC recommendations, Frederick warned OSHA will continue to respond to complaints of unsafe working conditions and conduct inspections to ensure compliance with the standard.

"Throughout the pandemic, healthcare workers in these settings continue to be the source of the highest number of complaints OSHA has received," he said. "We will continue inspections under our national emphasis program to hold bad actors accountable for failing to protect employees. When we open up an inspection, we are showing up to investigate."

In a provision protecting workers from retaliation, OSHA stated healthcare facilities must: "Inform employees of their rights to the protections required by the standard and do not discharge or in any manner discriminate against employees for exercising their rights under the ETS or for engaging in actions required by the standard."

The ETS requirements generally apply to all settings where any employee provides healthcare services or healthcare support services. "Our estimates are that there are approximately 10.3 million employees or workers in the establishments who will need to comply with the requirements of the standard," Frederick said.

OSHA posted a flowchart for employers who are unsure if the regulation applies to their facility or employees. "The ETS does not apply to the dispensing of prescriptions by pharmacists in retail settings, healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing), and telehealth services performed outside of a setting where direct patient care occurs," OSHA noted in the chart.[4]

All healthcare facilities with more than 10 employees must develop and implement a written COVID-19 plan that "includes a designated safety coordinator with authority to ensure compliance, a workplace-specific hazard assessment, involvement of non-managerial employees in hazard assessment and plan development/implementation, and policies and procedures to minimize the risk of transmission of COVID-19 to employees," OSHA stated.

The plan does not have to be in writing for facilities with 10 or fewer employees, nor do these small sites have to create a COVID-19 log. All others must establish a log of all COVID-19 cases in healthcare workers "without regard to occupational exposure," OSHA wrote. Employers also must report work-related COVID-19 fatalities and inpatient hospitalizations of workers to OSHA.

For organizations with a good safety and occupational health culture, most of the ETS requirements already should be in place this late in the pandemic, Worden says.

"For example, if an organization does not have an exposure prevention plan or even a hazard assessment, these will be needed quickly before the other controls can be implemented," he says. "Likewise, if an organization has not done due diligence to respiratory protection in the past, the now-urgent needs of the hazard assessment, medical evaluations, training, and fit testing will create a large to-do list."

In this sense, the COVID-19 ETS creates requirements for respiratory disease prevention with benefits beyond COVID-19.

"These same [requirements] are effective for other airborne transmissions, including influenza and tuberculosis," Worden says. "Ideally, COVID-19 exposure prevention will also help other disease exposure prevention efforts."

Single-Use N95s Are Back

Employees must "use respirators and other PPE for exposure to people with suspected or confirmed COVID-19, and for aerosol-generating procedures on a person with suspected or confirmed COVID-19," according to OSHA.

This requirement aligns OSHA with a recent call for a return to conventional single-use N95 respirators by the CDC and the FDA. *(For more information, see the June 2021 issue of* Hospital Employee Health*.)*

The longstanding recommendation by the CDC is to don a single-use N95 respirator (or comparable PPE) to care for a patient with a novel respiratory virus like COVID-19. However, an acute shortage of N95 masks occurred as the pandemic spread, and various contingency and reprocessing techniques were adopted.

In a "situational update" as of May 2021, the CDC stated, "The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices."[5]

The FDA wrote in a letter to industry that hospitals should begin phasing out reprocessing systems for single-use N95 respirators, as national supplies have been replenished and it is time to end the temporary crisis response to the pandemic.[6]

"With these workarounds, many interpreted this as legitimized 'permission' instead of a temporary [fix] due to pandemic circumstances," Worden says. "However, there are big caveats to these workarounds. [For example], the statements allowing [surgical masks] were due to N95 shortages, but not a change in the hazard analysis or risk assessment of the COVID-19 virus."

Likewise, the respirator reprocessing tactics for repeated use were "stopgap" measures until N95 stocks could be replenished. "It's important for there to be an emphasis on appropriate respirators so that the previous year's workarounds are not continued to be interpreted as long-term measures," Worden says. "With this ETS and actions taken by the current administration and many manufacturers to build production, organizations hopefully can now consistently procure NIOSH-approved respirators without emergency workarounds. From what I've seen and heard, I believe availability is much better than it was during 2020."

