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INSIDE

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OSHA Emergency COVID-19 Reg May Drive More Vaccine Mandates

'I think this pushes employers to require vaccine'

By Gary Evans, Medical Writer

Federal occupational health officials are being blasted for an Emergency Temporary Standard (ETS) requiring potentially labor-intensive changes to address a pandemic threat that is diminishing as vaccinations increase.

Designed to protect healthcare workers from COVID-19, the bulk of the ETS — particularly sections that relate specifically to SARS-CoV-2 — could be woefully out of date if growing mandated vaccination policies lead to immunizing virtually the entire hospital workforce against the pandemic virus.

"I hope there is an understanding that when you get people vaccinated some of these ETS requirements are not going to make sense," says **Connie Steed**, MSN, RN, CIC, director of infection prevention and control at Prisma Health in Greenville, SC.

The Occupational Safety and Health Administration's (OSHA) ETS was published in the *Federal Register* on June 21, 2021.[1] That means that employers must comply with most provisions within 14 days, but can take up to 30 days for requirements involving physical barriers, ventilation, and training. (*See* Hospital Infection Control & Prevention, *July 2021*). The ETS is in effect for six months, and OSHA requested comments by July 21, 2021, on whether it should become a final rule after that period.

Comments at the recent annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC), as well as those submitted to the *Federal Register*, found little to like about regulatory action this late in the pandemic. (*See* "*Comments to OSHA on ETS: 'Too Much, Too Late.'*")

"For me, the frustration is that this seems a little bit like too little too late," says **Ann Marie Pettis**, RN, president of APIC. "A lot of what is being

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recommended seems very much after the fact."

On its website, APIC encourages members to submit their own comments to amplify the voice of infection preventionists and provide input on the effect on their facilities. In a message sent to its members that likely will be part of its formal comments submitted to OSHA, APIC said it "is concerned that many parts of the ETS are not up-to-date with current scientific evidence or Centers for Disease Control and Prevention (CDC) guidelines, especially post-vaccination guidance."[2]

Provisions on screening patients and employees, physical distancing, and the use of barriers also need to updated to be consistent with current knowledge about SARS-CoV-2 transmission, APIC noted.

"This [ETS] could be temporary, and it could change again," Pettis says. "So, you spend all this time trying to implement this — and then is it going to change? There is a lot of frustration, a lot of work, and a lot of scrambling. You wonder just how much of this was advised by infection preventionists and epidemiologists."

Interim Final Rule

The ETS was published as an "interim final rule," meaning it has the potential to gain permanent status. Some question whether finalizing a permanent standard for COVID-19 makes sense, since the pandemic is expected to fade as widespread vaccine availability increases globally. In that regard, the ETS could form the basis of a more general respiratory protection standard for healthcare. 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, and this trend will most certainly continue," says **Gabor Lantos**, P.Eng, MBA, MD, president of Occupational Health Management Services in Toronto.

The OSHA delay in issuing regulatory protections against COVID-19 was caused, in large part, by the fact it essentially required a change in presidential administrations. President Joe Biden issued an executive order on Jan. 21, 2021, calling for OSHA to take action, if needed, to protect workers by March 15, 2021. The official ETS was published more than three months beyond that deadline, adding a level of exasperation to those tasked with implementing the requirements.

"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, Region 2 director for the Association of Occupational Health Professionals in Healthcare (AOHP). "We will never know how many exposures could have been prevented had exposure prevention controls been implemented and enforced earlier in the pandemic."

Steed was a little more blunt about the timing of the OSHA ETS.

"It's horrible — you couldn't have picked a worse time," she says. "If this had come out in March as President Biden requested — at that time we had a lot of COVID. But now it is a completely different picture. It's going to be really hard for organizations to apply this when our employees are seeing the public [without masks] with everything opened up. We have visitors who are resisting mask wearing in our hospitals."

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Comments to OSHA on ETS: 'Too Much, Too Late'

'A huge disappointment and unnecessary continued burden'

Some of the comments received by the Occupational Safety and Health Administration (OSHA) on its Emergency Temporary Standard, (ETS)[1] on COVID-19 in healthcare, include the following:

"This standard is too late. Healthcare facilities responded and served the public as well as possible for the past year and a half, and, once we got the pandemic stabilized, move[d] to mass vaccination processes since December. Now you are requesting to require written documentation and changes to processes that we utilized to survive the pandemic, i.e., increasing masking, screening of patients and visitors, and barrier requirements, at a moment where most healthcare organizations are starting to transition back. … I work in an organization that has a very high vaccination rate and yet some of the standards suggested in this proposal we may not meet, and at this point in our pandemic efforts [are] a waste of time and energy to a labor pool that has already gone above and beyond."

