

EXAMINING THE FEDERAL GOVERNMENT'S ACTIONS TO PROTECT WORKERS FROM COVID-19

HEARING BEFORE THE SUBCOMMITTEE ON WORKFORCE PROTECTIONS COMMITTEE ON EDUCATION AND LABOR U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MAY 28, 2020

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EXAMINING THE FEDERAL GOVERNMENT'S ACTIONS TO PROTECT WORKERS FROM COVID-19

**Thursday, May 28, 2020
House of Representatives,
Subcommittee on Workforce Protections,
Committee on Education and Labor,
Washington, D.C.**

The subcommittee met, pursuant to call, at 10:19 a.m., in Room 2175, Rayburn House Office Building, Hon. Alma Adams [chairwoman of the subcommittee] presiding.

Present: Representatives Adams, Takano, Jayapal, Wild, McBath, Stevens, Scott (ex officio), Byrne, Walker, Cline, Wright, Murphy, and Foxx (ex officio).

Also Present: Representatives Levin, Shalala, Bonamici, Courtney, Castro, Roe, Walberg, Guthrie, Comer, Grothman, Watkins, Meuser, Smucker, Johnson, and Keller.

Staff Present: Tylease Alli, Chief Clerk; Jordan Barab, Senior Labor Policy Advisor; Ilana Brunner, General Counsel; Ijeoma Egekeze, Professional Staff; Christian Haines, General Counsel; Sheila Havenner, Director of Information Technology; Eli Hovland, Staff Assistant; Stephanie Lalle, Deputy Communications Director; Jaria Martin, Clerk/Special Assistant to the Staff Director; Richard Miller, Director of Labor Policy; Katelyn Mooney, Associate General Counsel; Max Moore, Staff Assistant; Mariah Mowbray, Staff Assistant; Veronique Pluviose, Staff Director; Joshua Weisz, Communications Director; Cyrus Artz, Minority Staff Director; Gabriel Bisson, Minority Staff Assistant; Courtney Butcher, Minority Director of Member Services and Coalitions; Rob Green, Minority Director of Workforce Policy; Jeanne Kuehl, Minority Legislative Assistant; John Martin, Minority Workforce Policy Counsel; Hannah Matesic, Minority Director of Operations; Carlton Norwood, Minority Press Secretary; and Kelly Tyroler, Minority Professional Staff Member.

Chairwoman ADAMS. Good morning. The Subcommittee on Workforce Protections will come to order.

Welcome, everyone. I note that a quorum is present. I note for the Subcommittee that Mr. Courtney of Connecticut, Ms. Bonamici of Oregon, Mr. Norcross of New Jersey, Dr. Shalala of Florida, Mr. Levin of Michigan, Mr. Castro of Texas, Dr. Roe of Tennessee, Mr. Walberg of Michigan, Mr. Guthrie of Kentucky, Mr. Grothman of

Wisconsin, Mr. Smucker of Pennsylvania, Mr. Banks of Indiana, Mr. Comer of Kentucky, Mr. Watkins of Kansas, Mr. Meuser of Pennsylvania, Mr. Johnson of South Dakota, Mr. Keller of Pennsylvania, are all permitted to participate in today's hearing, with the understanding that their questions will come only after all Members of the Subcommittee on Workforce Protections on both sides of the aisle who are present, either in person or via remote participation, pursuant to House Resolution 965 and the accompanying regulations thereto, have had an opportunity to question the witnesses.

The Subcommittee is meeting today for a hearing to hear testimony on examining the Federal Government's actions to protect workers from COVID-19. All microphones, both in the hearing room and for those Members participating remotely, will be kept muted as a general rule to avoid unnecessary background noise. Members will be responsible for unmuting themselves when they are recognized to speak or when they wish to seek recognition.

While a roll call is not necessary to establish a quorum in official proceedings conducted remotely or with remote participants -- participations, wherever there is an unofficial proceeding with remote participation, the Clerk will call the role to help make clear who is present at the start of the proceeding.

At this time, I ask the Clerk to call the roll.

The Clerk. Chairwoman Adams?

Chairwoman ADAMS. Present.

The Clerk. Mr. DeSaulnier?

[No response.]

The Clerk. Mr. Takano?

Mr. TAKANO. Present.

The Clerk. Ms. Jayapal?

[No response.]

The Clerk. Ms. Wild?

Ms. WILD. Present.

The Clerk. Mrs. McBath?

Mrs. MCBATH. Present.

The Clerk. Ms. Omar?

[No response.]

The Clerk. Ms. Stevens?

Ms. STEVENS. Present.

The Clerk. Chairman Scott?

Mr. SCOTT. Present.

The Clerk. Mr. Byrne?

Mr. BYRNE. Here.

The Clerk. Mr. Walker?

Mr. WALKER. Here.

The Clerk. Mr. Cline?

Mr. CLINE. Here.

The Clerk. Mr. Wright?

[No response.]

The Clerk. Mr. Murphy?

[No response.]

The Clerk. Ms. Foxx?

[No response.]

The Clerk. Chairwoman Adams, this concludes the roll call.

Chairwoman ADAMS. Thank you very much.

Pursuant to Committee Rule 7(c), opening statements -- let me remind all of the Committee Members, whether you are here or if you are particularly remote, please mute your microphone. Thank you.

Pursuant to Committee Rule 7(c), opening statements are limited to the Chair and the Ranking Member. This allows us to hear from our witnesses sooner and provides all Members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement.

Today's Subcommittee hearing will explore the performance of the Federal Government in protecting worker safety during the COVID-19 pandemic. I want to thank OSHA Deputy Assistant Secretary Sweatt and NIOSH Director Howard for joining us today.

The COVID-19 pandemic has resulted in the worst worker safety crisis in OSHA's 50-year history. Nothing compares. In the past 4 months, more than 62,000 healthcare workers who we have asked to risk their lives without protective equipment have been diagnosed with COVID-19 and at least 291 have died. And this is an underestimate. According to CDC, these shocking numbers are a mere fraction of the true toll due to the absence of reporting by as many as 27 States, New York City, and the District of Columbia.

As we know, infection outbreaks have not been limited to healthcare facilities. More than 17,000 meat-processing workers have been infected and an estimated 66 have died. One Iowa Tyson plant saw 60 percent of its employees test positive. A Greeley, Colorado, meat-packing plant closed after hundreds fell ill. Although the plant promised to test every worker before reopening, the plant identified so many positive cases that it stopped testing and reopened anyway.

Prisons, long-term care facilities, grocery stores, transportation systems, and warehouses have all experienced deadly outbreaks. Earlier this month, the CDC reported 2,778 infections and 15 deaths among staff employed in correctional and detention facilities. From late January to late April, fully 36 percent of all reported infections at correctional facilities were suffered by staff.

At least six employees of one warehouse in New York have died from COVID-19. 129 New York City transit workers have died of the virus.

As of last week, 1,424 Veterans Administration employees have been diagnosed with COVID-19 and 31 have died.

Some 2,400 postal workers have tested positive and 6 have died from COVID-related illnesses. United Parcel Service is facing an outbreak of 36 cases at its facility in Tucson.

But as we will discuss today, we don't really know the toll to workers because this Nation has no system for collecting data on COVID-19 infections in the workplace, and employers are not obligated to publicly report these infections. Some government agencies refuse to make this information public due to employer concerns about adverse publicity, leaving workers and the public unaware of what risks they are facing.

We cannot lose sight of the fact that this is largely a tragedy inflicted on our Nation's essential workers, people who don't have a

choice on whether they have to go to work, people who don't have a choice on whether they -- and many of those are frontliners. They are low-income workers and disproportionately people of color who don't have the luxury of teleworking from home.

COVID-19 is largely a workplace disease and a community tragedy. In Iowa, Nebraska, South Dakota, coronavirus cases linked to meat workers represent 18, 20, and 29 percent of the States' total cases, respectively, according to the environmental working group. My home State of North Carolina leads the Nation with the number of meat-packing plants facing an outbreak, with the State Department of Health and Human Services reporting that at least 23 plants have outbreaks with more than 1,300 worker infections.

Yet OSHA, the agency that this Nation has tasked to protect workers, have been largely invisible. It has failed to develop the necessary tools that it needs to combat this pandemic and it has failed to fully use the tools that it has, instead, focusing principally on issuing press releases and voluntary guidance.

This hearing will focus on why that is and the price that this Nation's workers are paying for OSHA's inaction.

Deep into this pandemic, OSHA has still not developed any enforceable standards for employers to follow that can protect workers from the airborne transmission of the novel coronavirus. And OSHA's existing enforcement tools to combat this pandemic, which include standards covering respirators and personal protective equipment, are inadequate and unused.

While guidance issued by the Centers for Disease Control and Prevention can be useful, it is not binding. Only OSHA can enforce safe working conditions.

And although OSHA says it uses its enforcement authority to protect workers, OSHA's own data shows that the majority of its inspections are conducted only after workers have died. And OSHA has conducted complaint inspections for less than 1 percent of the complaints filed.

While the Secretary of Labor says it does not need an Emergency Temporary Standard because OSHA already has the tools that it needs to enforce its guidelines through the general duty clause, the embarrassing truth is that OSHA has not issued a single citation under the general duty clause to enforce that guidance. Not one.

This worker safety crisis was clearly foreseeable, and OSHA was warned. It was clear after the H1N1 swine flu, the pandemic in 2009, that an infectious disease standard was needed that requires employers to assess the infectious disease risks in the workplaces and mitigate the hazards. Such a standard was well along the way at the beginning of the Trump Administration, but in February 2017, that draft standard was mothballed and relegated to the long-term regulatory agenda, where it languishes today.

On January 1, I joined Chairman Bobby Scott in calling on OSHA to put the infectious disease standard back on the active agenda. In that letter, we also urged OSHA to issue a compliance directive for the healthcare sector and to issue an Emergency Temporary Standard if the situation deteriorated. At the time of our request, there were just five confirmed COVID-19 infections in the U.S.

Hearing nothing back, on March 5, we wrote OSHA again describing how hundreds of healthcare workers had been exposed and stated the obvious, that OSHA urgently needed to issue an Emergency Temporary Standard, an ETS.

In mid-March, OSHA rejected an ETS on the grounds that the healthcare industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers.

In April, with more than 720,000 infections nationwide, OSHA finally issued enforcement guidance but only covering the healthcare sector.

In mid-May, as workers continued to face risks of infection, illnesses, and death, the agency is still refusing to issue an Emergency Temporary Standard to protect workers from exposure to coronavirus.

And here is what OSHA Act says. It says, “shall provide . . . for an Emergency Temporary Standard” if it determines “that employees are exposed to a grave danger . . .” from “new hazards,” and “that such emergency standard is necessary to protect employees from such danger.”

Circumstances like this pandemic are the exact reason that this authority exists, yet OSHA continues to sit on the sidelines.

So my question to the Secretary of Labor is, after tens of thousands of workplace infections and hundreds of worker deaths, why is OSHA missing in action?

OSHA’s failure to take meaningful action has sent a clear message to workers across the country that they are on their own.

On Friday, May 15, the House of Representatives passed The Heroes Act, H.R. 6800, which included the “COVID-19 Every Worker Protection Act,” introduced by Chairman Scott, Representative Shalala, and myself. The bill directs OSHA to issue an Emergency Temporary Standard with 7 days to protect workers in hospitals, meat-packing plants, and retail stores, restaurants and offices and shipyards, and other workplaces where a person may face risk from exposure. The Heroes Act would also prohibit employers from retaliating against workers.

As the States across the country begin to reopen, more workers will be at risk of infection unless OSHA starts doing its job. And if the reopening of workplaces drives up infection rates, States will be forced to reinstate stay-at-home orders which do further damage to our economy.

The only logical conclusion I can draw is that OSHA’s inadequate response to this pandemic has been informed more by politics rather than modern science. The necessity to protect workers should not be cramped by stale ideological notions about regulation, nor campaign slogans about repealing two regulations for every new one that is created.

Today, we will explore and hopefully answer why there has been a lack of political will in the face of this public health disaster, and we will learn why no one seems to care enough to even track the number of workers who are getting sick and dying.

And finally, I feel the need to respond to two items in Ms. Sweatt’s written testimony. First, we note that because of a lawsuit, Ms. Sweatt will refuse to answer any questions about an Emergency Temporary Standard. And I want to note for the record

that there is no legal basis for this refusal. It is purely a political statement.

And secondly, I want to respond to Ms. Sweatt's testimony which implies that criticism of OSHA's failure to issue an emergency standard or enforce existing standards does a disservice to the hardworking men and women of OSHA. No one has more respect for the dedicated men and women -- or the dedicated staff of OSHA and the hard work that they do every day—than this Committee, as evidenced by our advocacy for the agency's budget and the opposition to the torrent of rollbacks to worker safety protection.

The failure to completely address the life-threatening hazards that working Americans are facing from COVID-19 is not the fault of OSHA professional staff, but rather due to the unfortunate decisions of OSHA's political leadership.

I would like to now yield to the Ranking Member, Mr. Byrne, for his opening statement.

Mr. Byrne, you are recognized.

[The statement of Chairwoman Adams follows:]

Prepared Statement of Hon. Alma S. Adams, Chairwoman, Subcommittee on Workforce Protections

Today's Subcommittee hearing will explore the performance of the federal government in protecting worker safety during the COVID-19 pandemic. I want to thank OSHA Deputy Assistant Secretary Sweatt and NIOSH Director Howard for joining us today.

The COVID-19 pandemic has resulted in the worst worker safety crisis in OSHA's 50-year history. Nothing compares.

In the past 4 months, more than 62,000 health care workers, who we have asked to risk their lives without protective equipment, have been diagnosed with COVID-19 and at least 291 have died. And this is an underestimate. According to CDC, these shocking numbers are a mere fraction of the true toll due to the absence of reporting by as many as 27 states, New York City and the District of Columbia.

As we know, infection outbreaks have not been limited to health care facilities.

More than 17,000 meat processing workers have been infected and an estimated 66 have died. One Iowa Tyson plant saw 60% of its employees test positive. A Greeley Colorado meatpacking plant closed after hundreds fell ill. Although the plant promised to test every worker before reopening, the plant identified so many positive cases that it stopped testing and reopened anyway.

Prisons, long-term care facilities, grocery stores, transportation systems and warehouses have all experienced deadly outbreaks.

Earlier this month, the CDC reported 2,778 infections and 15 deaths among staff employed in correctional and detention facilities. From late January to late April, fully 36% of all reported infections at correctional facilities were suffered by staff.

At least 6 employees of one warehouse in New York have died from COVID-19. One-hundred and twenty nine New York City transit workers have died of the virus.

As of last week, 1,424 Veterans Administration employees have been diagnosed with COVID-19 and 31 have died.

Some 2,400 postal workers have tested positive and 60 have died from COVID-related illnesses. United Parcel Service is facing an outbreak of 36 cases at its facility in Tuscon.