OSHA also made a technical requirement on ventilation, calling for HVAC systems to be used in accordance with the manufacturer's instructions and design specifications for the systems. Air filters must be rated Minimum Efficiency Reporting Value (MERV) 13 or higher if the system allows it. "If MERV-13 or higher filters are not compatible with the HVAC system(s), employers must use filters with the highest compatible filtering efficiency for the HVAC system(s)," the OSHA ETS noted.

This section also requires that "all air filters are maintained and replaced as necessary to ensure the proper function and performance of the HVAC system(s); and all intake ports that provide outside air to the HVAC system(s) are cleaned, maintained, and cleared of any debris that may affect the function."

However, in a note in the standard that might be open to some interpretation and discussion with OSHA inspectors, the ETS stated "this section does not require installation of new HVAC systems or AIIRs [airborne infection isolation rooms] to replace or augment functioning systems."

"Most hospitals already have [HVAC] ducts in place," says **Gabor Lantos**, PEng, MBA, MD, president of Occupational Health Management Services in Toronto. "There will be some requirement for redirection and isolation measures. It will require stronger fans to force the air through higher resistance of MERV-13 or higher HEPA filters."

Just bringing existing systems up to standard may create a compliance problem, as many healthcare HVAC systems vary widely by installation dates and technical specifications.

"While the benchmark in the past has been to optimize air filtration and circulation with the existing system, specific ETS specifications may require technical needs or maintenance needs, both of which possibly require personnel, costs, or both," Worden says.

The issue of airborne spread beyond aerosol-producing procedures has been somewhat contentious with COVID-19, recalling similar debates when SARS-CoV-1 struck in 2002-2003. The CDC recently said emerging science shows transmission of SARS-CoV-2 airborne viral particles can occur beyond six feet, particularly in enclosed, poorly ventilated spaces.

> "IN OUR GLOBALIZED WORLD, SINCE SARS-1, THERE HAS BEEN AN EPIDEMIC ABOUT EVERY FIVE YEARS. THIS TREND WILL MOST CERTAINLY CONTINUE."

This risk increases in "enclosed spaces with inadequate ventilation or air handling within which the concentration of exhaled respiratory fluids, especially very fine droplets and aerosol particles, can build up in the air space," the CDC reported.[7]

"I have been advocating for airborne precautions since SARS-1," Lantos says. "Of course, there will be costs, but tremendous benefits as well. How much has it cost society? How many lives have been destroyed physically, mentally, financially, by the transmission of COVID in nursing homes, hospitals, and workplaces, and by the consequent lockdowns? During SARS-1, Toronto was an absolute ghost town for weeks. How much did that cost?"

Will ETS Be Finalized?

The OSHA standard became effective upon its June 21 publication in the *Federal Register*. Employers must comply with most provisions within 14 days, but can take up to 30 days for requirements involving physical barriers, ventilation, and training.

The temporary standard also serves as a proposed permanent standard, at which point it is expected to be open to review and comment for six months before possible finalization. Some question whether finalizing a permanent standard for COVID-19 makes sense. The pandemic is expected to fade at some point as widespread vaccine availability increases globally. Some support the regulation in part because of the inevitable pandemic to follow.

"In our globalized world, since SARS-1, there has been an epidemic about every five years. This trend will most certainly continue," Lantos says.

The ETS could form the basis of some more general respiratory protection standard for healthcare, but that remains to be seen.

"The ETS has benefits and merits," Worden says. "Depending on the longevity of the COVID-19 virus, and pending a natural disappearance of the virus, the exposure prevention controls in the ETS will be useful. The need for exposure prevention of airborne-transmitted diseases will always be beneficial."

That said, the specific parameters and characteristics of airborne diseases differ in ways that could require

rethinking surface and airborne persistency and finding effective disinfectants.

"While the COVID-19 ETS contains principles and tenets that will be useful in the long term for all airborne-transmitted diseases, each organization will still need to analyze each [occupational] hazard and disease," Worden says. ■

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OSHA Publishes COVID-19 ETS with Tight Window on Comments

The Occupational Safety and Health Administration (OSHA), has published its Emergency Temporary Standard (ETS) to protect healthcare workers from COVID-19 as an interim final rule in the *Federal Register*, allowing only until July 21 to receive comments and feedback.

