Friday, June 11, 2021

On the morning of June 9, 2021, the White House Office of Management and Budget’s Office of Information and Regulatory Affairs (OIRA) announced it completed its review of the Occupational Safety and Health Administration’s (OSHA) Emergency Temporary Standard (ETS) for COVID-19. At a hearing later that day before the U.S. House of Representatives Education and Labor Committee, Secretary of Labor Marty Walsh told legislators that OSHA expected to release the ETS by June 10, 2021, and that it would be confined to the healthcare industry. All other industries would receive updated “strong guidance” on safely protecting unvaccinated workers.

On June 10, 2021, OSHA published, on its website, the COVID-19 ETS, as well as the updated guidance for all other industries. We cover the updated guidance in a separate article.
The COVID-19 ETS for the Healthcare Industry

**Compliance deadlines**

The COVID-19 ETS is located at 29 C.F.R. §§ 1910.502-509. The ETS goes into effect immediately upon publication in the *Federal Register* (expected to be on June 14, 2021). Compliance deadlines go into effect as follows:

- 14 days after publication in the *Federal Register*:
  - COVID-19 plans (1910.502(c));
  - patient screening and management (1910.502(d));
  - standard and transmission-based precautions (1910.502(e));
  - personal protective equipment—which includes “facemasks” (1910.502(f));
  - aerosol-generating procedures on a person with suspected or confirmed COVID-19 (1910.502(g));
  - physical distancing (1910.502(h));
  - cleaning and disinfection (1910.502(j));
  - health screening and medical management (1910.502(l));
  - vaccination (1910.502(m));
  - anti-retaliation (1910.502(o));
  - requirements implemented at no cost to employees (1910.502(p));
  - recordkeeping (1910.502(q));
  - reporting COVID-19 fatalities and hospitalizations to OSHA (1910.502(r));
  - mini-respiratory protection program (1910.504);

- 30 days after publication in the *Federal Register*:
  - physical barriers (1910.502(i));
  - ventilation (1910.502(k); and
  - training (1902.502(n)).

**Scope**

The ETS “applies to all settings where any employee provides healthcare services or healthcare support services.”
The ETS defines “healthcare services” as:

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.”

Specifically excluded from the scope provision are:

1. “the provision of first aid by an employee who is not a licensed healthcare provider;

2. the dispensing of prescriptions by pharmacists in retail settings;

3. 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 those settings;

4. well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;

5. home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present;

6. healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); or

7. telehealth services performed outside of a setting where direct patient care occurs.”

So how does a healthcare employer determine how an employee is fully vaccinated? The ETS does not say, but the preamble does:

In order to make the determination of which workers are fully vaccinated, employers could, for example, vaccinate their workforce themselves; review CDC [U.S. Centers for Disease Control and Prevention] vaccination cards or similar verification issued by a pharmacy, healthcare provider, or other vaccinator; if available, review state-issued passes; or simply ask workers to attest whether they have been fully vaccinated. If the employer is not able to determine that an employee is fully
vaccinated, the employer must treat that employee as not fully vaccinated. (Emphasis added.)

**COVID-19 Plans**

Healthcare employers must develop and implement COVID-19 plans for each worksite. COVID-19 plans may be developed by workplace type, rather than by individual workplace, so long as all required site-specific information is included in the plan.

Plans must be in writing if the employer has more than 10 employees. Plans must also designate one or more COVID-19 safety coordinators, who will ensure compliance with the plan, and “must be knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations.”

Plans must include worksite-specific hazard assessment to identify COVID-19 hazards, must address the hazards identified by the assessment and include policies and procedures to minimize the risk of COVID-19 transmission for each employee, provide effective communication with other employers, and where applicable, protect employees who, in the course of their employment, enter into private residences or other physical locations controlled by a person not covered by the Occupational Safety and Health (OSH) Act of 1970.

Plans need not delve into the minutiae of protection for each employee; instead, plans may do so generally, presumably by job title and type for workers with substantially similar duties and roles.

If an employer wishes to take advantage of certain exemptions for fully vaccinated workers, the plan must also include policies and procedures for determining an employee’s vaccination status. Plan development must include “input and involvement of non-managerial employees and their representatives” (e.g., the union steward).

The ETS notes that OSHA, on its website, provides model plans, which suggest use and implementation of OSHA’s model plan will meet the compliance requirements of this provision.

**Patient screening and management**

Healthcare employers must generally limit and monitor points of entry into locations where direct patient care is provided. Employers must screen and triage all clients, patients, residents, delivery people and other visitors, and other non-employees entering the premises. OSHA also requires employers to adhere to the CDC’s “COVID-19 Infection Prevention and Control Recommendations.”