But as we will discuss today, we actually don't really know the toll to workers because this nation has no system for collecting data on COVID-19 infections in the workplace. And employers are not obligated to publicly report these infections. Some government agencies refuse to make this information public due to employer concerns about adverse publicity, leaving workers and the public unaware of what risks they are facing.

We cannot lose sight of the fact that this is largely a tragedy inflicted on our nation's essential workers. People who don't have a choice on whether they have to go to work. Many of those on the frontlines are low income workers and disproportionately people of color who don't have the luxury of teleworking from home.

COVID-19 is largely a workplace disease and a community tragedy. In Iowa, Nebraska and South Dakota, coronavirus cases linked to meat workers represent 18,

20 and 29 percent of the states' total cases, respectively, according to the Environmental Working Group. My home state of North Carolina leads the nation with the number of meatpacking plants facing an outbreak—with the state Department of Health and Human Services reporting that at least 23 plants have outbreaks with more than 1,300 worker infections.

Yet OSHA, the agency that this nation has tasked to protect workers, has been largely invisible. It has failed to develop the necessary tools it needs to combat this pandemic and it has failed to fully use the tools it has; instead focusing principally on issuing press releases and voluntary guidance.

This hearing will focus on why that is and the price that this nation's workers are paying for OSHA's inaction.

Deep into this pandemic, OSHA has still not developed any enforceable standards for employers to follow that can protect workers from the airborne transmission of the novel coronavirus.

And OSHA's existing enforcement tools to combat this pandemic, which include standards covering respirators and personal protective equipment, are inadequate and unused.

While guidance issued by the Centers for Disease Control and Prevention can be useful, it is not binding. Only OSHA can enforce safe working conditions.

And although OSHA says it uses its enforcement authority to protect workers, OSHA's own data shows that the majority of its inspections are conducted only after workers have died. And OSHA has conducted complaint inspections for less than one percent of the complaints filed.

And while the Secretary of Labor says it does not need an Emergency Temporary Standard, because OSHA already has the tools it needs to enforce its guidelines through the General Duty Clause, the embarrassing truth is that OSHA has not issued a single citation under the General Duty Clause to enforce that Guidance. Not one!

This worker safety crisis was clearly foreseeable. And OSHA was warned. It was clear after the H1N1 Swine Flu pandemic in 2009 that an infectious disease standard was needed that requires employers to assess the infectious disease risks in their workplaces and mitigate the hazards. Such a standard was well along the way at the beginning of the Trump Administration, but in February 2017, that draft standard was mothballed and relegated to the "long term" regulatory agenda where it languishes today.

In January, I joined Chairman Bobby Scott in calling on OSHA to put the infectious disease standard back on the active agenda. In that letter, we also urged OSHA to issue a compliance directive for the health care sector, and to issue an Emergency Temporary Standard if the situation deteriorated. At the time of our request, there were just 5 confirmed COVID-19 infections in the United States.

Hearing nothing back, on March 5th we wrote OSHA again describing how hundreds of health care workers had been exposed and stated the obvious: that OSHA urgently needed to issue an Emergency Temporary Standard

(ETS). In mid-March, OSHA rejected an ETS on the grounds that "the health care industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers."

In April, with more than 720,000 infections nationwide, OSHA finally issued enforcement guidance, but only covering the health care sector.

In mid-May, as workers continue to face risk of infection, illness, and death, the agency is still refusing to issue an Emergency Temporary Standard to protect workers from exposure to the coronavirus.

Here is what the OSHA Act states: OSHA "shall provide . . . for an Emergency Temporary Standard" if it determines "that employees are exposed to a grave danger . . ." from "new hazards", and "that such emergency standard is necessary to protect employees from such danger."

Circumstances like this pandemic are the exact reason this authority exists, yet OSHA continues to sit on the sidelines.

My question to the Secretary of Labor is how, after tens of thousands of workplace infections and hundreds of worker deaths, why is OSHA missing in action?

OSHA's failure to take meaningful action has sent a clear message to workers across the country that they are on their own.

On Friday, May 15, the House of Representatives passed the Heroes Act (H.R. 6800) which included the COVID 19 Every Worker Protection Act introduced by Chairman Scott, Representative Shalala and myself. That bill directs OSHA to issue an Emergency Temporary Standard with seven days to protect workers in hospitals, meatpacking plants, retail stores, restaurants, offices, shipyards, and any other workplace where a person may face risk from exposure to the novel coronavirus

from the public or from other workers. The Heroes Act would also prohibit employers from retaliating against workers for sounding the alarm about unsafe conditions.

As the states across the country begin to reopen, more workers will be at risk of infection unless OSHA starts doing its job. And if the reopening of workplaces drives up infections rates, states will be forced to reinstate stay-at-home orders, which will do further damage to our economy.

We simply cannot safely and effectively reopen our economy until we secure the safety of our workers.

The only logical conclusion I can draw is that OSHA's inadequate response to this pandemic has been informed more by stale politics rather than modern science. The necessity to protect workers should not be cramped by stale ideological notions about regulation, nor campaign slogans about repealing two regulations for every new one that is created. The house is on fire, and we cannot waste time arguing about how to rewrite our building codes.

Today, we will explore and hopefully answer why there has been the lack of political will in the face of this public health disaster. And we will learn why no one seems to care enough to even track the number of workers who are getting sick and dying.

Finally, before I end, I feel the need to respond to two items in Ms Sweatt's written testimony.

First, we note that because of a lawsuit, Ms. Sweatt will refuse to answer any questions about an Emergency Temporary Standard. I want to note for the record that there is no legal basis for this refusal; it is purely a political statement.

Second, I want to respond to Ms. Sweatt's testimony which implies that criticism of OSHA's failure to issue a emergency standard or enforce existing standards "does a disservice . . . to the hardworking men and women of OSHA."

No one has more respect for the dedicated staff of OSHA and the hard work they do every day than this Committee, as evidenced by our advocacy for the agency's budget and opposition to the torrent of rollbacks to worker safety protections. The failure to competently address the life-threatening hazards that working Americans are facing from COVID-19 is not the fault of OSHA professional staff, but rather due to the unfortunate decisions of OSHA's political leadership.

I now yield to the Ranking Member, Mr. Byrne, for his opening statement.

Mr. BYRNE. Thank you, Madam Chairwoman, for yielding.

Let me state for the record that the Chairwoman is here physically present in this room. The Chairman of the Full Committee, Mr. Scott, is physically present in the room. The Ranking Republican Member on the Committee is physically present here in the room. I am physically present here in the room. In fact, there are 15 Members of this Committee physically present in the room, nine Republicans, six Democrats. It is a safe environment, a simple environment. As you can tell, we are socially distanced.

Not much has changed since the Democrats decided at the 11th hour to unilaterally call off last week's hearing. OSHA and NIOSH officials, my Republican colleagues and I were ready then to talk about the important work these agencies are doing to combat COVID-19, and we are here again to do so today. It is indeed unfortunate the Democrats decided to play politics on an issue that they assert is a top priority.

The COVID-19 pandemic has been an extraordinary time for all Americans. Many of us are coming out of mandatory stay-at-home orders after 2 months or more. People are returning to work in a new environment with a disease that is still relatively new and about which we still have much to learn.

We know the disease affects different people in different ways. Many people who test positive have no or mild symptoms, but a small percentage get very ill, and some of them, unfortunately, pass away. The two groups most likely to become very ill are those

over 65, who make up 80 percent of all deaths in this country, and those with underlying health conditions as listed by the CDC.

The disease also presents varied levels of risk for workers in different types of jobs. For example, an office worker who doesn't interact with the public faces much lower risk than a nurse in an ICU ward.

I say all of this to make a point about the inherent difficulty in coming up with a reliable, single standard for workplace safety, whether it is for infectious disease in general or COVID-19 specifically.

How did OSHA handle complex safety and health issues in the past? From SARS in the 2000s, during the Bush Administration, to MERS, H1N1 influenza, and Ebola during the Obama Administration, OSHA did not issue a new standard, but instead enforced existing standards and issued guidance, which, in turn, could be the basis for action against an employer under the general duty clause of the OSHA statute.

Let me say that again. During the Obama Administration, under three separate diseases, OSHA did not issue a standard. They issued guidelines and relied upon those guidelines for enforcing the general duty clause.

When the Acting Assistant Secretary for OSHA during H1N1, which the Chairwoman referred to, during that pandemic, a man named Jordan Barab, when he testified before this Committee in May of 2009, he said OSHA had created guidance, guidance, quote, to help employers determine the most appropriate work practices and precautions to limit the impact of the pandemic.

He went on to say: "Because safety risks are greater in certain workplaces, OSHA is focusing its direct efforts on educating employers and employees in the high-risk exposure categories."

At that time, he said OSHA issued an occupational risk pyramid to categorize workers' risk, which demonstrated that only a small portion of employees were at the highest exposure risk level. Mr. Barab specifically referenced standards already in place for personal protective equipment and respirators.

He said that OSHA would use the general duty clause, quote, to ensure that employers follow the practices that public health experts agree are necessary to protect workers' health.

Finally, he quoted President Obama's assessment for the situation as being, quote, one for cause for deep concern but not panic.

What has OSHA done with COVID-19? Just like the Obama Administration, it has issued detailed guidelines, placed an enforcement emphasis on high-risk workplaces, used an occupational risk pyramid categorizing workers' risks, and reminded employers of OSHA's existing standards on PPE, respirators, sanitation and others, as well as their obligations under the OSHA Act's general duty clause to provide employers with a safe and healthy workplace.

In addition, OSHA and the CDC have issued industry-specific guidance for healthcare, nursing home and long-term care, retail pharmacy, car service, package delivery, retail, construction, manufacturing, restaurant, and dental workplaces. And is still working on it.

There are two problems with requiring a standard. First, we are still learning about this disease. And we just don't know enough in-

formation to meet the level necessary and appropriate to construct an adequate Emergency Temporary Standard and a permanent Federal regulation.

That is why the various guidance documents already issued are so useful. They can be used -- they can be issued relatively quickly and modified as we learn more from the CDC and other public health officials and from the workplaces themselves. A standard, at this point, would be an unproductive burden for businesses already struggling to reopen, potentially exposing them to unnecessary liability risk during an already challenging time and would do little to advance workplace safety.

Second, setting a standard just takes too long. On average, it takes OSHA 7 years to compile all the data necessary and meet all the regulatory requirements for issuing a standard.

I know Democrats want an emergency technical -- temporary standard, or ETS, which according to their bill, must be done in 7 days. The last time OSHA issued an ETS was in 1983, and that one was overturned because OSHA could not meet the statutory threshold requirements for issuance. Indeed, OSHA has lost more ETS cases in Federal courts than it has won for the same reason.

I know the Speaker included a provision requiring a standard in the bill passed by the House two weeks ago, a bill she created in her office, without any consultation with the White House or the Senate, and on which we never had a hearing or markup in this Committee, the Committee of jurisdiction. No regular order and no effort to obtain bipartisan consensus. That is no way to operate the House with a challenge of this magnitude, posed by the pandemic and our response to the pandemic. No wonder that bill is dead on arrival in the Senate.

I also know the AFL-CIO filed a lawsuit last week to force OSHA to issue a standard. They filed a lawsuit. Expensive and time-consuming litigation against a Federal agency responsible for protecting our Nation's workers in the midst of a pandemic is unhelpful and very unlikely to succeed.

And, Madam Chairwoman, I take exception to your remarks about the witness' ability to talk about that lawsuit and matters involved in that lawsuit. No lawyer is going to let their client talk about something like that with pending litigation. It is a matter of every lawyer that has a client in litigation like that is going to ask them to be careful about that. And to expect them not to follow their lawyer's advice is totally unfair to them.

I must say that when I started preparing for this hearing with my staff two weeks ago, I was impressed, very impressed, with the diligence and speed with which OSHA has fashioned its response. Remember, we didn't know about this disease five months ago. Their experience with past pandemics surely helped, and I am glad they both followed and built upon this experience.

I have talked with hundreds of businesses trying to decide whether and how to reopen, and that is probably true for every Member in this room. Those conversations always include a real concern for the health of their employees. They have consulted CDC. They have consulted local and State public health officials and their industry organizations, and yes, they are closely following this OSHA guidance, which they are truly grateful for. They want

to provide their employees a safe workplace, and OSHA is helping them achieve that. Isn't that what the OSHA statute's purpose is? Helping employers and employees keep their workplaces safe and healthy?

I am looking forward to the testimony today. And I thank the witnesses for appearing in the midst of what I know is a very busy time for them. Let's all work together to protect the most important part of the American economy, the working men and women who make this country so very prosperous, including the healthcare workers, like my sister-in-law, Cynthia Dukes, who is an ICU nurse. I want her to be safe and healthy as she goes about her extremely important work, even as we sit here, taking care of the sickest of us. She and her colleagues deserve nothing less, and they are best served by us when we work together for them, and not for special interests, and we stop the wasteful litigation and the partisan legislative games.

America will get through this. We can protect our people who are most vulnerable to this disease and reopen the American economy safely as we start on another road to recovery and prosperity for all. President Obama was right, there is cause for great concern but not panic. And if OSHA's response was the best way to go for SARS, MERS, H1N1, and Ebola, why is it not best for COVID-19?

Thank you, and I yield back.

[The statement of Mr. Byrne follows:]

**Prepared Statement of Hon. Bradley Byrne, Ranking
Member, Subcommittee on Workforce Protections**

"Let me state for the record that I, Ranking Member Foxx, and other Members are here in the Committee room in Washington, socially distanced. It is a relatively simple and safe environment here.

In fact, not much has changed since the Democrats decided at the eleventh hour to unilaterally call off last week's hearing. OSHA and NIOSH officials, my Republican colleagues, and I were ready then to talk about the important work these agencies are doing to combat COVID-19 and we are here again today to do so. It's unfortunate the Democrats decided to play politics on an issue they assert is a top priority.

The COVID-19 pandemic has been an extraordinary time for all Americans. Many of us are coming out of mandatory stay-at-home orders after two months. People are returning to work in a new environment with a disease that is still relatively new and about which we still have much to learn.

We know the disease affects different people in different ways. Many people who test positive have no or mild symptoms, but a small percentage get very ill, and some of them, unfortunately, pass away. The two groups most likely to become very ill are those over 65, who make up 80% of all deaths, and those with underlying health conditions as listed by the CDC.

The disease also presents varying levels of risk for workers in different types of jobs. For example, an office worker who doesn't interact with the public faces much lower risk than a nurse in an ICU ward.

I say all of this to make a point about the inherent difficulty in coming up with a reliable single standard for workplace safety, whether it's for infectious diseases in general or COVID-19 specifically.

How did OSHA handle complex safety and health issues in the recent past? From SARS in the 2000s during the Bush Administration to MERS, H1N1 influenza, and Ebola during the Obama Administration, OSHA didn't issue a new standard but, instead, enforced existing standards and issued guidance, which in turn could be the basis for action against an employer under the General Duty Clause of the OSHA statute.