"As of May 24, 2021, over 491,816 healthcare workers have contracted COVID-19, and more than 1,600 of those workers have died," OSHA stated. "OSHA has determined that employee exposure to this new hazard, SARS-CoV-2 … presents a grave danger to workers in all healthcare settings in the United States and its territories where people with COVID-19 are reasonably expected to be present."[1]

The publication makes the ETS effective June 21, 2025. Upon publication, employers must comply with most provisions within 14 days, but can take up to 30 days for requirements involving physical barriers, ventilation, and training.

"[H]ealth effects are particularly relevant to healthcare workers because there is evidence that [they] are more likely to develop more severe COVID-19 symptoms than workers in non-healthcare settings," OSHA noted. "While the reason for this is not certain, one cause could be that healthcare workers are exposed to higher viral loads … because of the nature of their work often involving frequent and sustained close contact with COVID-19 patients."

ETS Will Prevent Infections

Comments and attachments, identified by Docket No. OSHA-2020-0004, can be submitted electronically at www.regulations.gov, the Federal e-Rulemaking Portal. All comments, including any personal information, are placed in the public docket without change and may be made available online at www.regulations.gov.

"The development of safe and highly effective vaccines and the ongoing nationwide distribution of these vaccines are encouraging milestones in the nation's response to COVID-19," the agency stated. "OSHA recognizes the promise of vaccines to protect workers, but as of the time of the promulgation of the ETS, vaccination has not eliminated the grave danger presented by the SARS-CoV-2 virus to the entire healthcare workforce. Indeed, approximately a quarter of healthcare workers have not yet completed COVID-19 vaccination."

In a cost-benefit analysis, OSHA projects the ETS will prevent 295,284 COVID-19 infections in healthcare workers and save 776 lives at a cost of $3.9 billion. ■

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Vaccine Mandates Gain Momentum

Court decision, EEOC language greenlight hospital mandates

A federal judge in Texas dismissed a lawsuit filed against Houston Methodist Hospital for mandating the COVID-19 vaccine for healthcare workers as a condition of employment.

The plaintiffs are appealing the dismissal, but the action sends a shot across the bow to healthcare workers and others who plan to challenge mandated COVID-19 vaccination programs in hospitals.

The hospital policy called for all employees to be vaccinated by June 7. The lawsuit was filed a little more than a week before that deadline. *(For more information, see the July 2021 issue of* Hospital Employee Health*.)* Filed by 117 unvaccinated employees, the lawsuit claimed Houston Methodist is "forcing an employee to participate in an experimental vaccine trial as a condition for continued employment."[1]

Arguing hospital employees were not allowed to refuse an experimental product, the suit compares the mandated immunization of American healthcare workers for COVID-19 to the medical experiments the Nazis conducted on unwilling volunteers. These atrocities led to the Nuremberg Code on Permissible Medical Experiments, which states "The voluntary consent of the human subject is absolutely essential," the plaintiffs noted.

In dismissing the case, Lynn Hughes, a federal judge for the Southern District of Texas, demolished the experimental vaccine claim and took the plaintiffs to task for bringing up the Holocaust to support their argument.

"The hospital's employees are not participants in a human trial," the judge wrote. "The hospital has not applied to test the COVID-19 vaccines on its employees. The Nuremburg Code does not apply because Methodist is a private employee and not a government. Equating the injection requirements to medical experimentation in a concentration camp is reprehensible."[2]

The ruling clarified that Texas law only protects employees from refusing to commit an act carrying criminal penalties to the worker. "Receiving COVID-19 vaccination is not an illegal act and it carries no criminal penalties," the judge ruled. "[Plaintiffs are] are refusing to accept inoculation that in the hospital's judgment will make it safer for their workers and the patients in Methodist's care."

EEOC Ruling Favors Mandates

Hughes also cited the recent position taken by the Equal Employment Opportunity Commission (EEOC), which said employers can require COVID-19 vaccination of employees with reasonable accommodations for exemptions and staying within existing antidiscrimination laws.