**Standard and Transmission-Based Precautions**

According to the ETS, employers must also develop and implement policies and procedures to adhere to the CDC’s “Guidelines for Isolation Precautions.”
“Facemask” Requirements

Healthcare employers must provide “facemasks” (essentially, surgical masks) to their employees for indoor use and when occupying a vehicle for work purposes. The ETS defines “facemask” (also known as “medical procedure masks”) to mean 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.” One facemask per person is not enough, according to the ETS; employers “must provide a sufficient number of facemasks to each employee . . . and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (e.g., patient care reasons).” According to the ETS, facemasks must be worn over the nose and mouth.

The ETS provides several exemptions to the facemask requirement, such as when an employee is alone in a room, eating or drinking (but still maintaining physical distancing), when an employee is wearing a respirator, when an employee needs to communicate with a deaf or hard-of-hearing individual (in which case OSHA suggests the temporary use of face shields), when an employee cannot wear a facemask due to a medical condition or disability or due to a religious belief, and when use of a facemask presents a hazard to an employee of serious injury or death (e.g., arc flash, heat stress, or interfering with the safe operation of equipment). In such situations, the ETS requires employees to use alternative protection (such as a face shield), if conditions permit. According to the ETS, employees must resume wearing a facemask when no longer engaged in the activity where the facemask presents a hazard.

Any employee not wearing a facemask must physically distance at least six feet away from all other individuals, unless the employer can demonstrate it is not feasible to do so.

Personal Protective Equipment (PPE) requirements

Employees exposed to individuals with suspected or confirmed COVID-19 (including when aerosol-generating procedures are performed) must wear respirators (such as an N95 respirators or greater protection) in accordance with the provisions of OSHA’s respiratory protection standard (29 C.F.R. § 1910.134) and, at a minimum, gloves, isolation gowns or protective clothing, eye protection, and any other PPE required by the CDC’s “Guidelines for Isolation Precautions.” For aerosol-generating procedures on a person suspected or confirmed with COVID-19, OSHA encourages the use of elastomeric respirators or powered air-purifying respirators (PAPR) instead of N95 respirators and other filtering facepiece respirators.

The “Mini Respiratory Protection Program”

The ETS’s mini respiratory protection program provisions are triggered in one of two ways:

1. Healthcare employers can opt to provide employees with respirators in lieu of facemasks; or
2. Healthcare employers must also permit employees to wear their own respirators instead of facemasks.

The mini respiratory protection program is detailed at 29 C.F.R. § 1910.504. When triggered, it requires healthcare employers to provide to applicable employees a notice with instructions on respirator use (for which the ETS provides the necessary text), conduct a user seal check, and provide brief training for each applicable employee. The provision includes details on the circumstances under which a respirator may be reused and when employers must discard and replace respirators.

Physical Distancing Requirements

The ETS requires employees to maintain six feet of distance from other individuals at all times, except where it is not feasible to do so and for people in movement (e.g., passerbys in hallways). When six feet of distancing is not feasible, employers must ensure employees physical distance from others as far as possible.

Physical Barriers

The ETS mandates the use of physical barriers “[a]t each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance.” Unless “the employer can demonstrate it is not feasible” to do so, “the employer must install cleanable or disposable solid barriers,” which must be appropriately sized and located to “block face-to-face pathways between individuals based on where each person would normally stand or sit.” Barriers may have a pass-through space at the bottom. Physical barriers are not required in direct patient care areas or resident rooms.

Cleaning and Disinfection

For patient care areas, resident rooms, and for medical devices and equipment, the ETS requires employers to implement and follow the CDC’s “COVID-19 Infection Prevention and Control Recommendations” and pages 86–103 and 147–149 of the CDC’s “Guidelines for Environmental Infection Control.”

In all other areas, healthcare employers must clean high-touch surfaces and equipment at least once per day, provide alcohol-based hand rub that is at least 60 percent alcohol, or provide readily accessible handwashing facilities.

Ventilation

Healthcare employers must ensure that their HVAC systems: are used in accordance with manufacturer’s instructions and their design specifications; use air filters rated Minimum Efficiency Reporting Value (MERV) 13 or higher, if the system allows it; and have intake ports that are cleaned and maintained. Airborne infection isolation rooms must be maintained and operated in accordance with their design and construction criteria.
Health Screening and Medical Management

With regard to health screenings and medical management, healthcare employers must do the following:

- “The employer must screen each employee before each work day and each shift. (Asking employees to self-monitor is fine.)
- Employers must provide employer-required testing at no cost to employees (but employers are not required to conduct screening testing).
- “The employer must require each employee to promptly notify the employer when the employee” is COVID-19 positive, suspected of having COVID-19, or experiencing COVID-19 symptoms.
- Employers must notify applicable employees within 24 hours when a person who has been in the workplace is COVID-19 positive.
- Employers must follow requirements for removing workers from the workplace.
- Employers must decide to return employees to work in accordance with guidance from a licensed healthcare provider or specified CDC guidance.