— **Deb Renner**, private citizen

"I am a pediatrician in a mid-sized private practice in Central Florida. … This is quite onerous. Several of the mandates are not entirely clear, further complicating the ability to implement them. After 16 months of providing a safe environment for our staff and patients and having zero cases of COVID among our staff from the workplace, I am now going to be held to a standard of having to pay employees who stay home, perhaps for weeks on end, while actively and currently struggling to fill open positions that no one wants since many are getting stimulus subsidies. … This timeline is much too short and will be unnecessarily challenging to implement. It is unclear why — when the vaccination numbers are rising, and cases are decreasing (especially compared to some past time periods) that there is such an urgency for implementation of something on this grand a scale. … We want to be safe for our patients, their families, our staff, and our families. We just need more time and more clarification, but especially more time."

— **Ayanna Rolette**, MD, private citizen

"I am a practice administrator of a pediatric office in Cary, NC. I supervise 29 individuals that provide pediatric primary care. Because we do not deny access to children with suspected/confirmed COVID-19 from treatment at our practice, the ETS applies to our workplace and our employees.

"I am concerned that this will reduce children's access to care. It is very easy to make the COVID ETS not apply to you if you simply refuse to see any child who might have COVID symptoms and instead refer them to the ER. … Finally, I feel that this is at least 12 months late in establishing. The pandemic is in drastic decline and 93% of my staff are vaccinated against COVID 19. I find this whole order to be too much, too late. It needs to be revoked immediately."

— **Michael Payne**, private citizen

"The Wisconsin Hospital Association (WHA) has received multiple comments from hospital leaders stating that the compliance steps to implement the OSHA rule will be viewed by healthcare workers as a huge disappointment and unnecessary continued burden on their daily jobs. After months of continuous mask wearing, daily screenings, social distancing, and other CDC recommended protocols, workers in healthcare settings, like workers in all industries, are ready for post-crisis normalcy. Unfortunately, just as other industries are removing COVID-19 restrictions and returning to work, implementation of the ETS will create new barriers to healthcare workers' return to normal, safe infection control practices. The ETS could also have the unintended effect of stymieing efforts to convince reluctant healthcare staff to receive a COVID vaccine. One key incentive for reluctant health are staff to be vaccinated has been the anticipation of a return to normal infection control procedures for vaccinated staff. Maintaining a more stringent standard that is different from CDC, removes that incentive."

— **Eric Borgerding**, WHA President & CEO

REFERENCE

1. 86 *Fed Reg* 32376 (June 21, 2021).

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Many of the basic measures, which are essentially codified CDC recommendations, already are in place at many hospitals, Steed says. Other requirements are more problematic, particularly since employee immunization seems to be largely irrelevant for most requirements.

"This standard talks about social distancing of all employees," she says. "It doesn't say only those [who] aren't vaccinated."

Hospital engineers have been consulted about building barriers in tight spaces where six feet of distance will not be possible between employees.

They also will assess the HVAC system, which the OSHA ETS requires be used and maintained in accordance with the manufacturer's instructions. Air filters must be rated Minimum Efficiency Reporting Value (MERV) 13 or higher if the system allows it.

"[Engineers] have to assess [initially] and we need to make sure that their ongoing plan of assessment is conducted with the filters etc.," Steed says. "I think hospitals in general have this under control, but we also have to make sure that our airborne isolation rooms are negative and that the pressure differential is checked."

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

"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 a similar debate when the original severe acute respiratory syndrome (SARS) struck in 2002-2003.

"I have been advocating for airborne precautions since SARS-1," Lantos says. "Of course, there will be costs, but tremendous benefits as well. 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?"

Elephant in the Room

The elephant in the room in all this comes back to COVID-19 vaccination of healthcare workers. OSHA requires that hospitals and other facilities under the regulation "provide reasonable time and paid leave for vaccinations and vaccine side effects." Beyond that, for the most part, those vaccinated essentially must follow the OSHA regulations as if they were not immunized.