When the Acting Assistant Secretary for OSHA during the H1N1 flu pandemic, Jordan Barab, testified before this Committee in May of 2009, he said OSHA had created guidance 'to help employers determine the most appropriate work practices

and precautions to limit the impact' of the pandemic. And 'because safety risks are greater in certain workplaces, OSHA is focusing its direct efforts on educating employers and employees in the higher-risk exposure categories.' OSHA issued an 'Occupational Risk Pyramid' to categorize workers' risk which demonstrated that only a small portion of employees were at the highest exposure-risk level. Mr. Barab specifically referenced standards already in place for personal protective equipment and respirators. He said that OSHA would use the General Duty Clause to 'ensure that employers follow the practices that public health experts agree are necessary to protect workers' health.' Finally, he quoted President Obama's assessment of the situation as being one of 'Cause for deep concern, but not panic.'

What has OSHA done with COVID-19? Just like the Obama Administration, it has issued detailed guidelines; placed an enforcement emphasis on higher risk workplaces; used an 'Occupational Risk Pyramid' categorizing workers' risk; and reminded employers of OSHA's existing standards on PPE, respirators, sanitation, and others, as well as their obligations under the OSH Act's General Duty Clause to provide employers with a safe and healthful workplace. In addition, OSHA and the CDC have issued industry-specific guidance for health care, nursing home and long-term care, retail pharmacy, car service, package delivery, retail, construction, manufacturing, restaurant, and dental workplaces.

There are two problems with requiring a standard.

First, we are still learning about this disease and we just don't know enough information to meet the level necessary and appropriate to construct an adequate Emergency Temporary Standard and a permanent federal regulation. That's why the various guidance documents already issued are so useful. They can be issued relatively quickly and modified as we learn more from the CDC and other public health officials, and from the workplaces themselves. A standard at this point would be an unproductive burden for businesses already struggling to reopen, potentially exposing them to unnecessary liability risks during an already challenging time, and would do little to advance workplace safety.

Second, setting a standard just takes too long. On average, it takes OSHA on average seven years to compile all the data necessary and meet all the regulatory requirements for issuing a standard. I know Democrats want an Emergency Temporary Standard, or ETS, which, according to their bill, must be done in seven days. The last time OSHA issued an ETS was in 1983 and that one was overturned because OSHA couldn't meet the statutory threshold requirements for issuance. Indeed, OSHA has lost more ETS cases in federal courts than it won for this same reason.

I know the Speaker included a provision requiring a standard in the bill passed by the House two weeks ago, a bill she created in her office, without any consultation with the White House or the Senate and on which we never had a hearing or markup in this committee, the committee of jurisdiction. No regular order and no effort to obtain bi-partisan consensus. That's no way to operate the House with a challenge of this magnitude posed by the pandemic and our response to the pandemic. No wonder that bill is DOA in the Senate.

I also know the AFL-CIO filed a lawsuit last week to force OSHA to issue a standard. Expensive and time-consuming litigation against the federal agency responsible for protecting our nation's workers in the midst of a pandemic is unhelpful and very unlikely to succeed.

I must say that when I started preparing for this hearing with my staff two weeks or so ago, I was impressed with the diligence and speed with which OSHA has fashioned its response. Their experience with past pandemics surely helped, and I'm glad they both followed and built upon this past experience.

I've talked with hundreds of businesses trying to decide whether and how to reopen. Those conversations always include a real concern for the health of their employees. They've consulted CDC, local and state public health officials, and their industry organizations. And, yes, they are closely following this OSHA guidance, which they are truly grateful for. They want to provide their employees a safe workplace, and OSHA is helping them achieve that. Isn't that what the OSHA's statute's purpose is, helping employers and employees keep their workplaces safe and healthy?

I'm looking forward to the testimony today and I thank the witnesses for appearing in the midst of what I know is a very busy time for them. Let's all work together to protect the most important part of the American economy, the working men and women who make this country so very prosperous, including the health care workers, like my sister-in-law, Cynthia Dukes, who is an ICU nurse. I want her to be safe and healthy as she goes about her extremely important work, even as we sit here, taking care of the sickest of us. She and her colleagues deserve nothing less. And they are best served by us when we work together, for them and not for special

interests, and when we stop the wasteful litigation and the partisan legislative games.

America will get through this. We can protect our people who are most vulnerable to this disease and reopen the American economy safely as we start on another road to recovery and prosperity for all. President Obama was right: there is cause for great concern but not panic. And if OSHA's response was the best way to go for SARS, MERS, H1N1, and Ebola, why is it not best for COVID-19?"

Chairwoman ADAMS. I want to thank the Ranking Member, but I just want to just respond for a moment, Mr. Byrne. Obama started work on a permanent airborne disease standard, and Trump put it back on the back burner, and still after a hundred thousand deaths, it is still pending, so --

Votes are going to be called in 5 minutes, but let me introduce the witnesses.

Any other Members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word by 5 p.m. on June 10, 2020.

Let me introduce the two witnesses before we will have to take a break.

Our first witness will be Ms. Loren Sweatt. Ms. Sweatt is the Principal Deputy Assistant Secretary for the Occupational Safety and Health Administration. She joined OSHA on July 24, 2017, coming from this Committee, where she was Senior Policy Adviser at the Committee on Education and Workforce for 15 years. In that role, Ms. Sweatt handled workplace safety issues before the Committee, including OSHA and the Mine Safety and Health Administration.

Our next witness will be Mr. John Howard -- or Dr. John Howard, excuse me. Dr. Howard is the Director of the National Institute for Occupational Safety and Health. He has held that position since 2009. Dr. Howard previously served as Director of the Institute from 2002 to 2008. Prior to coming to NIOSH, Dr. Howard was Chief of the Division of Occupational Safety and Health for the California Department of Industrial Relations, Labor, and Workforce Development.

We are going to -- I am going to -- do we adjourn?

Okay. We are going to proceed with the hearing and with the witness testimony.

So we appreciate the witnesses for participating today, and we look forward to your testimony. But let me remind the witnesses that we have -- we have read your witness statements, and they will appear in full in the hearing record.

Pursuant to Committee Rule 7(d) and Committee practice, each of you is asked to limit your oral presentation to 5-minute summary of your written statement. And let me remind the witnesses that pursuant to Title 18 of the U.S. Code Section 1001, it is illegal to knowingly and willfully falsify any statement, representation, written document, or material fact presented to Congress, or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to press the button on the microphone in front of you so that it will, in turn -- the Members can hear you. And as you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow to signal that you have 1 minute remaining. When the light

turns red, your 5 minutes have expired, and we ask that you please wrap it up.

We will let both witnesses make their presentations before we move to Member questions. When answering a question, please remember to once again turn your microphone on.

Ms. Sweatt, we are going to first recognize you.

STATEMENT OF LOREN SWEATT, PRINCIPAL DEPUTY ASSISTANT SECRETARY, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, WASHINGTON, D.C.

Ms. SWEATT. I am sorry. Thank you for the opportunity to highlight the Occupational Safety and Health Administration's important work of protecting our Nation's workers.

I am proud of the work this agency has done during the Trump Administration, but I am particularly proud of the work it is performing right now as it responds to a worldwide health crisis.

The work of the agency continues uninterrupted even as we respond to this pandemic. Between February 1 and May 21, OSHA received over 5,000 non-COVID-19 complaints and conducted 5,009 investigations based on these complaints and 969 inspections. During this time, OSHA has also received over 2,300 non-COVID-19 whistleblower complaints, which are being evaluated along with the COVID-19 whistleblower complaints.

I am so proud of the dedication to OSHA's mission of our hard-working compliance safety and health officers and all of the agency's personnel. Our CSHOs are initiating thousands of investigations of complaints. Our compliance assistance staff are working with employers across the country to help ensure safe and healthful working conditions for the Nation's workers.

Our training and education staff have moved quickly to provide training to CSHOs, and before, during, and after the pandemic, my goal is for OSHA's efforts to prevent workers from ever becoming ill or injured because they are doing their job.

OSHA's efforts to address COVID-19 has been its top priority since February. OSHA quickly pivoted to focus intensely on giving employers and workers the guidance they need to work safely in this rapidly changing situation. Where appropriate, OSHA has also enforced safety and health standards. Throughout this crisis, the incredible men and women of OSHA have remained committed to carrying out their mission to keep America's workers safe and healthy.

OSHA's initial response to the pandemic was to provide extensive guidance, often in conjunction with the CDC. Guidance has allowed the agency to be more nimble in response to the ever-changing understanding of the virus.

OSHA continues to issue industry-specific alerts that provide targeted guidance on practices and procedures that will help workers' health and safety. To date, OSHA has issued general industry guidance, and it has also issued guidance documents to protect workers in numerous specific industries, including meat-packing and processing, healthcare, nursing homes, restaurants, dentistry, and manufacturing. OSHA has also distilled its extensive guidance into a wide variety of useable worker education segments available on OSHA's website.

While extensive guidance is important to the rapidly changing dynamic of this pandemic as it continues, it is important to recognize OSHA's existing standards serve as the basis for its COVID-19 enforcement. Those standards include rules regarding respiratory protection, personal protective equipment, eye and face protection, sanitation, and hazard communication.

In addition to those existing authorities, OSHA has also the ability to take appropriate action against employers under the OSH Act's general duty clause.

OSHA was recently sued by the AFL-CIO for an Emergency Temporary Standard, and as we have discussed today, I cannot comment further surrounding the ETS or litigation.

The flexibility and responsiveness allowed through guidance is apparent in the two revised enforcement policies issued last week by OSHA. As States are beginning to reopen their economies, OSHA is acting to ensure employers are protecting their employees.

First, OSHA is increasing in-person inspections at all types of workplaces. Second, OSHA is clarifying its previous enforcement policy for recording cases of coronavirus. Under the new policy, OSHA will enforce recordkeeping requirements for employee coronavirus illnesses for all employers.

But to repeat, OSHA will not use guidance as a substitute for enforcement. Rather, the agency has the tools and intent to pursue both avenues. Where there are safety issues, OSHA remains, as always, shoulder to shoulder with America's workers.

OSHA is charged with protecting the rights of whistleblowers under 23 statutes. As the Secretary of Labor has made clear from the White House podium, multiple national interviews, and additional conversations with stakeholders, retaliation against workers is unacceptable.

In this pandemic, OSHA inspectors are initiating thousands of investigations. This is resulting in employers receiving up-to-date information about how to better protect their workers. During this same time, OSHA inspectors continue to respond to non-COVID-19 worker fatalities and complaints.

Through the tireless efforts of the entire agency, OSHA's continuous outreach and communication to workers and employers and its issuance of important guidance, OSHA is on the job protecting America's workers.

I am happy to answer any questions you may have.

[The statement of Ms. Sweatt follows:]

**TESTIMONY OF LOREN E. SWEATT
PRINCIPAL DEPUTY ASSISTANT SECRETARY
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
U.S. DEPARTMENT OF LABOR**

BEFORE THE

**SUBCOMMITTEE ON WORKFORCE PROTECTIONS
COMMITTEE ON EDUCATION AND LABOR**

UNITED STATES HOUSE OF REPRESENTATIVES

MAY 28, 2020

Chairwoman Adams, Ranking Member Byrne, Chairman Scott, Ranking Member Foxx, and Members of the Subcommittee, thank you for the opportunity to highlight the Occupational Safety and Health Administration's (OSHA) important work of protecting our nation's workers. OSHA operates every hour of every day, as it has for nearly half-a-century following the enactment of the Occupational Safety and Health Act (OSH Act). I am proud of the work this agency has done during the Trump Administration, but I am particularly proud of the work it is performing right now as it responds to the worldwide health crisis. I welcome this opportunity to update you on all of the agency's efforts.

During Fiscal Year (FY) 2019, OSHA conducted 33,401 inspections—more inspections than in each of the previous three fiscal years. A little more than half of those inspections—more than 17,000—were in the construction industry. Until March 2020, the agency was well on pace to meet or exceed that number of inspections in FY 2020. In FY 2019, the agency also provided a record amount of compliance assistance to help employers provide workplaces free of hazards. In FY 2019 alone, OSHA's On-Site Consultation Program identified 137,885 workplace hazards, and protected 3.2 million workers from potential harm.

OSHA also provided a record 1,392,611 workers with training on safety and health requirements in FY 2019. This training, which is critical in helping employers and workers understand workplace hazards and ways to address them, including how to comply with OSHA standards, was provided through the agency's various education programs, including the OSHA Training

Institute Education Centers, Outreach Training Program, and Susan Harwood Training Grant Program. In fact, current Harwood training supported by the FY 2019 awards for healthcare industry hazards and personal protective equipment can include worker protection as it pertains to COVID-19 for the target audiences approved in the grants. And the Harwood FY 2020 funding opportunity announcement was published last week – over a month ahead of the congressional deadline – and includes COVID-19 as a training topic. Grantees can address worker protection as it pertains to COVID-19, including training on personal protective equipment.

The work of the agency continues uninterrupted even as we respond to this pandemic. Since February 1, 2020, and through May 21, 2020, OSHA has received 5,978 non-COVID-19 complaints and conducted 5,009 investigations based on these complaints and 969 inspections. During this time, OSHA has received 2,380 non-COVID-19 whistleblower complaints, which are being evaluated along with the COVID-19 whistleblower complaints.

OSHA's efforts to address COVID-19 have been its top priority since February. Our world changed with the arrival and spread of the coronavirus. Although the pandemic has changed the way OSHA completes its mission, it has never faltered in its commitment to ensure employers provide a workplace free of hazards. OSHA quickly pivoted to focus intensely on giving employers and workers the guidance they need to work safely in this rapidly changing situation; where appropriate, OSHA has also enforced safety and health requirements. Never before has OSHA staff been so focused on a single health risk. Throughout this crisis, the incredible men and women of OSHA have remained committed to carrying out their mission to keep America's workers safe and healthy. Let me address that in more detail now.

OSHA has been in frequent conversation with Members of Congress and congressional staff over the past several months. OSHA is actively engaged to accomplish our mission to help ensure federal, state, local, and private stakeholders take the necessary steps to protect the safety and health of employees. As the head of OSHA, I speak daily with OSHA regional staff to ensure workers and employers have the knowledge and support they need. I am so proud of the dedication to OSHA's mission of our hard-working compliance safety and health officers

(CSHOs) and all of the agency's personnel. Unfortunately, I believe their efforts have not been properly characterized by some, and that is wrong. Our CSHOs are initiating thousands of investigations of complaints. Our compliance assistance staff are working with employers across the country to help ensure safe and healthful working conditions for the nation's workers. Our training and education staff have moved quickly to provide training to CSHOs through an electronic platform so CSHOs are ready to inspect and cite workplaces exposing workers to COVID-19 hazards. The Department's goal each day is to ensure OSHA protects the safety and health of America's workforce. Before, during, and after the pandemic, my goal is for OSHA's efforts to prevent workers from ever becoming ill or injured because they are doing their job.

