UNDERSTANDING OSHA'S NEW COVID-19 EMERGENCY TEMPORARY STANDARD AND WHAT IT NOW REQUIRES HEALTHCARE EMPLOYERS TO DO TO MINIMIZE EXPOSURE RISKS

Hodgson Russ OSHA Alert
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On June 10, 2021, the Occupational Safety and Health Administration ("OSHA") released a new COVID-19 Emergency Temporary Standard ("ETS") targeting the healthcare industry and aimed at protecting healthcare workers from COVID-19 exposures. OSHA hasn't exercised its emergency regulatory powers in nearly four decades, after its 1983 emergency temporary standard on asbestos was struck down by the courts.

The new COVID-19 ETS requires healthcare employers to develop and adopt a written COVID-19 plan covering numerous topics, such as hazard assessments, methods to minimize transmission risks, screening and management of patients and employees, PPE and respiratory requirements (including perhaps a Mini Respiratory Protection Program), environmental and ventilation changes, employee training, cleaning and disinfection, employee removal and return-to-work procedures, and new record-keeping and disclosure obligations. The ETS affords healthcare employers only fourteen to thirty days following its publication in the Federal Register to come into compliance. Notably, the ETS sets a floor for federal compliance, but local and state mandates may go beyond OSHA's requirements, provided they are not inconsistent.

While many healthcare employers may already have adopted practices and protocols based on CDC, health department, or local government requirements or guidance that address certain elements of the now OSHA-required COVID-19 plan, they may not have been written or formalized in the ways now required by OSHA. Perhaps more importantly, the ETS contains several entirely new requirements not previously the subject of OSHA guidance materials, and which will necessitate considerable investment of time, effort, and money by healthcare employers to develop and implement on a very short timetable. The new ETS incorporates various CDC guidance materials by reference, which will likely evolve over time. Therefore, the COVID-19 plan will necessitate continuous monitoring and updating to keep the plan current, and requires appointment of a responsible coordinator charged with

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that responsibility.

Key components of the ETS and COVID-19 plan requirements are outlined below. Healthcare employers should evaluate the ETS and its definitions carefully to ensure compliance with all the subtleties and nuances, which cannot be captured fully in an overview of this nature.

What healthcare employers are covered by the ETS?

All employment settings where an employer provides "healthcare services" or "healthcare support services." For purposes of the ETS, these are defined terms.

"Healthcare services" mean services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: hospitalization, long-term care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. For the purposes of this section, healthcare services include autopsies.

"Healthcare support services" mean services that facilitate the provision of healthcare services. Healthcare support services include patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.

Are there any types of healthcare employers or circumstances excepted from the scope of the ETS?

Yes, but few. These excluded situations include: the provision of first aid; dispensing of prescriptions by pharmacists; non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter; well-defined hospital ambulatory care settings where all employees are fully vaccinated and non-employees are screened upon entry and people with suspected or confirmed COVID-19 are not permitted to enter; home healthcare settings where employees are fully vaccinated and non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present; healthcare support services not performed in a healthcare setting; and telehealth services performed outside of a setting where direct patient care occurs. Employers should consult the specific definitions in the ETS defining these various types of services.

In addition, in well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, certain PPE, social distancing, and cleaning/disinfecting protocols otherwise required by the ETS will not be applicable to fully vaccinated employees.

What does "screen" and "fully vaccinated" mean?

For purposes of the ETS, "screen" means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19. "Fully vaccinated" means two weeks or more following the final dose of a COVID-19 vaccine.

How must employers adopt and administer their COVID-19 Plan?

Each covered healthcare employer must develop and implement a COVID-19 plan for each workplace, and that plan must be written if the employer has more than 10 employees. The employer must designate one or more "safety coordinators" who are knowledgeable in infection control principles and practices, as applicable to the workplace, to implement and monitor the plan. The safety coordinator(s) must be identified in the written plan, and must be given the authority to ensure compliance.

What is a healthcare employer required to do as part of its COVID-19 plan?

(1) Conduct work-place specific hazard assessments to identify potential COVID-19 workplace hazards.

(2) Seek input and involvement of non-managerial employees and their representatives in the hazard assessments and the development and implementation of the plan.