"I didn't see anywhere in the standard where they say it is OK not to mask if you are vaccinated in a hospital," Steed says. "I think people are asking the question and what [OSHA] is saying is, 'If you have a controlled area in the hospital where you know there is not going to be anyone with COVID — and you know everybody is vaccinated — you can take off a mask."

Meeting those requirements without mandating staff vaccinations is going to be problematic.

"It's going to be hard. I think this pushes employers to require vaccine," Steed says, noting that she is not in favor of the ETS being finalized as written currently.

"I'm concerned about this standard," she says. "I believe employees have a right to be protected. Are we overdoing it a little bit? Because this is a droplet, aerosol disease. Are we going to keep people in masks, socially distanced, forever? That doesn't make sense to me. To be honest with you, requiring COVID vaccine for employees is the only reasonable way for organizations to survive."

While pointing out that approximately a quarter of healthcare workers have not yet completed COVID-19 vaccination — and it is duty bound to protect them — OSHA left the door open for revisions as the pandemic continues and more people are vaccinated.

"OSHA will continue to monitor trends in COVID-19 infections and deaths as more of the workforce and the general population become vaccinated and the pandemic continues to evolve," the ETS states.

In other words, widespread mandatory vaccination of healthcare workers could be a game-changer, unless OSHA wants to make the questionable argument that employees in hospitals with fully immunized staff still meet the "grave danger" threshold required for an ETS.

In that regard, hospital and healthcare systems all over the country, representing tens of thousands of employees, are announcing mandatory vaccine policies with limited medical and religious exemptions. Some are going into effect in the immediate future while other hospitals announced they will go into effect when the Emergency Use Authorization (EUA) on the vaccines is lifted by the Food and Drug Administration. However, a recent judicial ruling on a lawsuit showed that COVID-19 vaccine can

be mandated successfully even under EUA status.

Judge: Vaccines Not 'Experimental'

A federal judge in Texas threw out a lawsuit filed against Houston Methodist Hospital for mandating the COVID-19 vaccine for healthcare workers as a condition of employment. The dismissal of the suit is being appealed, 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, 2021, with the lawsuit being filed a little more than a week before that deadline. 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."[3]

Arguing that the hospital employees were not allowed to refuse an experimental product, the suit compared 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 lawsuit states. 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 citing the Holocaust to support their argument.

"The hospital's employees are not participants in a human trial," Hughes states in the dismissal ruling.[4] "… 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 employer and not a government. Equating the injection requirements to medical experimentation in a concentration camp is reprehensible."

The ruling clarifies 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 dismissal states. "[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."

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

The momentum for mandated shots only will increase with two other developments, the first of which was APIC's announcement at its recent conference that the association favored mandatory COVID-19 vaccination and wanted to support the hospitals that are beginning to implement it.

"As healthcare professionals, we have an ethical responsibility to protect those individuals entrusted to our care," Pettis said.

APIC also is joining the Society for Healthcare Epidemiology of America (SHEA) and other infectious disease groups in an upcoming joint position paper that is expected to endorse mandated COVID-19 vaccines as a condition of employment in healthcare.

David Henderson, MD, who represented SHEA at the APIC meeting, said, "All the vaccines we have right now are under emergency use authorization and there is language in the EUA document that says that you can refuse the vaccine. The lawyers tell us that, 'You can refuse the vaccine, but you can't work here.' We make a lot of vaccines conditions of employment and I am very hopeful that the whole country will embrace this, and it will become mandatory for healthcare workers." ■

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Treatment, Research Centers Trying to Solve Long COVID-19

'[Some patients] are suffering 16 months later with these symptoms'

Lingering COVID-19 symptoms in many patients may be the last and most insidious wave of the pandemic, since people who have been infected experience a prolonged, sometimes changing array of ill effects. The concern is that a subset of these cases will develop a kind of chronic COVID-19 that becomes a lifelong condition.

By definition, "post-COVID conditions" that continue more than four weeks are called long COVID, and a variety of other names, the Centers for Disease Control and Prevention (CDC) reports.[1] These include post-acute COVID syndrome, long-haul COVID, and, for research purposes: post-acute sequalae of SARS-CoV-2 infection (PASC). Standard case definitions still are being developed, but the signs and symptoms include respiratory struggles, fatigue, post-exertional malaise, poor endurance, "brain fog" or cognitive impairment, cough, chest pain, headache, palpitations, and tachycardia.