Well before the World Health Organization declared a public health emergency and then a worldwide pandemic, OSHA staff had begun to track this new virus. In late December of 2019, OSHA learned of a pneumonia case in China believed to have been caused by a previously unidentified virus, and by mid-January of 2020, had developed a Safety and Health Topics Page on the 2019 novel coronavirus. Since January, OSHA has been coordinating with public health officials, including the Centers for Disease Control and Prevention (CDC), and providing information regarding COVID-19 through this dedicated safety and health topics page. OSHA has prioritized sharing up-to-date safety information with the public as soon as possible. This website is an important means of distributing information, and that is reflected in the increasing numbers of visits to OSHA's website, as well as the increasing numbers of outreach subscribers. As of May 21, 2020, OSHA has 288,267 subscribers to Quick Takes (bi-weekly online health and safety newsletter), 34,595 subscribers to its recently initiated COVID-19 Tip of the Day, and 22,050 Twitter followers.

OSHA's initial response to the pandemic was to provide extensive guidance, often in conjunction with the CDC. Guidance has allowed the agency a more nimble response to the ever-changing understanding of the virus. As our medical professionals and scientists learn more about the virus, guidance can be easily updated, while regulations are very cumbersome to revise. Guidance also allows us to speak more specifically to particular types of workplaces and controls than would be practicable in a generally applicable rule. From the beginning of this health crisis, OSHA was concerned about access to respirators, as the flu season had been more severe than

anticipated. On March 11, the President signed a Presidential Memorandum directing the Department of Labor to take “all appropriate and necessary steps to increase the availability of respirators.” To date, OSHA has issued five different enforcement guidance documents that seek to preserve the respirator supply for health care workers while ensuring protection of those workers. OSHA continues to issue industry specific alerts that provide targeted guidance on practices and procedures that will help protect workers’ health and safety. OSHA’s regularly issued guidance has been tailored to address the intricacies of multiple industries in detail. To date, OSHA has issued general-industry guidance and also has issued guidance documents to protect workers in numerous specific industries, including meatpacking and processing, healthcare, nursing homes, restaurants, dentistry, and manufacturing. These documents provide guidance to employers on the hierarchy of controls to protect workers. The guidance explains the use of engineering controls such as instituting physical barriers or distance between employees, reinforcing PPE usage where required and when engineering controls cannot be implemented. Some guidance also provides information on the use of facemasks by employees.

OSHA has also distilled its guidance into a wide variety of usable worker education segments available on the OSHA website. Among these items, OSHA has a daily COVID-19 tip of the day and a top ten list of actions employers and workers can take to prevent COVID-19 infection. The latter document alone is translated into 12 languages. OSHA has also developed a poster demonstrating the seven steps for wearing a respirator, and a video on applying social distancing in the workplace. These are just some of the steps that OSHA has taken to get health and safety information directly into the hands of employers and workers.

While extensive guidance is important as the rapidly changing dynamic of this pandemic continues, it is important to recognize OSHA also has existing standards that serve as the basis for its COVID-19 enforcement. Those standards include rules regarding respiratory protection, personal protective equipment (PPE), eye and face protection, sanitation, and hazard communication. In addition to those existing authorities, OSHA also has the ability to take appropriate action against employers under the OSH Act’s “general duty clause.” Some have tried to argue that because OSHA is only issuing COVID-19 guidance, employers have no compliance obligations. This is not accurate, and repeating this erroneous claim does a

disservice not only to the hardworking men and women of OSHA, but to the hardworking men and women OSHA aims to protect. It also misleads employers about the legal obligations they have. While the guidance documents clarify they do not create *new* legal obligations, this does not mean employers do not have extant legal obligations.

Since the start of the pandemic, OSHA has responded to almost double the number of complaints, compliance assistance requests, and questions than the previous time last year. As of May 21, 2020, OSHA has received 4,268 COVID-19 safety and health complaints, of which 2,995 have been closed. In addition, OSHA has received 1,328 COVID-19 whistleblower complaints, of which there are 243 complaints currently being screened. OSHA screens every complaint it receives, and investigates every timely complaint it receives that is within its jurisdiction.

As in other situations, such as natural disasters, OSHA has accepted mission assignments from the Federal Emergency Management Agency to provide safety and health information to our federal workers on the front line of the federal response. OSHA is also an active participant in ten federal task forces focused on the COVID-19 response and as always, continues its collaborations with its federal partners to share information and develop tools to meet the challenges of fighting this disease and protecting workers.

OSHA was recently sued by the AFL-CIO for an emergency temporary standard, and for that reason I cannot comment on issues surrounding an ETS or the litigation. I would note, however, that OSHA has standards in place to protect employees and employers who fail to take appropriate steps to protect their employees may be violating them. Such standards include conducting hazard assessments, ensuring sanitation and cleanliness, providing PPE, and requiring training and education, as well as the general duty clause itself.

I believe that our current approach allows the agency needed flexibility to be responsive to a virus that we learn more about each day. One example of OSHA's nimble approach is meatpacking. OSHA worked with the Centers for Disease Control and Prevention and U.S.

Department of Agriculture to provide meatpacking plants comprehensive guidance to continue operations.

Similarly, the flexibility and responsiveness allowed through guidance is apparent in the two revised enforcement policies issued last week by OSHA. As states are beginning to reopen their economies, OSHA is acting to ensure employers are protecting their employees.

First, OSHA is increasing in-person inspections at all types of workplaces. The new enforcement guidance reflects changing circumstances in which many non-critical businesses have begun to reopen in areas of lower community spread. The risk of transmission is lower in specific categories of workplaces, and personal protective equipment potentially needed for inspections is more widely available. OSHA staff will continue to prioritize COVID-19 inspections, and will utilize all enforcement tools as OSHA has historically done.

Second, OSHA is clarifying its previous enforcement policy for recording cases of coronavirus. Under OSHA's recordkeeping requirements, coronavirus is a recordable illness, and employers are responsible for recording cases of the coronavirus, if the case:

- Is confirmed as a coronavirus illness;
- Is work-related as defined by 29 CFR 1904.5; and
- Involves one or more of the general recording criteria in 29 CFR 1904.7, such as medical treatment beyond first aid or days away from work.

Under the new policy, OSHA will enforce the recordkeeping requirements of 29 CFR 1904 for employee coronavirus illnesses for all employers. Given the nature of the disease and community spread, however, in many instances it remains difficult to determine whether a coronavirus illness is work-related, especially when an employee has experienced potential exposure both in and out of the workplace. OSHA's guidance emphasizes that employers must make reasonable efforts, based on the evidence available to the employer, to ascertain whether a particular case of coronavirus is work-related. Recording a coronavirus illness does not mean that the employer has violated any OSHA standard.

In addition to providing guidance and ensuring enforcement, OSHA has conducted compliance assistance efforts. As part of OSHA's compliance assistance efforts, the agency has answered

employers' and workers' real-world questions through industry-specific webinars, OSHA's online portal, and phone conversations. OSHA has a standing meeting with State Plans states every two weeks to share best practices and discuss emerging data. OSHA has also participated in calls with industry stakeholders and union representatives. Since the start of the pandemic and as of May 21, 2020, OSHA's consultation programs have conducted a total of 4,134 outreach activities and OSHA's Regional and Area Offices have conducted a total of 945 outreach activities related to COVID-19.

But, to repeat, OSHA will not use guidance as a substitute for enforcement—rather, the agency has the tools and intent to pursue both avenues. Where there are safety issues, OSHA remains, as always, shoulder to shoulder with America's workers.

OSHA is charged with protecting the rights of whistleblowers under 23 statutes. As the Secretary made clear from the White House podium, multiple national interviews, and additional conversations with stakeholders: retaliation against workers is unacceptable. OSHA has already received more than a thousand COVID-19 related whistleblower complaints. These complaints are in addition to the several thousand complaints the agency already receives every year for other reasons. OSHA is actively reviewing and working to resolve the complaints. While privacy prevents me from speaking in specifics, OSHA is obtaining positive resolutions from its review of whistleblower complaints. These resolutions have reinstated workers and made significant policy changes to businesses.

COVID-19 is an unprecedented worldwide health crisis. In response, OSHA issued interim enforcement guidance preliminarily focused on the protection of our frontline health care workers. The enforcement guidance outlined OSHA's priorities to responding to the pandemic. Contrary to the way some have characterized this document, it applies to all areas of the agency's enforcement.

In this pandemic, OSHA inspectors are initiating thousands of investigations. This is resulting in employers receiving up-to-date information about how to better protect their workers. During the same time, OSHA inspectors continue to respond to non-COVID-19 worker fatalities and

complaints. Through the tireless efforts of the entire agency, OSHA's continuous outreach and communications to workers and employers, and its issuance of important guidance, OSHA is on the job protecting America's workers. I am happy to answer any questions you may have.

Chairwoman ADAMS. Thank you, Ms. Sweatt.
Dr. Howard, you have 5 minutes, sir.

STATEMENT OF JOHN HOWARD, MD, MPH, JD, LL.M, MBA, DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, WASHINGTON, D.C.

Dr. HOWARD. Good morning, Chairwoman Adams and Ranking Member Byrne, Chairman Scott and Ranking Member Foxx. My name is John Howard, and I am the Director of the National Institute for Occupational Safety and Health, which is part of the Centers for Disease Control and Prevention in the U.S. Department of Health and Human Services. I am pleased to provide the Subcommittee information about the COVID-19 response activities undertaken by NIOSH over the past few months.

To date, just over 1.6 million cases of COVID-19 have been reported to CDC. Many of these cases are in working-age adults. For example, as of today, May 28, there have been 62,690 cases of COVID-19 among healthcare workers, with 294 deaths. However, the total number of healthcare worker cases is likely to be an underestimate due to data collection challenges arising from the pandemic.

Currently, CDC and NIOSH are actively working to address the issue of capturing occupational data as it relates to COVID-19 cases.

A new case report form released on May 5 added questions about workplace exposures for healthcare workers and workers in other critical infrastructure industries. States have been asked to start using this new form by May 15.

Activities by NIOSH as a part of CDC's response to COVID-19 fall into three main categories. First, respiratory protective devices. Through NIOSH's National Personal Protective Technology Laboratory, NIOSH is responsible for establishing criteria, testing, and certifying respiratory protective devices, including filtering facepiece respirators. The most common type is the N95.

During the global supply shortage caused by the pandemic, NIOSH and CDC have taken steps to increase the supply of available certified respirators by, one, supporting existing NIOSH respirator approval holders to increase their ongoing production; two, quickly evaluating new domestic respirator applications for approval; three, providing up-to-date guidance, especially with regard to respirators made by non-U.S manufacturers; and four, tripling respirator approval decisions.

To expand the range of respirators available to healthcare workers, NIOSH works with FDA on its emergency-use authorizations which can significantly expand the inventory of respirators available for use in healthcare settings by, one, permitting the use of powered air purifying respirators, or PAPRs, elastomeric respirators, and other NIOSH-approved filtering facepiece respirators besides the N95, that had not been previously cleared by FDA for use in healthcare settings; second, permitting the use of stockpiled respirators that had exceeded their rated shelf life; three, permitting the use of certain respirators from foreign countries approved under the performance standards in those countries; and four, per-

mitting the reuse of certain decontaminated filtering facepiece respirators.

Second, field survey support for State health departments. NIOSH deployed staff to 34 States and 18 poultry, 11 beef, and 5 poultry processing workplaces, representing 15 separate companies.

The number of cases of COVID-19 in meat processing is significant. NIOSH has reviewed plant facilities, processes, operations. CDC's epidemiologists and partners from State and local health departments evaluated plant and community infection control plans through various methodologies. A typical site visit examines multiple features of the plant's operations.

Third, guidance. NIOSH has, through the Emergency Operations Center at CDC, worked with our partner agencies, including OSHA, the Department of Agriculture, and the Department of Transportation, to produce numerous guidance documents and fact sheets for employers and workers in various industries and occupations. For example, CDC and OSHA have coauthored interim guidance for the meat and poultry packing industry and interim guidance for manufacturing workers and employers.

Thank you again for the opportunity to participate in today's hearing. I look forward to answering your questions.

[The statement of Dr. Howard follows:]



**Testimony before the Committee on
Education and Labor Subcommittee on
Workforce Protections
United States House of Representatives**

Examining the Federal Government's Actions to Protect Workers
from COVID-19

John Howard, MD

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Health, Centers for Disease Control and Prevention, U.S.
Department of Health and Human Services**



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Statement of John Howard, M.D., J.D.,
Director, National Institute for Occupational Safety and Health

**Centers for Disease Control and Prevention
U.S. Department of Health and Human Services**

**Subcommittee on Workforce Protections
Committee on Education and Labor
U.S. House of Representatives**

May 28, 2020

Good morning, Chairwoman Adams, Ranking Member Byrne, Chairman Scott, Ranking Member Foxx, and distinguished members of the Subcommittee. My name is John Howard and I am the Director of the National Institute for Occupational Safety and Health, or NIOSH, which is part of the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS). I am here today to provide the Subcommittee information about the risks that workers face from coronavirus disease (COVID-19), and the actions taken by the CDC to protect workers.

Background

COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. This new disease, officially named Coronavirus Disease 2019 (COVID-19) by the World Health Organization (WHO), is caused by the SARS-CoV-2 virus. There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. Coronaviruses are a large family of viruses. Some cause illness in people, and others, such as canine and feline coronaviruses, only infect animals. Rarely, coronaviruses that infect animals have emerged to infect people and can spread between people. This is suspected to have occurred for the virus that causes COVID-19. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are two other examples of coronaviruses that originated in animals and then spread to people.

CDC is America's health protection agency and works 24/7 to save lives and protect America from health, safety and security threats, both foreign and in the United States. Addressing infectious diseases like COVID-19 is fundamental to our mission and is our highest priority. CDC is building upon decades of experience and leadership in responding to prior infectious disease emergencies, including

SARS, MERS, Ebola, Zika, and pandemic influenza to meet new challenges presented by COVID-19. These challenges are many, and they are historic. Every single American is affected by this pandemic, and CDC is leaning into this public health crisis with every applicable asset we have. CDC is drawing on its emergency response capacity and its relationships with state, tribal, local, and territorial (STLT), global, and private sector partners; and is leveraging our workforce's strengths in public health surveillance, and laboratory capacity, to address this public health emergency. CDC is developing guidance for healthcare professionals and the public to encourage safer practices, improve health outcomes, and save lives. CDC is also working with partners to develop guidance and decision tools to assist state and local officials and other stakeholders in adjusting mitigation strategies. Importantly, CDC is preparing the nation's public health system and the private sector for a vaccine when one is available. Abroad, CDC is leveraging investments in global health security, pandemic influenza preparedness and public health infrastructures and capacities built through programs like the President's Emergency Plan for AIDS Relief to support countries in mitigating and containing COVID-19. The emergence and rapid spread of COVID-19 confirms that an infectious disease threat anywhere is a threat to Americans everywhere, including here at home.