(3) Monitor each workplace to ensure ongoing effectiveness of the plan and update as needed.

(4) Address the hazards identified by the hazard assessments in order to minimize the risk of transmission of COVID-19 for each employee through: patient screening and management; standard and transmission-based policies; personal protective equipment ("PPE"); controls for aerosol-generating procedures; physical distancing; physical barriers; cleaning and disinfection; ventilation; health screenings and medical management of employees; supporting vaccination; and employee training.

(5) Effectively communicate and coordinate with other employers where different employers share the same physical location, and adjust the COVID-19 plan to address hazards presented by other employees and giving of notice to the other employer of employee exposures to conditions that do not meet the requirements of the ETS.

(6) Develop procedures to protect employees who enter private residences or other locations not covered by the Occupational Safety and Health Act.

(7) Inform employees of the anti-retaliation and anti-discrimination protections and rights afforded by the ETS for engaging in actions required by the ETS or exercising their rights of protection under the ETS.

(8) Develop and implement new COVID-19 log and procedures required by the ETS, continue recording of work-related COVID-19 positive cases on the OSHA 300 log, and report work-related COVID-19 fatalities and in-patient hospitalizations.

What Standard and Transmission-Based Precautions must employers implement in their COVID-19 plans to minimize employee risk?

Healthcare employers are required to adhere to Standard and Transmission-Based Precautions in accordance with CDC's "Guidelines for Isolation Precautions."

What must the COVID-19 plan address with respect to patient screening and management in a direct patient care setting?

The employer must limit and monitor entry points, except as it relates to emergency responders or other licensed healthcare providers. Employers must screen and triage all clients, patients, residents, delivery people, visitors, and non-employees entering the setting. Telehealth should be encouraged to limit the number of people entering the worksite. Healthcare employers must also implement other applicable patient management strategies in accordance with the CDC's "COVID-19 Infection Prevention and Control Recommendations."

What kind of screening or employee reporting of COVID-19 symptoms must a healthcare employer require of its employees?

Employers must screen employees daily before each shift, which may be performed in-person or through self-monitoring. Any COVID-19 tests used for screening must be provided at no cost to the employee.

Employers must require employees to promptly report both COVID-19 positive tests and instances where the employee is told by a licensed healthcare provider that he/she is suspected to have COVID-19. Employees must also report recent loss of taste and/or smell with no other explanation, or when the employee is experiencing both fever above 100.4° F and new unexplained cough with shortness of breath. Note that the symptom list is not the complete list of CDC-identified COVID-19 symptoms.

Are healthcare employers required to notify employees of workplace exposures to positive COVID-19 persons in the workplace?

Employers must notify the following persons within 24 hours of the employer being notified that a COVID-19 person has been in the workplace: (1) each employee who was not wearing a respirator and any other required PPE and had been in close contact with the COVID-positive individual; (2) all other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace in which that person was present during a potential transmission period; and (3) other employers whose employees were not wearing respirators and any other required PPE and have been in close contact with the person or worked in a well-defined portion of a workplace in which that person was present during the potential transmission period. These notice requirements, however, are not triggered by the presence of a COVID-positive patient in a workplace where services are normally provided to suspected or confirmed COVID-19 patients.

For purposes of the ETS, "close contact" means being within 6 feet of any other person for a cumulative total of 15 minutes over a 24-hour period during that person's potential period of transmission. The "potential transmission period" is two days before the person felt sick (or two days prior to test specimen collection for an asymptomatic individual) until the time the person is isolated.

The above notices must specify the date(s) of contact, but may not include any employee's name, contact information, or occupation.

When must a healthcare employer impose a "medical removal" on an employee due to a positive COVID-19 test or possible exposure?

Medical removal of an employee is immediately required for employees who test positive until they meet return to work ("RTW") criteria. Employees who have been told by a licensed healthcare provider that they might be positive, or who give their employer notice of experiencing reportable symptoms, must be immediately removed until they either satisfy the RTW criteria or have a negative COVID-19 polymerase chain reaction ("PCR") test. Note that employers may, for purposes of removal and testing, choose to expand the reportable symptom list to include additional symptoms from the CDC list that are not included as required reporting triggers in OSHA's ETS.