"Post-COVID conditions can occur in patients who have had varying degrees of illness during acute infection, including those who had mild or asymptomatic infections," the CDC states. "Medical and research communities are still learning about these post-acute symptoms and clinical findings."

One state-of-the-art program focusing on both treatment and research is at two Nuvance Health facilities in New York and Connecticut. **Sharagim Kemp**, DO, a primary care physician, is the coordinator of Nuvance's COVID-19 Recovery Program (CRP).

On virtually every front, there is more unknown than known about this malingering condition, but we asked Kemp to comment on her relatively new program on long COVID. She spoke with *Hospital Infection Control & Prevention* (*HIC*) in an interview that has been edited for length and clarity.

HIC: Are these long COVID patients considered infectious and are they treated in hospitals?

Kemp: All of our COVID Recovery Program (CRP) patients are outpatients. As far as what we know right now, these patients are not actively infectious. CRP patients are considered not infectious, as they are several weeks out from their initial diagnosis and early onset of their first symptoms. We also always defer to our infectious disease experts, who are part of our CRP program, if there is ever a question as to a patient's status. And we offer telehealth appointments.

In general, we screen all patients — not just [CRP] patients — for signs of infection, including fevers, and all of our facilities maintain social distancing and masking protocols. Physicians especially have appropriate gear when it comes to any type of patient care.

HIC: More and more healthcare workers are getting vaccinated. Do you recommend COVID-19 vaccine to people who are experiencing these long-haul symptoms?

Kemp: We do. Interestingly enough, in the unified data we have seen, individuals who get vaccinated are actually having some resolution of their symptoms. Can we explain why? Not with certainty. It could have to do with the immune response in general — maybe a different immune response that overrides what is already occurring.

Of the patients I see in New York, approximately 75% have noted some improvement in their symptoms after vaccination. Not complete resolution — but improvement. I would recommend long haulers get vaccinated if they have no underlying issues with getting vaccinated in general.

HIC: When was your program founded and how it is structured?

Kemp: We launched our program in March 2021. We have two sides to our system, one in Connecticut and the other in New York. Up until the time that we launched it, we were not doing marketing. We were doing a very small introduction to the process.

Now we have about 100 patients enrolled, and we are trying to ramp up marketing to increase exposure. We really wanted to get a sense of building the program first.

In January 2021, we all came together as a group and put together many different individuals to create a multidisciplinary approach to care. We have a very robust group of specialists who are all directors in their fields — psychology, neurology, pulmonary, critical care, cardiology. All of these individuals have stepped up to create this program, which has a primary care physician at its base.

HIC: Does that mean the primary care provider refers out to the specialists?

Kemp: There are lot of different approaches to recovery of post-COVID syndrome or long haulers. The primary care physician who is doing [this type] of COVID recovery is an individual who is well-read in the area, has had a lot of experience, and has dealt with all the nuances. This primary care provider deals with COVID and COVID only. We make sure the primary care physician is in the loop the entire time. We make sure to create access to care by providing and offering inpatient appointments that are primary care within the system. [If referred to the CRP], the patient comes into what we call a "circle of care." The pivotal point of the circle is the patient. All of us involved work together to create the best comprehensive program vs. sending the patient to [outside] specialists, where they have to wait for the appointment and then wait for any results to come back. I am in primary care myself and I am very aware of how tasking that process can be for a patient who is already feeling ill. We take that out of their hands. We make the appointments, do the follow-up, and do all those little things that a primary care office might not have the time for and the patients themselves may not have the energy or the will to do. Our directors of their respective programs have dedicated the time in their schedules to see these patients within two weeks, which is unheard of when you seek a specialist.

HIC: Are there any breakthroughs yet in treatment of this condition?

Kemp: What is interesting about this process is that it was born out of research. COVID recovery programs came to be because of the need to have a localized place where all this research comes in and all these data [are] filtered through. I wish I had a magic bullet. I don't. What I do have are comprehensive care plans that seem to be working better.

I am the COVID Recovery Program lead for the system, but I am also the primary care physician seeing the patients at the New York [facility]. I am taking that on myself simply because I want to be able to create the best possible experience for the patients. I have been in primary care for close to 20 years. What I have found is really the art of medicine is listening to individuals; we have hour-long visits where we examine everything from head to toe. A lot of times patients are just grateful and appreciative — not to say that their own doctors wouldn't want to do that. It's just impossible in today's world in a clinical setting. We spend that hour so that we can identify factors that can influence their health.