As of May 21, 2020, there have been 1,551,095 total cases of COVID-19 reported to CDC. Many of these cases are in "working-age" adults with over 900,000 cases in those aged 18-64. In this age group, over 57,000 are cases known to be among healthcare workers. It is not known how many of these infections occurred as a result of their work. Several states are reporting numbers of cases among healthcare personnel on their websites.

CDC is working to better understand the full scope of cases among workers in non-healthcare settings. The new CDC case report form, released on May 5, added questions about categories of healthcare workers and about workplace exposures in critical infrastructure industries. States have been asked to start using this new form by May 15, 2020. CDC is actively trying to learn more about the

burden of COVID-19 among various industries and occupations through other data collected by CDC, state and local health departments, and other organizations.

Actions taken by the National Institute for Occupational Safety and Health

The Occupational Safety and Health Act of 1970 established the National Institute for Occupational Safety and Health (NIOSH) as a research agency focused on the study of worker safety and health. NIOSH is a part of the CDC and has the mandate “to assure every man and woman in the Nation safe and healthful working conditions and to preserve our human resources.”

The actions taken by NIOSH as part of CDC’s response to COVID-19 fall into three main categories. First, NIOSH has taken actions to increase and augment the supply of respiratory protective devices, a key component of personal protective equipment (PPE) that workers use as the last line of defense against exposure to toxic and infectious agents. Second, NIOSH staff, with an expertise in workplace safety and health and trained in industrial hygiene, engineering, medicine, and epidemiology, are among members of CDC field teams deployed to carry out site visits at meat processing plants. These teams are responding to requests from state and local health departments, factories, and plants engaged in critical infrastructure activities. Third, NIOSH works in close partnership with our colleagues at the CDC, as well as those in the U.S. Food and Drug Administration (FDA), the U.S. Department of Labor’s Occupational Safety and Health Administration (OSHA), and the U.S. Department of Agriculture’s Food Safety and Inspection Service (FSIS), to develop information and guidelines for employers and employees to work safely and reduce their risk of workplace exposure to the SARS-CoV-2 virus that causes COVID-19 disease. I will now address these activities in some detail.

Personal Protective Equipment

Through its National Personal Protective Technology Laboratory (NPPTL), NIOSH is responsible for establishing criteria, testing, and certifying approval of respiratory protective equipment, including filtering facepiece respirators (FFRs), also known popularly as “N95” masks. This is a key part of the personal protective equipment (PPE) ensemble in many workplaces, and particularly within healthcare

settings. During this COVID-19 pandemic, NIOSH has taken aggressive steps to increase the supply of available certified FFRs. The focus for the respirator approval program at NPPTL during the COVID-19 outbreak includes: (1) supporting existing NIOSH respirator approval holders to increase their ongoing production; (2) quickly evaluating new domestic respirator applications for approval; and (3) providing up-to-date PPE guidance. According to the NIOSH Certified Equipment list, there are currently 535 active filtering facepiece respirator approvals. These include the N95 respirator, the most commonly used respirator in healthcare. In April 2020, NIOSH more than tripled the rate of respirator approval and denial decisions, from 30 to over 100 decisions per month. This was accomplished by having NPPTL staff scientists, engineers, and technicians working longer shifts, 7-days a week, to help increase the availability of respirators for the workers who need them.

To expand the range of respirators available to healthcare workers, NIOSH worked with the FDA who had developed Emergency Use Authorizations (EUA) to significantly expand the inventory of respirators available for use in healthcare settings. The FDA issued these EUAs: (1) permitting use of Powered Air Purifying Respirators (PAPRs), elastomeric respirators, and other NIOSH-approved FFRs that had not been previously cleared for use in health care settings by the FDA; (2) permitting the use of stockpiled respirators that had exceeded their rated shelf-life; (3) permitting use of certain respirators from seven foreign countries approved under the standards in those countries; and (4) permitting use of certain decontaminated FFRs.

CDC recognizes that more needs to be done during this COVID-19 pandemic to ensure health and safety products entering the United States from other countries provide the protection our workers have come to expect from NIOSH-approved equipment. To ensure this level of confidence, NIOSH has developed an assessment to evaluate the filter efficiency of respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators. Likewise, NIOSH has set up a limited evaluation program to examine samples from stockpiled respirators and from respirators that have been decontaminated for reuse under FDA EUAs. NPPTL is conducting these tests at our

laboratory in Pittsburgh, Pennsylvania, and Morgantown, West Virginia. The international assessments have resulted in the evaluation of over 130 international respirator models in the past two months. More than 50 percent of the models tested were substandard, providing data needed to support the FDA's EUA decisions and other Federal agency decisions to remove substandard and counterfeit products from the market, and data to support state and hospital purchasing decisions.

To further expand the types of devices available for the COVID-19 response, on April 14, 2020, NIOSH promulgated an interim final rule that created a new class of Powered Air-Purifying Respirator (PAPR). The PAPR is a type of respirator that includes a battery-powered blower that pulls air through an N95 or high efficiency particulate air (HEPA) filter and delivers clean air across the worker's face into either a tight-fitting face mask or a loose-fitting hood. They provide protection that is at least 2.5-times *better* than a N95 filtering facepiece respirator. With this rulemaking, parallel performance standards were added to existing regulatory requirements for PAPR, to allow for the approval of a new class known as the PAPR100. The performance requirements for the PAPR100 allow it to be lighter in weight and better suited to the needs of workers in the healthcare and public safety sectors. The previous existing PAPR standard resulted in a heavier unit since it needed to pass tests designed for heavy dust loads found in industry, such as exposures to mineral dusts and welding fumes. Over the past 20 years, PAPRs have played an increasing role in respiratory protection programs in the United States in the healthcare sector. As seen during the 2003 Severe Acute Respiratory Syndrome (SARS), the 2009 H1N1 influenza, and the 2014-15 Ebola virus outbreaks, PAPRs are often used in high-hazard procedures in the healthcare setting because they are designed to filter chemicals, blood-borne pathogens, and aerosol-transmissible pathogens. Current shortages of non-powered particulate respirators underscore the need for approval of PAPRs more suitable for use by the healthcare workers and first responders dealing with the disease. New, non-traditional manufacturers have entered the market to produce the new PAPR100, thus increasing the supply of reusable PPE for health care workers against COVID-19. With this expanding supply of PPE, this last line of defense against infection is also available for use in non-

healthcare workplaces where high dust-loading is not anticipated. For example, a PAPR100 might be used by transit and delivery drivers, grocery and retail store workers, and other non-dusty factory workers.

Field Survey Support to State Health Departments

The food and agriculture sector is a part of the U.S. critical infrastructure. Public health strategies need to be implemented to protect workers filling essential roles within the food system, including the meat and poultry industry, to preserve essential functions, and maintain the nation's food supply. Employers in the meat and poultry processing industry can help prevent and slow the spread of COVID-19 by reducing the spread of disease among employees and maintaining healthy business operations and work environments.

Since April 2020, NIOSH has deployed staff or assisted virtually to 36 sites in 12 states, covering 5 pork facilities, 19 poultry and 11 beef processing factories representing 18 separate companies. NIOSH scientists and engineers reviewed plant facilities, processes and operational plans. The CDC's epidemiologists and partners from state and local health departments evaluated plant and community infection control plans and infection rates through screening, testing and tracing for dealing with COVID-19 outbreaks. Together, these agencies are committed to protecting the health of workers, the health of communities, and collaborating to provide a secure supply of food.

A typical site visit would examine multiple features of the plant's operations. For example, the team examined the company's plans for employee screening prior to entering the plants. They observed the areas where arriving employees would be asked about their current symptom status and where and how they would be screened for fever and the criteria for following up if positive symptoms were reported or observed. The teams also examined supplementary infection control measures used by the facilities. For example, the availability and use of hand sanitizer dispensers, surface cleaning and disinfection procedures for high-touch areas, and the use of facemasks and other face coverings including face shields.

The plant's procedures for maintaining physical distancing of employees were also reviewed within the operational areas of the plant and in locker rooms, bathrooms, lunchrooms, break areas, and other locations where employees may congregate. Teams noted engineering controls, such as locations where physical barriers were installed between workstations at which maintaining the six-foot physical distancing requirements was not feasible. Additionally, the teams examined administrative controls such as company policies offering paid sick leave to encourage and incentivize symptomatic workers to stay home; or providing training and communications software to enable plant communications while maintaining distance.

The team examined the plant's own policies for using PPE, including training and demonstrations to determine whether workers knew how to follow proper donning and doffing procedures to avoid contamination, and to understand when PPE could be either disposed of or properly disinfected and stored in a clean location for later reuse. PPE could include respirators, face shields, helmets, gloves, and other protective garments.

NIOSH and CDC staff typically provide recommendations based on their observations and on the best available science, and after examining the company's written plans and policies. The recommendations follow the hierarchy of controls, wherever feasible. Hierarchy of controls is an approach to hazard intervention that starts with the controls perceived to be most effective and moves down to those considered least effective. In most cases, the preferred approach is to eliminate a hazard or exposures, install engineering controls, and implement appropriate sanitation and cleaning to shield or reduce employees' exposure to the hazard. Until such controls are in place, or if they are not adequately effective or feasible, administrative measures and personal protective equipment (PPE) may be recommended.

COVID-19 is a new challenge for our food system partners; there are many unknowns. There is no formal reporting or surveillance system indicating to health authorities when COVID-19 affects food facility operations. The number of outbreak reports likely underestimates the number of food system

workers affected by COVID-19. Employers need to be innovative in finding solutions to complex problems; there is no one-size-fits-all approach when implementing recommendations. Additional education and training are needed regarding measures workplaces can take to protect workers. Workers are also members of the community; thus, when there are ongoing outbreaks in the community, illness can be introduced into the workplace. Outbreaks of illness in workplaces can also result in increased illness in communities. Culturally appropriate community-based interventions are needed to protect health of workers with large or extended families living in the same household.

Scientific Information and Guidance

The American people, communities, public health professionals, medical providers, businesses, and schools look to CDC for trusted guidance on responding to COVID-19. CDC develops and disseminates guidance for individuals and communities. These recommendations include actions that every American should take, such as following good personal hygiene practices, staying at home when sick, and practicing social distancing to lower the risk of disease spread. CDC guidance is available here <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick-prevention.html>.

First responder and healthcare guidance documents cover a range of topics - from addressing potential work-related exposures, implementing infection prevention and control measures in health facilities, and optimizing the supply of personal protective equipment to clinical evaluation, testing, and clinical care. CDC is providing these recommendations to support communities' efforts, while recognizing that each sector and community is unique and will need to consider these in the context of their community-level data and circumstances. CDC teams on the ground and those aiding from Atlanta are and will continue working with state and local officials to integrate these recommendations into COVID-19 plans.

Mitigation and containment of COVID-19 are the key to public health strategies and CDC is committed to using our expertise and partnering with others on the frontlines.

NIOSH and other centers at CDC have worked with our partner agencies including OSHA, USDA, and the Department of Transportation, to produce guidance documents and fact sheets for workers. For example, NIOSH developed 8 fact sheets geared for airport workers including information for gate agents, baggage and cargo handlers, maintenance workers, catering kitchen workers and airport retail and service workers across the country. NIOSH also developed 11 fact sheets covering the millions of people working in small business, schools, and as transit and delivery drivers, first responders, and food and grocery workers. As a joint publication, we developed Interim Guidance from CDC and the Occupational Safety and Health Administration (OSHA) for the Meat and Poultry Packing Industry, and Interim Guidance from CDC and OSHA for Manufacturing Workers and Employers.

Summary

In summary, NIOSH and other CDC centers have been working tirelessly to protect workers from exposures to the SARS-CoV-2 virus in the course of their employment. We have responded to the unique challenges of this COVID-19 pandemic in multiple areas that impact workers. We continue to assist manufacturers of personal protective equipment and innovators ability to increase the supply of reliable personal protective equipment that workers depend on every day. We are deploying scientists and engineers on field investigations to critical infrastructure plants, particularly those in meat and poultry processing, examining how best to protect critical infrastructure workers. Finally, we are developing and disseminating through fact sheets, guidance, and videos the scientific information we have learned from our field efforts and from our experience and expertise in worker protection.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control
and Prevention (CDC)**Memorandum**

Date: April 21, 2020

From: Michael Grant, CDC National Institute for Occupational Safety and Health
Colin Basler, CDC National Center for Emerging Zoonotic Infectious Diseases
Jessica Jacobs, CDC Laboratory Leadership Service Officer
Erin Kennedy, CDC Center for Global Health
John Osburn, South Dakota Department of Health
Jonathan Steinberg, CDC Epidemic Intelligence Officer, South Dakota Department of Health
Suzanne Tomasi, CDC National Institute for Occupational Safety and Health

To: Joshua Clayton, South Dakota Department of Health

Copy: Russ Dokken, Smithfield Foods
Scott Reed, Smithfield Foods
Mark Wiggs, Smithfield Foods
B.J. Motley, President, UFCW Local 304A Union

Subject: Strategies to reduce COVID-19 transmission at the Smithfield Foods Sioux Falls Pork Plant

Background

The South Dakota Department of Health requested an Epi Aid for assistance in developing strategies to help reduce SARS-CoV-2 infections among Smithfield Foods Sioux Falls pork processing plant employees. SARS-CoV-2 is the virus that causes coronavirus disease 2019 (COVID-19). A team from the Centers for Disease Control and Prevention (CDC) traveled to Sioux Falls, South Dakota for an Epi Aid on April 14, 2020. The CDC team included veterinary epidemiologists, an Epidemic Intelligence Service Officer, an industrial hygienist, and a Laboratory Leadership Service Fellow. One component of this effort was to visit the Smithfield Foods pork processing plant to evaluate existing health and safety controls and provide recommendations for improvement. This memorandum provides observations and recommendations based on our visits to the plant on April 16 and 17, 2020 and conversations with plant management and the United Food and Commercial Workers Union (UFCW) local president.

No slaughtering or further production work were taking place in the plant while we were on site. The first case among employees was detected on March 24, 2020. Smithfield Foods announced that the process to halt production began on April 1, 2020. The plant informed us that all processing activities were completed on April 14, 2020 and that the plant would be shut down indefinitely while Smithfield continued extensive sanitation and modification efforts in the plant. The few employees we observed in the plant during our walkthroughs were performing maintenance and distribution center tasks. We

toured the plant and observed workstations from the pens where the swine are delivered through the distribution center, where product is shipped out of the plant. We also observed the route that employees take from the parking lots through the symptom screening tents and into the facility. Additionally, we observed administrative areas, the occupational health clinic and quarantine room, and the common areas (e.g., break rooms, cafeterias, locker rooms) shared by employees.