On May 28 — the same date the lawsuit was filed by employees of Houston Methodist for its COVID-19 vaccination mandate — the EEOC posted the opinion on its website.

"The federal Equal Employment Opportunity (EEO) laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEO considerations."[3]

Reasonable accommodations include allowing an appropriately exempted employee to wear a face mask, as has been done with flu vaccination in many facilities, the EEOC stated. Employees who are not vaccinated because of pregnancy may be entitled (under Title VII) to adjustments to keep working, if the employer makes modifications or exceptions for other employees. These modifications may be the same as the accommodations made for an employee based on disability or religion.

Employers that have instituted a vaccine requirement "may need to respond to allegations that the requirement has a disparate impact on — or disproportionately excludes — employees based on their race, color, religion, sex, or national origin under Title VII; or age under the Age Discrimination in Employment Act (40)," the EEOC stated.

Employers should keep in mind that some individuals or demographic groups may face greater barriers to receiving a COVID-19 vaccination. A mandate could negatively affect them.

"It would also be unlawful to apply a vaccination requirement to employees in a way that treats employees differently based on disability, race, color, religion, sex (including pregnancy, sexual orientation, and gender identity), national origin, age, or

genetic information, unless there is a legitimate nondiscriminatory reason," the EEOC concluded.

With the EEOC statement and the court decision, it appears healthcare facilities will survive challenges to mandate COVID-19 vaccine, says **Lawrence Gostin**, JD, O'Neill Chair in Global Health Law at Georgetown University.

"I have little doubt that healthcare institutions can require COVID-19 vaccinations of all staff," he says. "The fact that COVID vaccines are under an emergency use authorization does not matter. Hospitals still have the power to mandate vaccines as long as they provide appropriate — and narrow — exemptions for medical or religious purposes."

Many states have proposed bans against vaccine mandates by employers. As of this report, none had been approved. Most have gained little traction in state legislatures.

"A state can enact a statute that prohibits hospitals or other businesses from mandating vaccines," Gostin says. "It requires a statute and not just a governor's executive order." ■

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DC, Maryland Mandate Vaccine for Healthcare Workers

Hospital groups require COVID-19 immunization

Seventy-four hospitals in Maryland and Washington, DC, have announced they will mandate the COVID-19 vaccine for healthcare workers under conditions that may vary at individual sites.

"Maryland's 60 hospitals and health systems are committed to making the state's hospitals safe for every patient, every visitor, and every staff member," the Maryland Hospital Association (MHA) announced. "Each health system or hospital will set a date after which vaccination against COVID-19 will be a condition of employment, or contract engagement for non-employees who work at hospitals. Medical and religious exemptions will be determined by each health system or hospital."[1]

All hospitals will continue to require other infection control measures for COVID-19 as recommended by the CDC.

Rupali Limaye, PhD, associate scientist in infectious diseases at John Hopkins University in Baltimore, commented on the announcement at a June 9 webinar on vaccine hesitancy.

"Students have always been required to have the vaccine to come to campus in the fall," she said. "We just found out today that faculty and staff will also be required. There was a huge debate [on this]. For those of us who have been advising on this, I think it is a no-brainer. If you are going to have a safe campus and to really reduce the risk of community exposure, you have to require it in a way that is equitable."

Incentives rather than mandates will probably work better for the general public, she said, mentioning Washington state's "Joints for Jabs" program run by the state's Liquor and Cannabis Board.

"A less restrictive [approach] is going to be better for the public because that is more likely to engender trust," Limaye said. "However, mandates for those of us of who work on medical campuses [are appropriate]. We are already required to have flu vaccination to come on campus."

The MHA statement said approximately 70% of all Maryland hospital employees have been fully vaccinated, gaining protective benefits of immunization with few side effects.

The District of Columbia Hospital Association (DCHA) released a similar statement for its 14 hospitals, estimating a 70% immunization rate for healthcare workers and telling hospitals to pick a date to mandate the vaccine.[2]

The DCHA also issued implementation guidance with its consensus statement, calling for hospitals to begin developing a policy that includes a communication plan and addresses exemptions and other issues as summarized below.