HIC: Can you give some examples of the care you are delivering?

Kemp: Some of the things we are working through is the neurology piece in dealing with brain fog. These patients may need ancillary physical therapy or occupational therapy (PTOT) where we teach them how to adapt their energy expectations. It is a big broad concept, but a lot of times what is happening with people with COVID is they are pushing themselves to get better. It's a natural phenomenon — as human beings we are going to push ourselves to get better. Unfortunately, with COVID the harder you push, the harder it pushes back. We literally retrain individuals. You know the concept of zero to 60. We actually go back from 60 to zero. We teach them they need to slow it down with breathing exercises, how to increase exercise tolerance, and to improve muscle energy reserves. A lot of these variables are in a whole-person holistic approach. There are defined articles and data out of Europe and large U.S. centers where these individuals use specific healing therapies that will teach them to retrain their bodies to do something as simple as going up and down three flights of stairs without being winded.

HIC: What percent of total COVID-19 case are estimated to develop long-term COVID, fitting the CDC definition of symptoms beyond four weeks?

Kemp: There [are] a lot of different data out there. The European models initially estimated 10% of [infected cases]. But this [condition] is a very underestimated. At the height of COVID, we had anywhere from 40% to 60% of individuals who would have at least one lingering symptom.

What I would say in my experience with COVID since day 1 — and I have been dealing with this since day 1 — is at the low end of percentages, one out of 10 will experience some type of lingering symptoms. The severity of that symptom may be fatigue, insomnia — may be the milder versions. I estimate [overall] that I am seeing closer to 30% to 40% of individuals who are experiencing lingering symptoms. Now whether or not they are seeing that as a debilitating symptom is very different. We are not telling everybody you are a long hauler and you need to be in this program. Remember, time is sometimes the best healer.

HIC: So even with the low estimate of 10%, with some 34 million cases reported in the United States as of mid-July, there could be several million people with long haul COVID. Has a natural endpoint for the condition been established yet, or can symptoms continue indefinitely?

Kemp: The data [are] still evolving and that is part of our research. The most important part of our program is that we provide integrated services, ancillary services, PTOT, massage, acupuncture. The other part of it is research. You don't have to be a part of research, but if our patients want to be, we tell them we appreciate it and we might learn things like is this going to be a condition that lasts? I've seen patients who had COVID day 1, when this country shut down, and are still having symptoms. I have also seen patients who had COVID six weeks ago and are still having symptoms. Our timeline is only since the pandemic began. Because of this, we have to be patient with all the data. But, unfortunately, there are individuals who are suffering 16 months later with these symptoms.

HIC: Do you think it will be necessary to have many programs like yours and special clinics for these long COVID patients even after the pandemic has ended?

Kemp: I hope not. I hope we are going to help these patients. I think, unfortunately, we are going to have a subset of those who are going to be suffering just like we have seen with chronic Lyme [disease], chronic pain, and chronic fatigue. There is going to be a group of individuals who will always need this multidisciplinary approach, and as the research evolves, hopefully we will be able to nail down very specific treatment plans. Remember, our treatment plans are specifically for the patient. We don't have general treatment where everybody is treated the same, nor do we have [standardized] medication. Not only will this be the wave of the future, it will also be the wave of healthcare to a certain extent; dealing with individuals who are experiencing disease states that are considered chronic and not treatable. ■

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Major Medical Groups Call for OSHA to Delay COVID-19 Regulation

Postpone at least six months and extend comment period

Many of the nation's leading medical groups are calling for the Occupational Safety and Health Administration (OSHA) to delay its Emergency Temporary Standard (ETS) on COVID-19 by at least six months and to extend the comment period.

OSHA's ETS to protect healthcare workers from COVID-19 became effective with publication in the *Federal Register* on June 21, 2021.[1] That means that employers must comply with most provisions within 14 days, but can take up to 30 days for requirements involving physical barriers, ventilation, and training. (*See* Hospital Infection Control & Prevention, *July 2021*). The ETS is in effect for six months, and OSHA requested comments by July 21, 2021, on whether it should become a final rule after that period.

Comments gleaned from the OSHA docket show few making that argument, with private citizens and prestigious organizations alike essentially saying OSHA was late in intervening and now demands immediate compliance from those regulated.

"Healthcare facilities need time to thoughtfully review this rule and understand the requirements and to request and receive clarification where needed," said the Association of American Medical Colleges (AAMC).