Our team was unable to identify important demographic information about this workforce, limiting our ability to understand the diversity of the employees. However, plant management reported that there were approximately 40 different languages spoken by employees in the plant and that English, Spanish, Kunama, Swahili, Nepali, Tigrinya, Amharic, French, Oromo, Vietnamese are the top 10 languages. We were also unable to obtain information about the workstations of confirmed positive cases. This type of information could provide a better understanding of what workplace factors may have contributed to the spread of COVID-19 among employees. Key demographic and workstation information was requested from the company to help answer some of these questions in the future. Additional recommendations and findings may be provided upon receipt of demographic and workstation information.

Observations and Discussion

Employee Screening

Employees were screened before entering the plant prior to their shift. The company had set up two screening locations, one on either side of the plant. Visual markers were added every six feet to decrease crowding while employees approached and moved through the screening tents. The screening consisted of walking past a thermal imaging system for body temperature measurement and self-reported symptom checks. Screening was conducted by a contracted health care professional who informed the employee of their temperature and asked whether the employee had a cough or shortness of breath.

We were informed that if an employee had a fever ($>99.8^{\circ}$) or reported experiencing symptoms, the employee underwent secondary screening by a contracted nurse. Additionally, we learned that the screening process also looked for visible signs of symptoms as employees were screened. Secondary screening consisted of a temperature check with an infrared thermometer and a more in-depth evaluation of symptoms. We understand that if an employee was found to have a fever or symptoms consistent with COVID-19, they were given an informational packet (in English) and instructed to return home. Employees were provided two weeks of paid sick leave (40 hours pay per week) when sent home and were asked to call a hotline operated by a local health system for guidance regarding next steps.

Plant management informed us that they had identified a department of the plant (Pork Conversion) with a high density of positive cases. The whole department was placed on two weeks paid sick leave. We also learned that efforts had been taken to adjust schedules to facilitate distancing of employees working in essential operations (e.g., wastewater treatment). Additionally, we learned of a "responsibility bonus" of \$500 being offered to employees who did not miss time (e.g., were not late or sick) during the time period of April 1 through May 1, 2020. The company informed us that COVID-19-related absence will not impact the receipt of the bonus.

Increasing Distance Between Employees During Work and Breaks

Plant screening tents had posters on the wall to remind employees to maintain a social distance of 6 feet during the screen process. In all lunchrooms and break areas that we observed, dividers had been placed on tables to remind employees to maintain a physical barrier between each other. Some tables had been marked “off-limits” by tape. Additional tables were placed in one hallway (the “flag hallway”) to decrease the density of employees inside the nearby cafeteria. Some outdoor picnic tables had been moved to facilitate social distancing, although other outdoor tables were less than 6 feet apart.

In at least one department (Ground Seasoned Pork), line speed had been reduced to accommodate fewer employees on the line due to social distancing efforts and workforce availability constraints (i.e., illness amongst employees). Plant management had identified and installed approximately 800 plexiglass barriers in locations where distancing was not possible (e.g., production lines). Plant management reported that, on some production lines prior to shutting down the plant, employees on opposite sides of the line alternated workstations to maintain distancing. On other lines, barriers had been hung in an attempt to separate employees. Management reported that the barriers were made of plexiglass. Among the few employees that were present in the plant during our walk throughs, we observed several who were congregating less than 6 feet apart when away from their workstations.

Supplementary Infection Control Measures

We saw hand sanitizer dispensers located in limited locations throughout the plant, notably at the entrances to the building and within cafeterias and break rooms. Plant management indicated that more hand sanitizer dispensers will be added as COVID-19 prevention measures. We learned of plans to increase the number of dispensers to 3500 (i.e., roughly one dispenser station per employee). The hand sanitizing dispensers were all manually operated (i.e., not touchless). Limited handwashing stations were available in locker rooms and in some production areas of the plant. We learned from the union that there were approximately 30 employees in a locker room at any given time. Some handwashing stations were touchless, but the majority were not. Management also indicated they were developing a plan to have people assigned to enforce hand sanitizing for every employee in the plant every 30 minutes. However, the plant had not yet finalized the rollout plans for this effort.

Additional staff have been assigned to clean and sanitize commonly touched surfaces more frequently, such as handrails, doors and door handles, and lunch tables. Time clocks in the plant were touchless for plant employees, and the plant informed us of plans to install over 100 additional time clocks to decrease bottlenecks.

Use of Facemasks and Other Face Coverings

Plant management informed us of plans to institute a universal facemask requirement for all employees in accordance with CDC recommendations for critical infrastructure employees and the public. We learned that plant management will provide a facemask with moldable nosepiece to all employees before entering the plant each day. We learned that they have a plan to provide additional facemasks to employees throughout the day if facemasks become wet or soiled. We also learned that face shields will be provided to all non-administrative employees moving forward. These face shields will be affixed to

the hard hat. We observed some employees still working at the plant either not wearing facemasks or wearing them incorrectly (e.g., wearing them over the mouth but not the nose). Plant management indicated that they had estimated the number of facemasks and face shields that would be required for a 30-day supply for the plant running at full capacity. Plant management was also conducting informal experiments with both commercial and home-remedy-style anti-fogging products (e.g., shaving cream) for the face shields.

Educating Employees on COVID-19 Risks, Prevention, and Company Policies

There were informational flyers with pictures representing COVID-19 symptoms of fever, cough, and shortness of breath on the walls of the screening areas, but not at the screening table itself. Throughout the plant, informational flyers were posted on walls encouraging employees to practice social distancing, keep their mouth and nose covered, regularly wash their hands, and report symptoms to occupational health. Some flyers were translated into multiple languages and there were some that included pictograms. Most flyers were approximately 9" x 11" but were not positioned at eye level. Many flyers had densely packed words and limited pictograms. There were video loops on display in cafeterias and break rooms, but we did not observe any COVID-19-related educational information. The plant had recently implemented a new messaging strategy using an application called "Beekeeper" that allowed management to mass-communicate with employees in a language of their choice. We learned from the union that they also have the ability to send mass communications to their members. The union also reported the ability to translate messaging for members and identified key plant employees who served as translators when needed. Although plant management stated that many of their employees used smart phones, it was unclear how widely the app was being used among employees at the time of our visits. The plant also utilized a text messaging alert system that could send COVID-19 related messages to employees. Management expressed that communicating messages to their diverse staff presented challenges due to the number of languages spoken.

Pending Activities Reportedly Planned by the Company

1. Developing and finalizing standard operating procedures for new infection prevention and control measures, especially related to supplementary disinfection of high-touch areas.
2. Increasing engagement with the Beekeeper application. We were informed that approximately 1,400 employees have signed on to receive text messages from this system.
3. Completing installation of plexiglass barriers in close contact workstations.
4. Increasing the number of hand sanitizer dispensers in the plant to 3,500 (i.e., roughly 1 per employee).
5. Installing over 100 additional time clocks to prevent bottlenecks.
6. Promoting increased adoption of mass communication methods to communicate COVID-19 prevention and informational messages to employees. We learned that they are planning to start this process during the plant closure.
7. Having designated staff walk around lines to provide hand sanitization to line employees every 30 minutes.
8. Relaxing sick leave policies related to COVID-19. Eliminating premiums, copays, and waiting periods for COVID-19 testing.

Conclusions

The company implemented several controls at the plant to help reduce and mitigate the spread of coronavirus between employees while in the plant and is in the process of implementing additional strategies as discussed above. Additional recommendations are provided below to help both management, employees, the union, the South Dakota Department of Health, and strategic community partners to limit virus transmission in the plant. Consult with the United States Department of Agriculture (USDA) staff at the plant to determine if proposed controls are acceptable with regards to food safety and sanitation.

Recommendations

The following actions are recommended to ensure that existing and future control efforts are effective in preventing the spread of COVID-19 between employees while they are at work. With ongoing community transmission, COVID-19 cases among staff will likely continue to be identified. A combination of control measures with ongoing education and training will be useful in reducing or eliminating transmission in the workplace. These recommendations are intended for this specific Smithfield plant, but broader interim recommendations for meat and poultry processing industries are in development. Management, along with the safety committee and employee representative/union representative at the plant, and in direct collaboration with the South Dakota Department of Health and strategic community partners should develop an implementation plan for these and any other interventions to reduce the spread of COVID-19 to be rolled out in the workplace.

Hierarchy of Controls

The following recommendations should be implemented according to the hierarchy of controls. [Hierarchy of controls](#) is an approach to hazard intervention that starts with the controls perceived to be most effective and moves down to those considered least effective. In most cases, the preferred approach is to eliminate a hazard or exposures, install engineering controls, and implement appropriate sanitation and cleaning to shield or reduce employees exposure to the hazard. Until such controls are in place, or if they are not adequately effective or feasible, administrative measures and personal protective equipment (PPE) may be needed.

Social Distancing, Screening, and Sick Leave

In addition to [everyday steps to prevent COVID-19](#), keeping space between individuals ([social distancing](#)) is one of the best strategies to avoid being exposed to the virus and slowing its spread. Barriers are one method to physically separate employees in areas of the plant (including work areas and other areas such as break rooms, parking lots, hallways and corridors, entrance/exit areas, and locker rooms). Other practices such as use of visual cues at six-foot intervals (e.g., floor markings, signs) can be used to encourage physical distancing. Follow CDC Interim Guidance – “[Implementing Safety Practices for Critical Infrastructure Employees Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19](#)” for best practices regarding screening and sick leave. Until the broader interim recommendations for meat and poultry processing industries are completed, many strategies for social distancing, screening, and sick leave can be utilized from CDC’s [Interim Guidance](#)

[for Businesses and Employers to Plan and Respond to COVID-19](#). Some specific recommendations that the plant can follow include the following considerations:

- Consider the following actions to physically separate employees (at least 6 feet, where possible) and reduce employee density in non-work areas of the facilities, such as cafeteria, break rooms, equipment dispensing stations, locker rooms, smoking areas, entrance/exit areas, and other areas where employees may congregate (e.g., the box shop):
 - Adding more visual cues at six-foot intervals (e.g., floor markings, signs, traffic cones) in the cafeterias, knife and gear acquisition areas, and other areas where lines may form. Additional areas where visual cues may be implemented include:
 - Areas where knives, uniforms, and PPE are checked out. Consider methods to increase the physical distance between employees picking up equipment and ensure contactless interactions between employees as much as possible.
 - The tattoo stations in the pig barn to maintain at least 6 feet between the truck door (and the truck drivers offloading swine) and the employee that is tattooing swine.
 - Areas around the sinks in the locker rooms.
 - Areas where employees punch in and out for the day.
 - Outside the front of the building where employees may congregate waiting for rides.
 - Cafeterias and break rooms (e.g., around food lines, vending machines, cash registers).
 - The bridge and main staircases used by employees to enter the plant.
 - Outdoor common areas.
 - Expanding distance between tables in the 3rd floor flag hallway – remove some tables to facilitate more space between the chairs of adjacent tables.
 - Reducing the number of tables in the 6th floor cafeteria to reduce crowding.
 - Changing the orientation of table dividers in the 3rd floor cafeteria to promote one employee per side of the table.
 - Spreading out the shelving that is used for storage of lunch boxes in the cafeteria so there is some distance between each set of shelves. Place markings on the shelves to encourage employees to keep their personal items separate. Place visual cues of six feet so that people do not come into close contact when retrieving their personal items.
 - Increasing the flexibility around shift start times and break times to decrease the number of employees in locker rooms or break areas at one time.
 - Identifying alternative locker locations (e.g., converting currently unused spaces into temporary locker areas).
 - Installing portable or temporary bathroom and handwashing facilities could be utilized near the temporary locker rooms (or in general) to ease the density of employees in bathrooms during break and lunch times.
 - Staggering employees along line workstations so that employees are not working directly across from each other. Changes in production practices (e.g., line speed reductions) may be necessary in order to maintain appropriate distancing among employees.

- Altering additional workstations to minimize close contact among employees by adding plexiglass, stainless steel, or durable polycarbonate barriers between workstations. Barriers should be used in combination with (and not replace) other social distancing, hand hygiene, and personal protective equipment efforts outlined in these recommendations.
 - Staggering shifts, start times, and break times as much as feasible to decrease number of employees in locker rooms, break areas, and cafeterias at one time.
 - Setting up break and lunch areas outdoors to reduce the density of employees in existing breakrooms and cafeterias and encourage employees to spend their breaks in locations with air movement and space for social distancing. For example, tents could be set up and have the capability of being heated to encourage use of the outdoor space in inclement weather. Other facilities have implemented similar controls and are incentivizing outdoor breaks and lunches. Consider including portable or temporary bathroom and handwashing facilities as a part of this setup.
 - Adding additional touchless clock in/out stations throughout the plant to reduce crowding and congregating at these areas.
 - Adjusting the physical layout and the maximum class size for trainings. Consider moving training online, by video, or other methods to increase distance between employees while receiving training and orientation.
 - Increasing the space between outdoor tables to at least six feet to reduce the density in spaces where employees or truck drivers may congregate.
 - Making unidirectional paths through facility, where possible, including stairs, hallways, and cafeterias. This will ensure less contact in narrow hallways, stairs, and break areas.
 - Limiting the number of employees in the cafeteria serving and payment area at one time.
 - Encouraging employees, drivers, and contractors to maintain distancing in indoor and outdoor common areas.
 - Assigning an individual to monitor the social distancing efforts in communal spaces (e.g., break rooms, cafeterias, locker rooms).
- Source Control and Hygiene
 - Face coverings are generally recommended as an addition to social distancing. They are especially important for source control. Cloth face coverings keep the person wearing one from spreading respiratory droplets when talking, sneezing, or coughing; is also referred to as “source control.” The face covering is meant to protect other people in case employees are infected but not symptomatic.
 - All employees should wear the face covering being used by the company to cover their nose and mouth in all areas of the plant (including break areas and locker rooms). Some specific recommendations that the plant can follow include the following considerations:
 - Continuing with the plan to mandate all employees wear a face covering and a face shield anytime they are at work. The face shield is being used in this plant to supplement the use of the face covering.