Where an employer gives notice to an employee due to a close contact, the employee must be removed for 14 days, unless (a) the employee is not experiencing reportable symptoms, and has been fully vaccinated for more than two weeks, (b) had COVID-19 and recovered within the past 3 months and is not experiencing reportable symptoms, or (c) receives a negative COVID-19 test result. Such test must be administered at least five days after the exposure. If the result is negative, the employee may return no earlier than seven days after the exposure.

If an employee refuses a COVID-19 test, the employer must keep the employee removed from the workplace until he/she meets the RTW criteria, and the employer is not obligated to pay medical removal benefits. However, absent undue hardship, reasonable accommodation must be made for employees who cannot take the test for religious or disability-related medical reasons.

Whenever any employee returns to the workplace after having been removed, the ETS prohibits any adverse actions against the employee relating to such removal.

Must the employer pay an employee who must be removed from the workplace under this COVID-19 ETS?

Where the employee is permitted to work remotely or in isolation, the employer must continue the employee's regular pay and benefits until the employee meets the RTW criteria.

The ETS also requires employers with more than ten employees to pay employees "medical removal protection benefits," which consists of their regular pay and benefits, up to $1,400 per week, unless the employee meets RTW criteria or refuses to be tested for COVID-19. For employers with less than 500 employees, that amount is reduced beginning in the third week of removal to two-thirds of the regular pay and benefits, up to $200 per day.

The employer's payment obligation, however, is reduced by compensation the employee receives from any other source, such as a public- or employer-funded compensation program (e.g, paid sick or administrative leave benefits), for lost earnings.

What RTW rules must a healthcare employer follow under the ETS?

OSHA requires employers to make RTW decisions following a medical removal based on guidance from a licensed healthcare provider or CDC's "Isolation Guidance" and "Return to Work Healthcare Guidance."

Is a facemask now a form of PPE, or otherwise defined differently, for purposes of the COVID-19 ETS and plan?

The ETS lists facemasks under the PPE heading. A facemask, however, is now a defined term that does not include home-sourced cloth masks or similar items. A facemask is "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as medical procedure masks."

Employers must provide, and ensure that healthcare employees are wearing, facemasks while indoors and when occupying a vehicle with others for work purposes. A sufficient number of facemasks must be available to employees, and employees must be required to change them at least once per day, or more frequently if soiled, damaged, or otherwise necessary. In some instances, a "face shield" without facemask may be used in settings presenting infection control concerns, as determined by the employer. Where face shields are used, the employer must ensure they are cleaned and inspected for damage at least daily.

Facemasks must be worn at all times, except as follows: when an employee is alone in a room; while eating and drinking, absent barriers between individuals or staying six feet apart; when wearing other respiratory protection; when necessary to see a person's mouth, provided an alternative such as a face shield is used; when the employee cannot wear a facemask due to medical necessity, medical condition, a disability defined in the Americans with Disabilities Act, or due to religious beliefs; or when the use of the facemask would present a hazard of serious injury or death, provided the employee wears an alternative and maintains at least a six foot distance from others.

What respiratory protection and PPE is required for employees with suspect or confirmed COVID-19 exposure?

In cases of suspected or confirmed exposure to COVID-19, employers must provide gloves, isolation gown or protective clothing, eye protection, and at least a filtering facepiece respirator. An N95 respirator may be used, but employers are encouraged to select elastomeric respirators or powered air-purifying respirators ("PAPR") to minimize impacts on N95 supply chains. The same PPE requirements apply during aerosol-generating procedures, but the encouragement to select elastomeric respirators or PAPR in that setting is presumably for better protection.

Employers must provide any required respirators in accordance with 29 C.F.R. 1910.134, which means that the employer must also follow the requirements of that regulation and implement an appropriate respiratory protection program with all required elements.

Healthcare employers are also required to provide protective clothing and equipment to each employee pursuant to Standard and Transmission Based-Precautions, in accordance with CDC's "Guidelines for Isolation Precautions."

Are there other requirements that must be addressed in the COVID-19 plan with respect to potential exposures during aerosol-generating procedures?