Asking for a six-month delay and an extension of the comment period for 30 days, AAMC stated, "As our members continue to respond on the front lines of the COVID-19 pandemic, we are concerned that it will take significant effort and divert resources for teaching hospitals to review this complex ETS, provide meaningful feedback to OSHA on provisions, … and make any necessary changes to comply."

A non-profit group, the AAMC represents all 155 accredited U.S. medical schools. It is affiliated with more than 400 teaching hospitals and health systems, including those in the Department of Veterans Affairs.

"Compliance with this rule will require academic medical centers, and all healthcare facilities, to make modifications to their hospital policies and procedures, and

undertake structural changes to their facilities, such as creating physical barriers," the AAMC stated.

Increased Risk?

The American Hospital Association (AHA), representing about 5,000 facilities, made a similar request, saying "changes in hospital policies and procedures are not simply a matter of changing words on paper; they require careful analysis and planning, the acquisition of needed materials and tools, and the retraining of personnel. For organizations that are already busy caring for their communities' ill and injured, it will take time to accomplish all of these required changes."

The AHA cited ETS requirements that actually could increase risk, including barrier requirements that could impede airflow.

"Our members also are unsure how they will implement the provisions in the mini respiratory protection standard that permit employees who are not required to wear respirators to bring their own into the hospital," the AHA said. "Moreover, this provision will allow employers to provide respirators to employees who are not required to wear them, and without the benefit of fit testing, medical evaluation, or a written program. Many of our members have noted that these requirements, which contradict OSHA's own PPE (personal protective equipment) and respiratory protection standards, raise huge liability exposures for the employer and put these employees at additional risk."

> 'CHANGES IN HOSPITAL POLICIES AND PROCEDURES ARE NOT SIMPLY A MATTER OF CHANGING WORDS ON PAPER.'

The National Association for Behavioral Healthcare (NABH) echoed the other requests, saying mental health facilities and addiction treatment centers have been hit hard by the pandemic.

"[They] continue to experience increased need for their services as indicated by the dramatic increase in drug overdose deaths over the past year and continued elevated levels of anxiety and depression and suicidal ideation," the NABH said. "In addition, behavioral healthcare providers across the United States are struggling to hire staff to address this increased need for treatment services. Shortages of behavioral healthcare providers were already widespread before the pandemic. Nearly one-third of the U.S. population lives in mental health provider shortage areas."

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 14,500 nonprofit and proprietary skilled nursing facilities and skilled assisted living communities.

"Long-term care has been hit extremely hard by this pandemic and continues to confront substantial staffing challenges," the AHCA/NCAL said. "While many of these standards are already in place in our provider's communities, some of the new standards require a level of resources that many centers do not currently have available and will take extended time to fully implement. For example, designating a COVID-19 workplace safety coordinator is challenging for small or independent facilities with limited resources staffing-wise as well as financially due to census impacts from COVID-19." ■

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Annual Costs of MDRO Infections: $5 Billion

Investment in prevention could offset costs

With healthcare systems across the nation focused on the COVID-19 pandemic, other priorities have largely gone by the wayside, including the formidable and longstanding problem of multidrug-resistant organisms (MDROs). Difficult to treat with the existing formulary, these bacteria beset hospitalized patients with costly infections that have high morbidity and mortality.

A paper published recently quantifies the costs of these infections, finding that it costs $30,998 (range: $25,272 to $36,724) to treat methicillin-resistant *Staphylococcus aureus* (MRSA) infections. The price goes up considerably for MDROs that respond to few antibiotics. For example, carbapenem-resistant (CR)

Acinetobacter costs $74,306 (range: $20,377 to $128,235) for treatment.

"What's interesting is that on a per-infection basis, CR-*Acinetobacter* infections are extremely high-cost, but the sheer prevalence of the MRSA infections made those the biggest driver for overall costs," says lead author **Richard Nelson**, PhD, a professor of healthcare economics and infectious diseases at the University of Utah School of Medicine in Salt Lake City. "At a population level, the MRSA infections are extremely expensive."

The goal of this large research study was to generate national-level estimates of the economic burden of drug-resistant infections in the United States.

"Treatment of these infections cost an estimated $4.6 billion ($4.1 billion to $5.1 billion) in 2017 in the U.S. for community- and hospital-onset infections combined," Nelson and colleagues concluded.