• **Communication plan:** Meet in person with hesitant employee groups. Share facts behind the

science, safety, and efficacy of the COVID-19 vaccine. Conduct ongoing education sessions and town halls on the vaccine. Provide physicians, nurses, and pharmacists to speak one on one with employees who request more information via phone, text, email, or in-person.

• **Scope of policy:** Apply to all categories of healthcare workers, including employees, contractors, volunteers, medical staff members, students, vendors, and others. Delineate roles and responsibilities related to the implementation and management of the vaccination policy. Outline the consequences of noncompliance.

• **Considerations for new hires:** For example, new hires must provide evidence of vaccination. If unvaccinated, share a specific time frame for new employees to complete vaccination. ■

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The Joint Commission Issues Hospital Violence Prevention Standards

Effective next year, standards signal violence is no longer part of job

Effective Jan. 1, 2022, new and revised workplace violence prevention standards will apply to all accredited hospitals and critical access hospitals, The Joint Commission (TJC) recently announced.[1]

"According to U.S. Bureau of Labor Statistics data, the incidence of violence-related healthcare worker injuries has steadily increased for at least a decade," TJC stated. "Incidence data reveal that in 2018, healthcare and social service workers were five times more likely to experience workplace violence than all other workers — comprising 73% of all nonfatal workplace injuries and illnesses requiring days away from work."

As employee health professionals are well aware, workplace violence has traditionally been underreported and seen mistakenly by some as part of the job of dealing with patients. No more. In the sweeping re-evaluation of the healthcare system that is coming amid the COVID-19 pandemic, protecting valuable healthcare workers from patient attacks seems like an idea whose time has come.

"Exposure to workplace violence can impair effective patient care and lead to psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs," TJC noted. "The high incidence of workplace violence prompted the creation of new accreditation requirements."

These new and revised standards define workplace violence broadly, describing it as "an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

The new standards are summarized as follows (please consult the full TJC standards for details):

• **Environment of Care Standard EC.02.01.01:** "The hospital manages safety and security risks."

• **Requirement EP 17:** The hospital performs a worksite analysis annually to identify and resolve workplace violence, safety, and security risks.

• **Standard EC.04.01.01:** "The hospital collects information to monitor conditions in the environment."

• **Requirement EP 1:** The hospital monitors, reports, and investigates safety and security incidents, including those related to workplace violence.

• **Standard HR.01.05.03:** "Staff participate in ongoing education and training."

• **Requirement EP 29:** The hospital trains staff on workplace violence issues on hire, annually, and when changes to the program warrant re-education. This education should include roles of responsibilities of workers, de-escalation training, emergency response, and incident reporting requirements.

• **Standard LD.03.01.01:** "Leaders create and maintain a culture of safety and quality throughout the hospital."

• **Requirement EP 9:** Designate

an individual to lead a violence prevention program developed by a multidisciplinary team. This should outline the process for support of victims and witnesses of a violent incident who may require counseling. ■

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The Greatest Fear Healthcare Workers Have Faced

A new lethal virus appeared in the early 1980s

It began with the first five cases reported by the CDC on June 5, 1981.[1] What would become known as HIV/AIDS struck fear in healthcare workers (HCWs) possibly only rivaled by Ebola virus.

HCWs worked at mortal risk, with some dying after needlesticks or other sharps injuries that exposed them to patient blood. What was essentially a terminal diagnosis became treatable when the first antiretrovirals were developed in 1995-1996.

"Of the adults reported with AIDS in the United States through Dec. 31, 2002, 24,844 had a history of employment in healthcare," the CDC reported. "These cases represented 5.1% of the 486,826 AIDS cases reported to CDC for whom occupational information was known."[2]

At this time, the CDC reported 57 HCWs in the United States are documented as having seroconverted to HIV following occupational exposures via needlesticks, cuts, or mucocutaneous exposures. In addition, 139 other cases of HIV infection occurred among HCWs with no reported risk factors for infection and who reported a history of occupational exposure to blood, body fluids, or HIV-infected laboratory material. The difference in these cases is their HIV seroconversion after exposure was not documented.