- Employees should wear the supplied facial covering to cover their nose and mouth – this may prevent people who do not know they have the virus from transmitting it to others.
- The facial covering should allow for breathing without restriction, not be touched after putting on to prevent transferring infected materials and be discarded and replaced when dirty or wet.
- Management and supervisors will be essential for continued training and encouragement of employees to follow these guidelines.
- Having replacement face masks available in case an employee's face mask becomes wet or soiled.
- If possible, distribution should be contactless, while still allowing for control of the number of face masks distributed. For example, consider placing face masks on a table and having employees step forward one at a time while another employee oversees the process.
- The employee distributing face masks should be following appropriate social distancing and wearing appropriate PPE (gloves) and facial covering.
- Providing face coverings to truck drivers when they check in at the office. Consider asking drivers about symptoms or screening them when they arrive to the plant.
- Encouraging or requiring contractors and FSIS inspectors to follow face covering and face shield use recommendations. Work with the appropriate partners to discuss how to roll this out among contractors and FSIS employees.
- Face shields are not acceptable substitutions for eye protection (such as safety glasses) that are used for impact protection. If needed, face shields should be used in addition to the eye protection, not as a replacement for jobs requiring eye protection, as identified by the plant's OSHA PPE hazard assessment ([29 CFR 1910.132](#)).
- Consider the following actions to improve the existing screening policies and processes:
 - Screening all individuals entering the plant (e.g., employees, management, contractors, FSIS inspectors).
 - Adjusting the orientation of the screening tent exit so that employees exiting the screening tent do not exit into the path of employees who are leaving the facility.
 - Identifying off site housing for employees who have tested positive for COVID-19 and live in a household where they do not have the ability to self-isolate from other household members, especially individuals who are at high-risk for developing severe illness or other critical infrastructure employees.
 - Specifically ask employees about recent history of fever in addition to the symptoms (e.g., cough and shortness of breath) and the objective measurement of temperature.
 - Temperatures should be measured individually using a temporal, tympanic, or oral thermometer with a probe cover.
 - If continuing to use thermal imaging systems, procure FDA-approved system(s) and use in accordance with the manufacturer specifications.

- If such a system cannot be procured, use the existing thermal imaging system in accordance with all manufacturer specifications and FDA guidance. Ensure that it is set up in such a way to accommodate the height variation of all individuals being screened.
 - Including large pictograms in the screening process to increase non-verbal communication.
 - Instructing employees to report to supervisors if they get sick during work shift.
 - Continuing to send ill employees [home immediately](#) if they become ill during the day. Employees who are ill should stay home, and not work or be allowed in the workplace. Surfaces in their workspace should be [cleaned and disinfected](#). Continue to work with your state and local public health authorities in using CDC guidance in identification and follow up of contacts of ill persons.
 - Translating the secondary screening packet into other languages commonly spoken in the plant to improve communication with employees. Additional steps to improve communication may include:
 - Having the screener point to large pictures of symptoms for employees whose primary language is not English.
 - Adding CDC guidance: “[What to do if you are sick](#)” to the informational packet provided to employees being sent home after screening. There are multiple languages available on the CDC website.
- Consider the following actions to improve the existing sick leave policies and practices:
 - Ensuring that sick leave policies are flexible and consistent with public health guidance and that employees are aware of and understand these policies.
 - Adjusting any incentive programs such that employees are not penalized for taking sick leave related to COVID-19.
 - Maintaining flexible policies that permit employees to stay home to care for a sick family member or take care of children due to school and childcare closures. Additional flexibilities might include giving advances on future sick leave and allowing employees to donate sick leave to each other.
 - Discontinuing any policies requiring a positive COVID-19 test result or a healthcare provider’s note for employees who are sick to validate their illness, qualify for sick leave, or to return to work. Healthcare provider offices and medical facilities may be extremely busy and not able to provide such documentation in a timely manner.
 - Reviewing human resources policies to make sure that policies and practices are consistent with public health recommendations and are consistent with existing state and federal workplace laws (for more information on employer responsibilities, visit the [Department of Labor’s](#) and the [Equal Employment Opportunity Commission’s](#) websites).
 - Connecting employees to employee assistance program (EAP) resources (if available) and community resources as needed. Employees may need additional social, behavioral, and other services, for example, to cope with the death of a loved one.

- Continuing to evaluate and augment the return to work plan. Employees with COVID-19 who have stayed home (home isolated) should not return to work until the [criteria to discontinue home isolation](#) are met, in consultation with healthcare providers and state and local health departments.

Hand Hygiene and Sanitation

[Hand hygiene](#) and sanitation (infection prevention and control) are other important tools to avoid being exposed to the virus and slowing its spread. Follow the [CDC recommendations for cleaning and disinfection during the COVID-19 response](#). Monitor these recommendations for updates. Cleaning and disinfection of surfaces and objects that are frequently touched, especially in common areas, several times per day is an important component to control the spread of COVID-19. Until the broader interim recommendations for meat and poultry processing industries are completed, many strategies for hand hygiene can be utilized from CDC's [Interim Guidance for Businesses and Employers to Plan and Respond to COVID-19](#). Some specific recommendations that the plant can follow include the following considerations:

- Encouraging frequent handwashing with soap and water for at least 20 seconds. Use hand sanitizer with at least 60% alcohol if soap and water are not available.
- Increasing access to hand washing and hand sanitizing stations throughout the facility.
 - Continue with the plan to put hand sanitizer at every table in the break hallway (or periodically along the hallway).
 - Focusing on adding stations before and after high touch surfaces (e.g., bottoms and tops of stairwells, doffing areas, entrance and exit points for break areas and lunchrooms).
 - Ensure hand sanitizing stations are located immediately before employees take anything out of a bin (e.g., frocks, gloves, silverware in the lunch room).
 - Increasing the number of hand sinks available, especially in locker rooms.
- Installing no-touch sinks, soap dispensers, sanitizer dispensers, and paper towel dispensers (preferred over hand dryers) wherever possible – make everything as touch free as possible.
- Encouraging employees to perform hand hygiene when coming off the line for break, lunch, or end of shift. Utilize the current plan for roaming sanitizing employees to coordinate these actions.
- Emphasize proper hand hygiene after gloves are removed and before and after facial coverings are donned or doffed. Installation of hand hygiene stations, training, and routine monitoring will encourage compliance.
- Adding portable or temporary bathroom and handwashing facilities near any temporary locker room areas or break areas.

- Continuing to frequently disinfect high-touch areas in food production areas with products meeting [EPA's criteria for use against SARS-CoV-2](#), the virus that causes COVID-19, and approved under the facility's sanitation standard operating procedures.
 - If EPA-registered disinfectants are not available, diluted household bleach solutions (final concentration at least 1000 ppm sodium hypochlorite), or alcohol solutions with at least [70% alcohol](#), can be used. Additional guidance on cleaning and disinfecting non-food production areas of your facility can be found on the [CDC website](#).
- Continuing to conduct targeted and more frequent cleaning of high-touch areas of shared spaces (e.g., time clocks, bathroom fixtures, break room tables and chairs, locker rooms, vending machines, railings, door handles, handles from ceiling, plug attachments and orange door cords hanging from ceiling). Follow [CDC guidance for disinfection](#). Some additional recommendations to improve the existing efforts include:
 - Sanitizing break areas between breaks, between shifts, and between groups of employees using these areas.
 - Developing sanitization guidelines for administrative areas of the plant.
 - Developing a standard operating procedure for environmental sanitization that includes a list of areas considered high-touch, frequency of disinfection, what product to use, training requirements, and required personal protective equipment. Comply with the Occupational Safety and Health Administration (OSHA) PPE ([29 CFR 1910.132, 1910.138](#)) and Hazard Communication ([29 CFR 1910.1200](#)) Standards.
 - Disinfectants should be applied according to the [label instructions](#).
 - Coordinate disinfectant product use with United States Department of Agriculture (USDA) if used in food production areas.
 - For other high-touch areas (outside of food production areas), such as door handles, bathroom surfaces, railings, and tables, use products that meet [EPA's criteria for use against SARS-CoV-2](#).
- Replacing any plexiglass barrier if it becomes damaged (e.g., cracks cannot be sanitized effectively) to be consistent with USDA Food Safety and Inspection Service (FSIS) [Sanitation Performance Standards Compliance Guide](#) that requires inspected establishments to build their facilities and maintain it in a sanitary manner.
- Continuing to disinfect tools between use when used by multiple employees.
- Performing enhanced cleaning and disinfection after persons with suspected or confirmed COVID-19 have been in the plant
 - If a sick Employee is suspected or confirmed to have COVID-19, follow the [CDC cleaning and disinfection recommendations](#).
- Ensuring that contracted cleaning services are meeting the guidelines listed above.

- Developing a protocol for sanitizing hard hats and face shields at the end of the shift.
- Developing a protocol for how employees can safely store their hardhats while going on break without bringing them into the shared areas (e.g., break rooms, locker rooms, cafeterias).

Training and Communication

When developing training and communication materials, the plant should use current, correct messaging from a trusted source. Follow the CDC [Interim Guidance for Businesses and Employers to Plan and Respond to COVID-19](#) for general information related to training and communication for employees. Training should be reinforced by the use of signage (preferably infographics) placed in strategic locations. Graphics and suggested messages are [available from CDC](#) for use on social media profiles and web pages. [Print resources](#) are also available from CDC. [Communication guidance](#) exists for three phases: before a COVID-19 outbreak occurs, during a COVID-19 outbreak, and after a COVID-19 outbreak. It is important to maintain ongoing communication and message coordination with plant preparedness workgroup members, partners, stakeholders, news media, and other channels to ensure consistent messaging. If technical terminology and concepts must be used in training or communications, definitions and examples should be included to help improve understanding. Communications should be early, empathetic, accurate, and effective. Early communication of COVID-19 information helps limit misinformation and rumors that could contribute to confusion and fear. Empathetic communication conveys concern and reassurance, empowers people, and reduces emotional turmoil. Accurate communication provides the facts about a situation and what is being done to resolve it. Effective communication helps build understanding and guide the response to COVID-19 and complying with public health recommendations. Some specific recommendations that the plant can follow include the following considerations:

- Continuing to provide COVID-19 informational signage throughout the plant.
- Enlarging and simplifying signage. Remove as much outdated signage as possible or relocate historical signs to a more appropriate viewing area (e.g., visitors center).
- Using more pictures/pictograms and adding more languages to increase the percentage of the workforce that engages with signs and messaging.
- Adding additional signage in cafeterias, locker rooms, and break areas to remind employees about hand hygiene, social distancing, and PPE.
- Ensuring signage is at eye level and can be easily seen by the employees.
- Installing additional video monitors throughout the plant to deliver messaging throughout the day.
- Developing or providing existing training and messaging (in multiple languages) for social distancing, hand hygiene, donning, doffing, and sanitizing PPE, and messaging about what to do

if you are sick. Consider alternatives to traditional in-person trainings for delivery of this information (e.g., videos). Develop a method to verify employee understanding and participation in these strategies.

- Provide the training materials in multiple languages, whenever possible. Be aware of potential concerns (e.g., comfort, anxiety) that employees may have around wearing face coverings at work.
 - Use a mass distribution method for transmission of training (e.g., the Beekeeper application to which the employees already have access).
 - Partner with community organizations to distribute messaging to employees.
 - Include use of facial coverings, hand hygiene, and social distancing messaging on the televisions in the cafeteria on a continuous loop.
 - Include messaging about social distancing and hand washing guidelines over the speakers in the flag hallway during breaks and lunch.
 - Work with the South Dakota Department of Health and other partners to develop specific messaging that address the communication needs of the employees of Smithfield Foods.
- Providing training to employees, supervisors, and management whenever changes are implemented in the workplace. Refresher trainings should be provided on a regular basis.
 - Utilizing current down time to “pre” train employees about what changes to policies and practices are occurring in the plant before they come back to work.
 - Adopting simplified messaging for staff. For example, the “top three things to protect yourself from COVID-19 at work: Social Distancing, Hand Hygiene, and PPE.”
 - Empowering employees to provide corrective guidance to other employees about improperly worn PPE.
 - Encouraging employees to download and utilize the Beekeeper application and sign up for other mass-communication methods available to the plant.
 - Deploying training through the Beekeeper application and other mass-communication methods. Use read receipt functions to gauge participation and engagement. Consider ways to incentivize employee utilization of these trainings.
 - Following the [Interim Guidance for Businesses and Employers to Plan and Respond to COVID-19](#) to provide more education around steps employees can take to protect themselves at work and at home. The guidance includes the following suggestions for communications with employees:
 - Employees can [take steps to protect themselves](#) at work and at home. Older people and people with serious chronic medical conditions are at [higher risk for complications](#).
 - Follow the policies and procedures of your employer related to illness, cleaning and disinfecting, and work meetings and travel.

- Stay home if you are sick, except to get medical care. Learn [what to do if you are sick](#).
- Inform your supervisor if you have a sick family member at home with COVID-19. Learn what to do [if someone in your house is sick](#).
- Wash your hands often with soap and water for at least 20 seconds. Use hand sanitizer with at least 60% alcohol if soap and water are not available.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow. Throw used tissues in the trash and immediately wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer containing at least 60% alcohol. Learn more about [coughing and sneezing](#) etiquette on the CDC website.
- Clean and disinfect frequently touched objects and surfaces such as workstations, keyboards, telephones, handrails, and doorknobs. Dirty surfaces can be cleaned with soap and water prior to disinfection. To disinfect, use [products that meet EPA's criteria for use against SARS-CoV-2](#), the cause of COVID-19, and are appropriate for the surface.
- Avoid using other employees' phones, desks, offices, or other work tools and equipment, when possible. If necessary, clean and disinfect them before and after use.
- Practice social distancing by avoiding [large gatherings](#) and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

Personal Protective Equipment (PPE)

Workers should continue to wear PPE required for the job tasks being performed.

- Provide appropriate PPE for specific jobs and ensure it is used by all workers as needed
 - Use videos or in-person visual demonstrations of proper PPE donning and doffing procedures. (Maintain social distancing during these demonstrations.)
 - Emphasize that care must be taken when putting on and taking off PPE to ensure that the worker or the item does not become contaminated.
 - PPE should be: (1) disposed; or (2) properly disinfected and stored in a clean location when not in use.
 - PPE worn at the facility should not be taken home.
- Consider the use of face shields or other types of PPE that may serve as both PPE and source control
 - If helmets are being used, use face shields designed to attach to helmets
 - Face shields can provide additional protection from both potential process-related splashes and potential person-to-person droplet spread
 - Safety glasses may fog up when used in combination with masks or cloth face coverings
 - Face shields can help minimize contamination of masks and cloth face coverings
 - If used, face shields should be cleaned and decontaminated after each shift and when not in use should be kept in a clean location at the work facility

- Stress hand hygiene before and after handling all PPE

The US Government is developing additional guidance for meat and poultry processing facilities to prevent and mitigate the spread of SARS-CoV-2 between employees while at work. Please review this guidance when it becomes available and institute recommended controls in your plant. Consult with USDA to determine if proposed controls are acceptable with regards to food safety and sanitation. Continue communicating and working with the South Dakota Department of Health, strategic community partners, and union leadership.

End of Memo

Chairwoman ADAMS. Thank you very much.

Mr. SCOTT. I think, are we going to go vote and then come right back? Can we do that?

Chairwoman ADAMS. They have called for votes, so we are going to go and vote in vote rotations until we get further information. I am on that first rotation, so, Mr. Scott, will you --

[Discussion held off the record.]

Mr. SCOTT. [Presiding.] We apologize. We were hoping to go vote all at the same time, but apparently that is -- we don't have permission to do that yet.

First question will be the gentleman from California, Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

And thank you, Chairwoman Adams, for organizing this critical hearing on the need to protect workers from coronavirus.