The staggering price tag raises the inevitable question of how much money could be saved with fully staffed infection prevention programs and antibiotic stewardship programs.

"Putting a dollar amount on these negative outcomes that these patients incur is a way to show the value of the resources that could be used [for prevention] and treatment," Nelson says. "Those resources could be very valuable if we prevented these infections."

Neil Clancy, MD, who was not an author of the paper, commented on the costs of MDROs.

"The patients that are most vulnerable, either in the community or the hospital, to these types of highly resistant pathogens are ones in whom costs accumulate quite rapidly," says Clancy, an infectious disease physician at the VA Pittsburgh Health System. "These are ICU (intensive care unit) patients, transplant, and other immunosuppressed patients. It really puts it in stark terms. On the one hand it is costs, but on the other [it shows] how investment up front to tackle these infections actually can be quite cost-effective."

This is also a clear message from the COVID-19 pandemic: Investing in preparation for an infection disease event costs a lot less than when its consequences are unleashed.

"If these things emerge and start causing big problems, that money up front can save money and lives down the road," he says. *Acinetobacter* is a good example of a bug that really can be controlled by infection prevention, he says.

"We see an awful lot of *Acinetobacter* infections associated with respiratory tract and burn infections in ICUs," Clancy said. "A number of the respiratory tract infections are associated with ventilators. A lot of these are down to just scrupulous infection prevention with ICU patients — care of burns and wounds, managing the ventilator and respiratory tract."

Lacking this level of care, expensive outbreaks can occur.

"*Acinetobacter* tends to get into ICUs and cause outbreaks where a number of patients get infected — often due to infection prevention lapses," Clancy said. "Tightening up infection prevention is what breaks the outbreak. These are relatively small investments in the grand scheme of the $5 billion investment for the costs of these [infections] in the paper."

Many aspects of medical care are being rethought as the coronavirus pandemic exposed gaps and wasted resources in healthcare. In that regard, Clancy was asked if this thought of investing in prevention could take hold: preventing MDROs before they can harm patients and drive up costs.

"I would hope so, but the track record in the U.S. for long-term attention to problems after they quiet down a bit isn't necessarily the greatest." ■

REFERENCES

1. Nelson RE, Hatfield KM, Wolford H, et al. National estimates of healthcare costs associated with multidrug-resistant bacterial infections among hospitalized patients in the United States. *Clin Infect Dis* 2021;72:S17-S26.

ID Groups Call for Mandatory COVID Vaccination of Healthcare Workers

'We, as a group of societies, feel that this is the right thing to do'

The nation's leading infectious disease groups have issued a joint paper recommending COVID-19 vaccination as a condition of employment for healthcare workers, with limited exemptions.[1]

The broad consensus adds considerable momentum to the mandate movement, and now it may be only

a matter of time before universal COVID-19 immunization of employees will be the standard across healthcare.

This consensus statement was issued by the Society for Healthcare Epidemiology of America (SHEA), the Society for Post-Acute and Long-Term Care Medicine (AMDA), the Association for Professionals in Infection Control and Epidemiology (APIC), the HIV Medicine Association (HIVMA), the Infectious Diseases Society of America (IDSA), the Pediatric Infectious Diseases Society (PIDS), and the Society of Infectious Diseases Pharmacists (SIDP).

"The bottom line is that we, as a group of societies, feel that this is the right thing to do for our communities, patients, and healthcare providers," lead author **David Webber**, MD, said at a press conference. "We have a precedent for doing this for other [occupational] diseases. We believe the benefits of the vaccine for our healthcare providers far outweigh any possible harm, and we strongly endorse this statement."

As has been seen with seasonal flu shots, optimal vaccination rates are unlikely to be reached without making immunization a condition of work, the paper observed.

Delta Variant Concerns

Representing SHEA, Webber said the rapidly emerging Delta variant of SARS-CoV-2 also underscores the importance of vaccinating healthcare workers and the public in general.

"It is much more transmissible and has a higher risk of hospitalization," he said. "The most rapid spread is occurring in those states with the highest percentage of unvaccinated people. There [are] good data that the mRNA vaccines continue to provide protection against hospitalizations, but a little less protection against illness. This is the time to be pushing vaccination to the general public and our healthcare providers as well."

The group did not specify the methods of establishing mandatory programs, but said it was time to start outlining COVID-19 vaccination requirements, while both talking and listening to healthcare workers.