In addition to PPE requirements, the employer must ensure that aerosol-generating procedures performed on persons with suspected or confirmed COVID-19 are conducted in an airborne infection isolation room ("AIIR"). The employer must limit the number of employees present for the procedure to those essential for patient care and procedure support. When the procedure is completed, the employer must clean and disinfect the surfaces and equipment in the AIIR, room, or area where the procedure was performed.

What is a Mini Respiratory Protection Program and when do healthcare employers need one as part of their COVID-19 plan?

The Mini Respiratory Protection Program ("MRPP") is a type of partial respiratory protection program that does not require medical evaluation, fit testing, or a written program. It requires only the elements of seal checks and training. It is somewhat similar to the voluntary use concept set forth for general industry in 29 C.F.R. § 1910.134, but the MRPP is applicable only to the limited circumstance where respirators are being used in a healthcare setting where not required, and in place of a required facemask, to provide additional comfort and protection to healthcare workers.

If an employer permits employees to provide and use their own respirators where not required, the employer must now provide employees with a specific notice regarding the hazards of wearing a respirator, the specific content of which is set forth in the ETS.

An employer may also provide respirators (including N95 filtering facepiece types, elastomeric, or PAPR) for voluntary use to employees, except to individuals who were previously disqualified from respirator use on medical fitness grounds. Providing respirators triggers training requirements associated with donning, wearing, using, removing, storing, maintaining, and cleaning the respirator. And the employer will be required to ensure that employees perform, and are trained to perform, a seal check each time the respirator is used. The employer must ensure that any voluntary use of a respirator be discontinued when the employee or supervisor reports medical signs or symptoms related to the ability to use the respirator. The employer must also develop policies and procedures governing the reuse and storage of used filtering facepiece respirators, if applicable, and cap their re-use at a maximum of five days.

What are the requirements for physical distancing and barriers between employees in a healthcare setting?

Physical distancing of at least six feet while indoors must generally be maintained, unless infeasible for a specific activity (e. g., hands-on medical care) or momentary exposure (e.g., passing in a hallway or aisle).

When a six-foot distance cannot be maintained, physical barriers must be installed and located to block face-to-face pathways between individuals at each fixed work location outside of direct patient care areas, such as in the entryway, lobby, check-in desks, triage, hospital pharmacy windows, and billing/payment areas. Cleanable or disposable solid barriers must be installed, unless the employer can demonstrate infeasibility.

Are there any specific cleaning and disinfection requirements for healthcare settings under the ETS?

The CDC's standard practices for cleaning and disinfecting as set forth in its "COVID-19 Infection Prevention and Control Recommendations" and "Guidelines for Environmental Infection Control" must be followed with respect to patient care areas, resident rooms, and medical devices and equipment.

In other areas, all high-touch surfaces and equipment must be cleaned daily. Where a COVID-19 positive individual has been in the workplace within the prior 24 hours, the employer must follow the CDC's "Cleaning and Disinfecting Guidance" to clean and disinfect any areas, materials, and equipment that have likely been contaminated by that person.

Are healthcare employers being required to install new HVAC systems or AIIRs as part of the ETS or COVID-19 plan?

No, the focus is on maximizing existing operational capability, and the ventilation portion of the ETS applies to those healthcare employers who own or control the building or structure in which they operate. For those meeting that criteria, the employer must ensure that the following actions are undertaken:

(1) The HVAC system is used in accordance with the HVAC manufacturers' instructions and design specifications;

(2) Outside air changes per hour are maximized to the extent appropriate;

(3) Use Minimum Efficiency Reporting Value ("MERV") 13 air filters, or in non-MERV 13 compatible systems, filters with the highest compatible filtering efficiency;

(4) Air filters are maintained and replaced as necessary;

(5) All fresh air intakes are cleaned, maintained, and cleared of debris;

(6) AIIRs are maintained and operated in accordance with design and construction criteria;

(7) Consider other measures to improve ventilation in accordance with "CDC's Ventilation Guidance."

What specific COVID-19 training must be provided to employees under the ETS?

Training of employees must be employer-specific, and in a language and literacy level that the employee understands. The required subject matter for training encompasses the following topics:

- COVID-19, including signs and symptoms, how the disease is transmitted, importance of hand hygiene, reducing risk through proper covering of the nose and mouth, risk factors for severe illness, and when to seek medical attention.
- Policies and procedures on patient screening and management.
- Tasks and situations in the workplace that could result in COVID-19 infection.
- Policies and procedures to prevent the spread of COVID-19 as applicable.