Paid Leave Requirements

Employers with more than 10 employees must provide “medical removal protection benefits,” which largely entitle removed employees to paid leave, in most circumstances. The ETS instructs healthcare employers to provide removed employees “benefits to which the employee is normally entitled,” and “must also pay the employee the same regular pay the employee would have received had the employee not been absent from work, up to $1,400 per week, until the employee meets the return to work criteria.” Employers with fewer than 500 employees are permitted, beginning in the third week of an employee’s removal, to reduce pay to two-thirds of regular pay the employee would have received had the employee not been absent from work, up to $200 per day (which totals $1,000 per week in most cases).

The paid leave may be reduced by the amount of compensation that the employee receives from any other source, such as a publicly or employer-funded compensation program (e.g., paid sick leave or administrative leave), for earnings lost during the period of removal or any additional source of income the employee receives that is made possible by virtue of the employee’s removal.

Support for Employee Vaccinations

The employer must support COVID-19 vaccinations for each employee by providing reasonable time and paid leave (e.g., paid sick leave or administrative leave) to each employee for vaccination and any side effects experienced following vaccination.
Employee training

The employer must provide training to each employee on at least the following:

1. “COVID-19, including how the disease is transmitted (including presymptomatic and asymptomatic transmission), the importance of hand hygiene to reduce the risk of spreading COVID-19 infections, ways to reduce the risk of spreading COVID-19 through the proper covering of the nose and mouth, the signs and symptoms of the disease, risk factors for severe illness, and when to seek medical attention;

2. employer-specific policies and procedures on patient screening and management;

3. tasks and situations in the workplace that could result in COVID-19 infection;

4. workplace-specific policies and procedures to prevent the spread of COVID-19 that are applicable to the employee’s duties...;

5. employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace;

6. Employer-specific policies and procedures for PPE worn to comply with [the ETS], including:
   a. when PPE is required for protection against COVID-19;
   b. limitations of PPE for protection against COVID-19;
   c. how to properly put on, wear, and take off PPE;
   d. how to properly care for, store, clean, maintain, and dispose of PPE; and
   e. any modifications to donning, doffing, cleaning, storage, maintenance, and
   f. disposal procedures needed to address COVID-19 when PPE is worn to address workplace hazards other than COVID-19;

7. workplace-specific policies and procedures for cleaning and disinfection;

8. employer-specific policies and procedures on health screening and medical management;

9. available sick leave policies, any COVID-19-related benefits to which the employee may be entitled under applicable federal, state, or local laws, and other supportive policies and practices (e.g., telework, flexible hours);

10. the identity of the safety coordinator(s) specified in the COVID-19 plan,

11. this section [the ETS]; and

12. how the employee can obtain copies of this section [the ETS] and any employer-
specific policies and procedures developed under this section [the ETS], including the employer’s written COVID-19 plan, if required.”

The employer must also ensure that the training is provided, or overseen, by an individual knowledgeable in the subject matter as it relates to the employee’s job duties, and is interactive, providing the employee an opportunity to ask the trainer questions.

Additional training must be provided to an employee whenever changes occur that affect the employee’s risk of contracting COVID-19 (e.g., a job change or new tasks); when policies or procedures change; or if there is an indication that the employee has not retained the previous training provided.

**Antiretaliation**

The employer must inform each employee that they have a right to the protections required by the ETS, and employers are prohibited from discharging or in any manner discriminating against employees for exercising their rights to the protections required by the ETS, or for engaging in actions that are required by the ETS.

**Requirements implemented at no cost to employees**

All requirements of the ETS, except for employee self-monitoring, must be implemented at no cost to employees.

**Recordkeeping**

In addition to existing recordkeeping requirements for all work-related confirmed cases of COVID-19 on the employer’s OSHA Forms 300, 300A, and 301, or the equivalent forms, if required to do so under 29 C.F.R. part 1904, the ETS includes a host of new recordkeeping requirements.

Employers with more than 10 employees must:

- “retain all versions of the COVID-19 plan implemented to comply with [the ETS], while [the ETS] remains in effect.

- establish and maintain a COVID-19 log to record each instance identified by the employer in which an employee is COVID-19 positive, regardless of whether the instance is connected to exposure to COVID-19 at work. (Emphasis added.)

a. The COVID-19 log must contain, for each instance, the employee’s name, one form of contact information, occupation, location where the employee worked, the date of the employee’s last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced.

b. The information in the COVID-19 log must be recorded within 24 hours of the employer learning that the employee is COVID-19 positive and must be
maintained as though it is a confidential medical record and must not be disclosed except as required by this ETS or other federal law.”