Occupational HIV infections diminished sharply with the development of post-exposure prophylaxis, the effectiveness of universal/standard precautions, and safer sharps devices. Only 12 occupational HIV infections were documented by the CDC between 2003 and 2013.[3]

Going back to the beginning of the AIDS pandemic, the CDC reported gay men in New York and California with an aggressive cancer called Kaposi sarcoma.[4]

"The first U.S. cases in women were reported later that same year," CDC Director **Rochelle Walensky**, MD, MPH, said in an email statement. "Over the next five years, 29,000 cases of HIV/AIDS were reported in the U.S. With no effective treatment available for 15 years, death was the only certain outcome."

As a young physician, Walensky saw patients dying of AIDS when the medical community could provide little but supportive care.

"The epidemic raged in the halls of the hospitals and the streets of Baltimore where I worked," she wrote. "Fifty thousand people were dying each year. Then, we reached a turning point. In December 1995 and in 1996, the FDA authorized the first combinations of highly effective treatment. My message at the bedside changed: You can live."

No Vaccine

A constantly mutating retrovirus that attacks the immune system directly, HIV was isolated as the cause of AIDS in 1984. There was initial optimism that a vaccine could be developed, but it was not to be. The quest continues, with millions of dollars of research ongoing. The threat of HIV to healthcare workers remains to this day.

"HIV challenges the standard vaccine approaches first and foremost because, unlike diseases such as measles and chickenpox, no one naturally recovers from infection with HIV," researchers noted. "Without a model for natural immunity, researchers do not have a way to identify an immune response that would be effective against HIV, and thus developing an HIV vaccine is much more difficult."[5]

HIV incidence decreased by 73% in 2019 from the 130,400 reported in 1984, but about 70% of cases today are occurring in Black and Hispanic people, according to the CDC.

"The proportion of infections attributed to heterosexual contact

was higher in 2019 (22%) than in 1981 (2%)," the CDC reported. "[T]he proportion of infections among persons who inject drugs was lower in 2019 (7%) than in 1981 (22%)."[6]

"It is unacceptable that 37,000 people are newly diagnosed with HIV each year in the United States," Walensky wrote. "Disparities in diagnoses and access to treatment and prevention persist. More than half of new HIV infections are in the South, and new infections remain high among transgender women, people who inject drugs, and Black/African American and Hispanic/Latino gay and bisexual men."

The CDC has come a long way since that first 1981 report, when it described the five men as "active homosexuals" in the first sentence. Thus began the long-standing stigma against those with "gay cancer" or the "gay plague." This stigma further undermined the tepid federal response. It bears repeating the well-documented observation that then-President Ronald Regan did not say the word "AIDS" publicly until four years into the pandemic.

"This public health crisis triggered unprecedented activism that drove support for the thousands of people dying from the virus each year," Walensky said.

Much has been gained in research and treatment, but it is hard to see the glass half-full when there are about 34 million dead worldwide since that first report of five hospitalized men in Los Angeles. With the amazing effectiveness of antiretroviral therapies, people with HIV/AIDS can live long lives similar to their uninfected peers.

Still, in some sense, HIV remains much as it began: a story of the haves and the have-nots. Some infected people are living normal lives with almost complete viral suppression; others wither for the lack of that same treatment.

Monica Gandhi, MD, an HIV specialist at UC San Francisco, is passionate about the discrepancy between those who can access care and those who still die of AIDS, untreated.

"There are 38 million people living with HIV worldwide, and only 26 million of them have access to antiviral therapy," she says. "I know that is called a success — I call that a total failure. Knowing that in the world we have 12 million people who don't have HIV therapy that we have had since 1996 — I call that a massive failure."

There are great disparities in populations with infectious diseases, much as we are seeing now with COVID-19, Gandhi says. Even in the United States, where treatment is available, "the people who are doing poorly despite having access are those in overlapping pandemics of homelessness, mental illness, and now COVID," she says. "Those are a lot of the people I treat."

It is well to remember that driving the fear and stigma of HIV in the early 1980s was the lack of understanding about transmission routes. Some provocateurs said it was spread by casual contact, an unnerving consideration for what was then a terminal disease. With all the current discussion and controversy about the origins of SARS-CoV-2, note also that HIV has long been questioned as a man-made virus.