Healthcare leaders must consider both requiring the vaccine and how to operate the policy. "Approach this process in a respectful, thoughtful, and inclusive manner and apply the principles of diversity, equity, and inclusion," said **Rekha Murthy**, MD, a member of the SHEA board.

On the legal questions of mandating a vaccine that is approved under Emergency Use Authorization, the consensus paper states, "an individual has a right to refuse vaccination, but has no right to a particular job." We still are early in the process, but this "condition of work" approach has been approved in at least one court ruling. A key is allowing for specific exemptions to vaccination for medical and religious reasons.

"A medical exemption is based on contraindications and precautions set forth by the manufacturer or CDC (Centers for Disease Control and Prevention) and usually requires review and signature by a medical professional," the consensus paper states. " … While not a contraindication, healthcare facilities may wish to allow pregnant [healthcare workers] to postpone receipt of the vaccine until post-delivery. …Pregnant and lactating HCP (healthcare personnel) should be allowed to receive a vaccine because, as noted by the CDC, 'pregnant and recently pregnant people are more likely to get severely ill from COVID-19 compared to non-pregnant people.'"

For religious exemption requests, employers could use a form allowing objectors to detail their sincerely held beliefs and practices, the panel suggested. "While affiliation with a traditionally organized religion may be evidence to support a claim of a sincerely held religious belief, the lack of such an affiliation cannot be the basis for rejecting an exemption request," the consensus paper states.

Benefits and Boosters

Full vaccination against COVID-19 confers several advantages to healthcare workers, including self-protection and preventing transmission to patients and coworkers who may be contraindicated for the vaccine or less immune responsive. Another key benefit — perhaps the most persuasive to healthcare workers — is that vaccination can protect the family members they come home to. The consensus statement also supports COVID-19 vaccination of non-employees in a healthcare facility, such as students, contract workers, and volunteers.

"Given the short duration of immunity to seasonal coronaviruses after infection and the speed with which disparate viral variants with mutated spike proteins are emerging, at some point in the future, a booster may be required for waning immunity and/or improved coverage for emerging variants," the authors note.

Similarly, it important to specify that persons who have had COVID-19 should still be vaccinated. If a healthcare facility decides that a mandatory policy is not possible at

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the present time, it should ensure healthcare workers continue to be educated about the vaccine and be given convenient opportunities to get immunized at no personal cost, the panel noted.

"If minimal adequate coverage (e.g., greater than 90% based on minimum influenza vaccination rates) is not achieved within a reasonable time period (e.g., one to three months), the facility should implement a policy of requiring COVID-19 vaccination as a condition of employment," the paper concludes. ■

REFERENCE

1. Weber DJ, Al-Tawfiq J, Babcock H, et al. Multisociety statement on COVID-19 vaccination as a condition of employment for healthcare personnel. *ICHE*. Cambridge University Press. Published July 13, 2021. https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/multisociety-statement-on-covid19-vaccination-as-a-condition-of-employment-for-healthcare-personnel/690D1804B72FFF89C5FC0AED0043AD62

CME/CE QUESTIONS

1. **Which of the following is one of the thresholds the Occupational Safety and Health Administration (OSHA) must meet in its assessment of whether employees warrant an Emergency Temporary Standard (ETS)?**

   a. There is no vaccine available.
   b. The hazard has a high fatality rate.
   c. Workers are in grave danger.
   d. There is the potential for violence in responding to the threat.

2. **By definition, long COVID, also known as post-acute sequalae of SARS-CoV-2 infection (PASC), is defined by symptoms that continue beyond what time period?**

   a. Four weeks
   b. Six weeks
   c. Three months
   d. Six months

3. **Sharagim Kemp, DO, coordinator of Nuvance Health's COVID-19 Recovery Program, said vaccinating long COVID patients:**

   a. has no perceivable effect.
   b. worsens symptoms in many patients.
   c. is not possible because they are contraindicated for COVID-19 immunization.
   d. causes many to have improvements in symptoms, but not complete resolution.

4. **The American Hospital Association said which of the following provisions of the OSHA emergency COVID-19 standard could increase risk?**

   a. Allowing vaccinated workers to not wear masks in treating patients
   b. Allowing outdated HVAC systems to remain in place if they meet manufacturer's instructions
   c. Barrier requirements that could impede airflow
   d. Requirements that men with beards wear N95s that are not fit tested