• provide, for examination and copying, by the end of the next business day after a request:
  
  i. “All versions of the written COVID-19 plan to all of the following: any employees, their personal representatives, and their authorized representatives.

  ii. the individual COVID-19 log entry for a particular employee to that employee and to anyone having written authorized consent of that employee.

  iii. A version of the COVID-19 log that removes the names of employees, contact information, and occupation, and only includes, for each employee in the COVID-19 log,” other limited information to “any employees, their personal representatives, and their authorized representatives.”

  iv. “All records required to be maintained by [the ETS] to the Assistant Secretary [of OSHA].”

**Reporting COVID-19 Fatalities and Hospitalizations to OSHA**

According to the ETS, “[t]he employer must report to OSHA:

  i. Each work-related COVID-19 fatality within 8 hours of the employer learning about the fatality.(Emphasis added.)

  ii. Each work-related COVID-19 in-patient hospitalization within 24 hours of the employer learning about the in-patient hospitalization.”(Emphasis added.)

The new reporting requirement also eliminates the reporting exceptions present in OSHA’s regular reporting regulation at 29 C.F.R. § 1904.39(b)(6). Those provisions exclude from reporting fatalities that occurred over 30 days from the work-related incident and in-patient hospitalizations that occurred over 24 hours from the work-related incident.

**Takeaways**

**Areas of Focus**

Overall, many healthcare employers already have in place policies and procedures that meet or exceed CDC guidelines and thus meet or exceed most of OSHA’s new ETS. Healthcare employers should focus compliance efforts on new or revised requirements, including training requirements, the new mini respiratory protection program, new recordkeeping obligations, the changes to healthcare employer’s reporting obligations to OSHA and, last but not least, OSHA’s paid leave requirement.

*Why is COVID-19 a “grave danger” in healthcare?*
OSHA declared that healthcare employers face a “grave danger” from the “new” hazard of COVID-19 in the workplace—which is required by law for the agency to implement an ETS. “The fact that COVID-19 is not a uniquely work-related hazard does not change the determination that it is a grave danger to which employees are exposed,” OSHA explains in the preamble to the ETS. “Nor does it excuse employers from their duty to protect employees from the occupational transmission of SARS-CoV-2.” The agency cites to evidence that COVID-19 is a deadly disease in general. But it fails to explain why only a grave danger exists in healthcare, and not other U.S. workplaces. OSHA cites to one source—a two-page document authored by CDC officials (known as “Birhane” document) as the best available evidence that “in healthcare settings where workers are vaccinated, ... a grave danger still exists, given the greater potential for breakthrough cases in light of the greater frequency of exposure to suspected and confirmed COVID-19 patients in those settings.” But the Birhane document only discusses breakthrough cases in general, and does not distinguish between healthcare and nonhealthcare settings.

While the healthcare industry may be at an elevated level of risk of exposure to COVID-19, due to the nature of the work, that does not mean the hazard does not exist outside of healthcare. It is also debatable whether COVID-19 is a “new” hazard at this point in time. By issuing the ETS, OSHA is essentially claiming that COVID-19 is a new hazard; in the grand scheme of things, it has only been in the United States since approximately January 2020. But the delay in promulgating the ETS undermines OSHA’s point. If it has been a grave danger since January 2020 (and was gravest in the Fall of 2020, when infection and death rates were at their peaks), then why is OSHA issuing an ETS now, when vaccinations appear to be exponentially lowering infection and death rates?

**Medical Removal Benefits**

OSHA’s new medical removal benefits provision will generate controversy and, quite possibly, litigation. The agency plays off the paid leave provision as insignificant, citing to paid medical leave provisions in its lead and formaldehyde standards, among others. But no provision in the OSH Act of 1970 gives OSHA the power to order employers to pay employees when they are not at work. The subject is beyond OSHA’s authority and jurisdiction.

OSHA’s new deadlines for reporting COVID-19 fatalities and in-patient hospitalizations, coupled with the removal of the regular reporting exceptions, will result in more reports to OSHA for employers covered by the ETS. This, in turn, invites more OSHA inspections for healthcare employers.

**Physical Distancing in Direct Patient Care Settings**

The physical distancing requirement is impractical for any healthcare employee providing direct patient care. (For example, would a nurse be required to immediately leave a room upon administering a chemotherapy infusion to a cancer patient?) While OSHA seems to acknowledge infeasibility will preclude enforcement in many instances, the ETS imposes the burden on the healthcare employer to establish infeasibility, and invites inspectors to quibble over how much physical distancing an employer should require in direct patient settings.