"Throughout the history of AIDS, that has been brought up multiple times in the context of oppression and racism," Gandhi says. "I have been studying AIDS a long time. No one has been able to create a virus."

These pandemic viruses arise out of nature, she says. This pattern is likely to continue as humans encroach on animal habitats or unsafely farm them in a time of rapid global air travel. HIV arose in Africa in the last century, and its natural reservoir is *Pan troglodyte* chimpanzees in Cameroon and the Republic of the Congo, researchers reported.[7] Slaughtered for bushmeat, these viruses — including related strains of simian immunodeficiency virus — in chimpanzee blood found their way into humans.

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Reassuring Vaccine-Hesitant Healthcare Workers

COVID-19 shots stood on the shoulders of giants

A common misperception that has led to vaccine hesitancy in healthcare workers and the public is the COVID-19 vaccines were produced with undue haste, seemingly coming out of nowhere to respond to the pandemic. The extensive scientific work with many other viruses that enabled the rapid development of the pandemic vaccines often is left out of the equation.

"The various vaccines present the spike protein to the immune systems in different way but with a common purpose: triggering the immune system to produce antibodies that neutralize the virus as soon as it is encountered, thereby preventing or limiting the infection," two research scientists explained in an article. "Decades of work, first on the corresponding HIV spike protein and then its counterparts from other viruses, including SARS, MERS, and seasonal coronaviruses, showed how best to design and produce the SARS-CoV-2 version."[1]

When people who are vaccine-hesitant cite this concern, it is important to remind them of the large clinical trials and the strong foundation of research that enabled a safe vaccine to be produced, **Christienne Alexander**, MD, associate professor at Florida State University College of Medicine, said at a recent webinar.

"Tens of thousands of people [were immunized or given placebo] before the vaccine was even authorized for emergency use," she said. "All of those people had to pass through the various phases of trials in order for the vaccines to reach emergency use authorization by the FDA."[2]

It is trickier to explain the connection of ongoing research to a vaccine for a novel virus, but Alexander told the vaccine-hesitant "they've been working on variations of this for coronavirus, and various other viruses for years."

Of course, in the absence of a pandemic, there was no need to develop such a vaccine, but it was credit to ongoing research that it could happen so quickly.

"People [also] have to realize that when there's a global pandemic, everything gets put on hold," Alexander explained. "This becomes the primary focus. This vaccine became the primary focus for everyone globally. When we talk about 'Well, why was it taking so long beforehand?' Well, because we were working on other things, other things were more important, but this [vaccine] became the most important thing for the health of the world."

To the inevitable protestation of not wanting to be a "guinea pig," Alexander sometimes tells the vaccine-hesitant, "Well, I've gotten it and many [other] healthcare workers have received it. If anybody's been a guinea pig, we were, as we went first. You can talk about it in lots of different ways so that the people that you're talking to have a better understanding of the [vaccine] process." ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **OSHA determined healthcare workers are in "grave danger" from COVID-19, which is a requirement to:**

   a. conduct an on-site inspection.
   b. order emergency production of respirators.
   c. issue an emergency temporary standard (ETS).
   d. levy fines on employers.

2. **In defending the need for the ETS, OSHA said approximately:**

   a. one-quarter of healthcare workers have not yet completed COVID-19 vaccination.
   b. half of healthcare workers are not wearing PPE properly.
   c. one-third of vaccinated surgeons are reverting to surgical masks for COVID-19 patients.
   d. six months from publication, the ETS will be reworked as general respiratory protection standard.

3. **In dismissing the suit against a hospital COVID-19 vaccine mandate, a federal judge said which famous human research ethics code does not apply in these cases?**

   a. Declaration of Helsinki
   b. Nuremberg
   c. The Belmont Report
   d. The Common Rule

4. **How many documented seroconversions to HIV infection following an occupational exposure were reported by the CDC between 2003 and 2013?**

   a. Zero
   b. 12
   c. 57
   d. 139

CE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative, and regulatory issues particular to the care of hospital employees affect healthcare workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.