- Multi-employer workplace agreements related to infection control policies, use of common areas, and use of shared equipment.
- Policies and procedures for wearing PPE, including when PPE is required; PPE limitations; how to properly put on, wear, take off, care for, clean, store, maintain, and dispose of PPE; and any modifications when PPE is worn to address other workplace hazards.
- Policies and procedures for cleaning and disinfection.
- Policies and procedures for health screening and medical management of employees.
- Identity of the safety coordinator(s).
- The temporary, emergency COVID-19 ETS itself.
- How to obtain copies of the COVID-19 plan and any other COVID-19 policies and procedures.
- Informing the employee of anti-retaliation, nondiscrimination, and whistleblower protections of the ETS for exercising any rights thereunder.

The ETS provides that employers may rely upon pre-ETS training to the extent it meets these requirements. But clearly some elements of training are specific to this ETS, necessitating additional training. Re-training of employees must also occur where there are changes in the workplace that change an employee's risk of contracting COVID-19, policies or procedures are changed, or there is an indication that the employee has not retained necessary understanding or skill.

All training must be overseen or conducted by a person knowledgeable in the subject matter as it relates to the employees' job duties, and the training must provide an opportunity for interactive questions and answers with such a person.

Have the record-keeping obligations related to COVID-19 changed or been clarified?

Healthcare employers must now establish and maintain a new COVID-19 log on which to record all instances where employees have COVID-19 positive test results, whether or not the instance is connected to a workplace exposure. The log entry for each employee must be completed within 24 hours of the employer learning that the employee is COVID positive. The log must contain at least the following information: employee name, one form of contact information, occupation, work location, last date of work, date of positive test or diagnosis of COVID-19, onset date of one or more symptoms (if any).

The employer must maintain the COVID-19 log while the ETS is in effect and treat it as a confidential medical record subject to non-disclosure. Employers with more than 10 employees are also required retain copies of all versions of their COVID-19 plans prepared pursuant to the ETS.

An employee (or a person with written authorized consent of the employee) may request a copy of his/her own entry on the COVID-19 log. And any employee or their personal or authorized representatives may request all versions of the COVID-19 plan or a version of the COVID-19 log that removes the employee names, contact information, and occupations. Documents must be produced to the requesting individual by the end of the next business day. And any or all records required to be maintained under the ETS must be made available to the Assistant Secretary of Labor upon request

on the same timetable.

Employers must also still record work-related COVID-19 cases on their OSHA 300 logs and report work-related COVID-19 fatalities (within eight hours of learning of the fatality) and in-patient hospitalizations (within 24 hours of learning about the in-patient hospitalization). Presumably, employers are to refer to prior OSHA guidance on how to determine work-relatedness, as the ETS does not address those issues.

Is OSHA requiring healthcare employers to vaccinate all employees?

No. Employers, however, must support COVID-19 vaccination and afford reasonable time and paid leave to employees to obtain vaccinations, including any side effects of the vaccination.

When does the ETS become effective, and what is the deadline for healthcare employers to become compliant with the new ETS?

OSHA initially released the ETS in non-final form. The ETS will become effective upon its publication in the Federal Register. Employers will be required to be in compliance with the ETS within 14 days of that publication, except those provisions relating to the installation of physical barriers, ventilation/HVAC requirements, and completion of employee training. Employers must become compliant with those three elements of the ETS within 30 days of publication.

All written comments, including as to whether the temporary emergency standard should become a final rule, must be submitted by interested parties within 30 days following publication in the Federal Register.

Where can a healthcare employer obtain help on understanding the ETS and developing and implementing the COVID-19 plan and COVID-19 log?

OSHA has created a website (https://www.osha.gov/coronavirus/ets) with some resources, including a COVID-19 log and links to CDC guidance and other documents incorporated by reference.

If you have additional questions about OSHA's new temporary COVID-19 ETS, require compliance assistance developing a plan, or have other OSHA-related concerns pertaining to COVID-19, please contact Jason Markel (716.848.1395), Glen Doherty (518.433.2433), or Charles H. Kaplan (646.218.7513).