The role of the Occupational Safety and Health Administration is to, quote, ensure safe and healthful working conditions for working men and women by setting and enforcing standards, end quote. During this current pandemic, where nearly 1.5 million people have been infected with COVID-19 and nearly 100,000 people in this country have died, OSHA has completely abandoned its responsibilities and is not holding up to its mission.

The general duty clause of the Occupational Safety and Health Act requires employers to provide employees with, quote, a workplace free from recognized hazards likely to cause death or serious physical harm, end quote. And based on my review of the nearly 5,000 COVID-19-related complaints filed by workers, it is evident that many employers are not making good-faith efforts to protect their workers.

Ms. Sweatt, is OSHA prepared to conduct mandatory onsite inspections in response to worker complaints that allege serious health violations, not just for those complaints that result in a fatality?

Ms. SWEATT. Yes. OSHA is working proactively since the beginning of February to address the COVID-19 hazard. We have, as you said, over 5,000 complaints, and our inspectors are investigating all of them. Where they are getting information from employers that is not adequate, they are opening investigations. And so, yes, the agency has been doing its job since the beginning of this pandemic.

Mr. TAKANO. Do you have enough inspectors to be able to do this in a timely manner?

Ms. SWEATT. I think folks know that we have been actively trying to hire investigators since August of 2017. We are appreciative of Congress providing us more funding so that we can hire 50 this year. Until March of this year, we were in an unprecedented competition with the private sector to find and hire adequate workers. This is a highly skilled profession, and we have been trying to get folks to come in and serve the mission of the agency. It has been something that is a priority of mine since I started in July of 2017. But it was very challenging with record low unemployment numbers to get people to come in with the skills that we need. So, yes, we are pursuing more inspectors --

Mr. TAKANO. Ms. Sweatt, how many, if I may, excuse me, how many workers do you need, and how many positions remain unfilled?

Ms. SWEATT. Well, we have 50 that are funded by Congress this year that we are trying to fill. Even in the midst of this pandemic, we are actively recruiting folks to come and work for us, and we are seeing results. So we will work as hard as we can and as diligently as possible to hire those folks and get them through our process and get more people to have more boots on the ground.

Mr. TAKANO. Ms. Sweatt, as the lead agency, how will OSHA work to enforce national policies for each agency that you work with and make sure rules are applied and followed uniformly from facility to facility?

Ms. SWEATT. Well, I think the question is about our engagement with our Federal partners.

Mr. TAKANO. Yes.

Ms. SWEATT. And, you know, our folks are on about 10 Federal task forces related to COVID specifically. We are engaged with NIOSH and the CDC to write these guidance documents that you have seen. The most important that we have issued lately is the meat-packing guidance. We issued construction on Monday.

We are working on more as we identify industries that need to understand what we are requiring, and we will continue to do that to the best of our ability.

Mr. TAKANO. Ms. Sweatt, just recently -- I am looking at the clock and I just --

Staff. Yeah. It was never --

Mr. TAKANO. Okay. All right.

You know, rather than enforcing OSHA's role, the Trump Administration plan for opening up America again attempts to shift workplace safety preparedness to the States by highlighting the States' responsibility for the health and safety of workers in critical industries. Ms. Sweatt, was OSHA consulted in preparing this plan?

Ms. SWEATT. All of those plans go through clearance, and I would say that they may be talking about the State and local health authorities, but, you know, OSHA is in approximately 26 States, and then there is 22 States with State plans --

Mr. TAKANO. But specifically on the Trump Administration's plan to open up America again, was OSHA consulted in preparing this plan?

Ms. SWEATT. I do believe that OSHA participated in the clearance plan, yes.

Mr. TAKANO. You don't know for sure?

Ms. SWEATT. I do believe that we did, yes.

Mr. TAKANO. Does this approach effectively sideline OSHA in its role for protecting workers?

Ms. SWEATT. No, I do not believe it does.

Mr. TAKANO. Even though it highlights the States' responsibilities? I mean, it does not deemphasize OSHA?

Ms. SWEATT. I do not think so.

Mr. TAKANO. Is this plan consistent with the OSHA Act?

Ms. SWEATT. As I said, Federal OSHA exists in specific States, and then there are State plans, of which we provide grant money to. So where we are in jurisdiction, we will be in enforcement mode,

and we will be doing our job. I do not believe that plan changes our obligations.

Mr. TAKANO. Thank you. I yield back.

Mr. SCOTT. (Off mike.)

Ms. SWEATT. I can come work the clock.

Mr. SCOTT. The gentleman from Alabama.

Mr. BYRNE. Thank you, Mr. Chairman.

First of all, let me thank you again, both of you, for being here. I know you are very busy.

Ms. Sweatt, you heard me recite the testimony of one of your predecessors during the Obama Administration, and so I want to ask you a simple question. How is OSHA's COVID-19 response similar or different from the approach taken by the Obama Administration during the H1N1 pandemic?

Ms. SWEATT. We have followed the H1N1 pandemic strategy almost to the T. It has been very important for us to get the message out. We started as early as January with the safety and health topics page. We provided general guidance for all industries so that they could plan to protect their workers.

And as the pandemic has spread, we have provided industry guidance for very specific industries, and I think we are doing what we are supposed to do -- enforcement, compliance assistance, and training and education of everyone that will come to us and work with us on our guidance. And I don't think that we have diverted from what the plan was with H1N1.

Mr. BYRNE. Can you elaborate on how OSHA has historically responded to emerging workplace hazards and why the agency has used compliance initiatives, coupled with enforcement of existing standards, including the OSHA Act's general duty clause, as effective measures to respond quickly during a pandemic?

Ms. SWEATT. Thank you. I would like to say that we respond to a lot of different issues and have since I started in July of 2017, natural disasters, hurricanes. Typically, in those situations we suspend enforcement. In this instance, we proactively determined that we would stay in enforcement mode and we would use all the enforcement tools available to us.

One of those is the investigation for complaints. As we have noted, we have received over 5,000 complaints, and the approach that we have taken -- and this gets us into the employer almost immediately, puts them on notice that someone has said there is a problem and that we are following up. It is one of the fastest ways to achieve resolution in the situation to get the worker on -- or the employer on notice and the worker out of the hazard.

Mr. BYRNE. Thank you.

Dr. Howard, what resources has NIOSH developed to educate employers and workers on how best to keep workplaces safe, and do you anticipate that NIOSH will continue to update this information?

Dr. HOWARD. Well, let me take the second question. The answer is definitely yes. Our guidance changes rapidly, and I always tell people, don't print out CDC guidance from your printer because it may be out of date the next time you go to the website. This is a rapidly evolving situation. So our guidance changes pretty much every week and sometimes every day.

The first question, we do a lot of educational guidance with regard to both these congregate working situations which are at highest risk, such as a nursing home, a meat-packing plant, situations in which congregate commerce occurs, where you have a worker and a customer close together. So we are doing a lot to educate the worker and the employer on these situations.

Mr. BYRNE. Good.

So, Ms. Sweatt, let me go back to you for a second. We are beginning to see a lot of businesses reopen, which I want to say I think is a very good thing. So how does OSHA plan to engage with employers and workers, as Dr. Howard said, to ensure successful workplace safety outcomes?

Ms. SWEATT. We are going to continue providing guidance, and as folks look to reopen, we will be working -- or we are actually working on reopening guidance so that when employers are looking at what they are going to do to protect their workers, we can explain how that intersects with our existing standards and regulations and what they need to do in order to be in compliance as they go forward.

But the existing guidance that we have, that we have worked with NIOSH and others, really does provide a very productive roadmap for what employers should be doing as they look to reopen their businesses.

Mr. BYRNE. And, Dr. Howard, I think you kind of alluded to this earlier, let me go back to you about this, but CDC and all the rest of us are learning about this disease, like, literally, something new every day. So as you issue new guidance, you are taking into account what CDC and other people are telling you? But as you said earlier, it is happening so rapidly, you don't even print it out. You just put it on -- you know you are going to have to change it the next day. How difficult does that make it for both of you to actually try to come up with a, quote, standard as opposed to guidance?

Dr. HOWARD. I think it is very difficult. Guidance is, as you mentioned, an easier pathway, based on the best professional judgment and hopefully the best science that we have. And it can be easily done, although the review process is long and detailed, as it should be. But when we learn something new, that guidance can be changed almost instantaneously.

In the case of the meat-packing guidance, which we and OSHA put together, one of the big issues now is establishment level testing. Well, that is not really something that we put in the current edition of the guidance, but we are beginning to think more seriously about how you do that, because as we know, many meat-packing processing plants are doing that kind of testing. So we are beginning to think about that. So in the next iteration of our guidance, we may have more information about testing.

Mr. BYRNE. Thank you. And I yield back.

Mr. SCOTT. Thank you. The gentlelady from Georgia, Mrs. McBath.

Mrs. MCBATH. Thank you, Mr. Chairman, and thank you for convening this hearing this morning. And thank you to both of our witnesses. We appreciate you being here.

Over the last 3 months, we have watched as the COVID-19 coronavirus has made its devastating impact on this Nation.

100,000 Americans have died from this disease. The magnitude of loss is simply staggering. For those that we have lost and the millions of Americans who have lost someone, we continue to mourn.

In this time of crisis, we have seen time and time again that everyday heroes simply live among us and from every part of our communities. Frontline healthcare providers working around the clock to treat our families, first responders, grocery store workers, essential employees, and delivery workers have all answered the call to ensure that all Americans can have access to vital services and goods during this period.

We have seen outbreaks in meat-packing plants, COVID wards filled with healthcare workers and essential employees, and yet there is no infectious disease standard for these workers. My colleagues and I are committed to strengthening protections for these workers, and I was very pleased to join Chairman Scott and other Committee Members as an original co-sponsor of the COVID-19 Every Worker Protection Act.

This bill strengthens OSHA protections by creating an Emergency Temporary Standard for frontline workers, while considering the constraints that have been placed on employers during this crisis. However, this legislation is not necessary for OSHA to act.

Ms. Sweatt, my question is for you. As you know, the following H1N1 pandemic, OSHA began work in earnest on infectious disease standards. Yet 3-1/2 years into this administration and 100,000 American deaths into this pandemic, please explain why the OSHA infectious disease standard is still languishing on the long-term regulatory agenda.

Ms. SWEATT. What I can explain is that OSHA has prioritized the protection of healthcare workers. We did that very early on, if you look at the guidance and the information that we sent out. We are very concerned about access to respirators for these individuals, and we issued no less than five enforcement guidance documents to ensure that our frontline healthcare workers were given the best access to respirators that they could have. And I would note that it languished on the regulatory agenda of the previous administration for 8 years.

Mrs. MCBATH. Now, if the permanent standard had been put into effect, would it have provided OSHA with additional tools to deal with the pandemic?

Ms. SWEATT. OSHA is using its existing tools to address the concerns that are related to healthcare workers and all workers with this pandemic.

Mrs. MCBATH. But does OSHA intend to resume work on this standard, on the standards that you are talking about?

Ms. SWEATT. I think we are getting very close to this is in litigation, and I really cannot comment further.

Mrs. MCBATH. All right. So then, basically, I see that you are still moving forward full steam ahead with OSHA'S tree care standard. Is that really a good way to be spending your time during this unprecedented crisis?

Ms. SWEATT. Our folks were able to multitask, and we were able to complete that standard. Tree care work is very dangerous work, and it is an important standard for us to address. That has been languishing on the regulatory agenda for 20 years.

Mrs. MCBATH. Well, it is apparent that you would have more resources if you had not cut OSHA'S standards by 10 percent in 2017. So given the crisis, would you consider a significant increase in OSHA's regulatory budget helpful to you?

Ms. SWEATT. I think that this Congress has increased our budget, and we will use those dollars wisely.

Mrs. MCBATH. I will ask a question. When is your next plan of action for that standard? And when do you expect to have a proposed rule? Can you give us a date or a month or a time?

Ms. SWEATT. I am sorry, for which standard?

Mrs. MCBATH. For the proposed standards that you are already using.

Ms. SWEATT. The regulatory agenda, it speaks for itself.

Mrs. MCBATH. Okay. Thank you. I have no further questions.

Chairwoman ADAMS. [Presiding.] Thank you very much.

I am going to yield now to the gentlelady from North Carolina, Ranking Member of Education and Labor.

Dr. Foxx, you are recognized.

Ms. FOXX. Thank you, Madam Chairwoman. I want to thank our witnesses for being here today.

Ms. Sweatt, it is very nice to see you again. Dr. Howard, very nice to see you all again.

Ms. Sweatt, on March 5, 2020, 6 days before the World Health Organization classified COVID-19 as a pandemic, Committee Democrats sent a letter to Secretary of Labor Scalia demanding that OSHA immediately issue an Emergency Temporary Standard for COVID-19. Since March 5, a great deal has changed in both the scientific understanding of COVID-19 and the application of appropriate and effective safety protocols in combating workplace exposure to the coronavirus.

Can you explain further the rationale behind the detail workplace safety guidance OSHA has issued to date and whether this approach has been effective?

Ms. SWEATT. I do believe that this approach has been effective. We started with our general industry guidance. We provided as much information as we had available. And we have since brought on more industry-specific guidance. We have manufacturing, construction, meat processing. It has been a way for us to, as we learn more about the virus and spread, for us to really dig into the specific places and put out better guidance for employers.

And then we have also managed to take these guidance documents and break them into usable pieces for workers. And we have translated almost everything that we have into Spanish. And some of our materials is in about 12 other languages.

Ms. FOXX. Thank you. Ms. Sweatt, Committee Democrats and their union allies have been circulating an untruthful talking point, which has been echoed in various media outlets, including The Washington Post, that OSHA has been, quote, "missing in action," end quote, when it comes to protecting workers from COVID-19.

Do you believe the administration's critics and their media allies undermine workplace safety when they misleadingly claim that OSHA is neglecting its responsibilities, that employers are willfully ignoring safety in their workplaces and that workers have few, if any, protections under the law?

Ms. SWEATT. Dr. Foxx, thank you very much for highlighting this. I felt so strongly about the accusations that I wrote a letter to The Washington Post refuting those assertions, and they printed it. I am happy to provide that for the record.

Ms. FOXX. I think it would be useful if we put that into the record.

I want to add to that one of our colleagues earlier said that the absence of the rules that the Democrats want means that there is nobody out there protecting the health and safety of workers.

It is an abysmal misunderstanding of how the private workplace operates, and that is that every employer wants his or her workers kept safe. They are their most valuable assets. And we hear that accusation over and over and over on this Committee. And, again, it is very clear that they have no concept of what happens in the private working sector.

Dr. Howard, since the beginning of the COVID-19 pandemic, NIOSH and the CDC have constantly updated their guidance as the outbreak has developed and as more is learned about the coronavirus. What process does NIOSH use to update or change its recommendations? And what factors does the agency take into account on considering updates to its guidance?

Dr. HOWARD. Well, thank you very much for that question. You know, there is a lot of our guidance, both NIOSH guidance as well as CDC guidance, coming from our emergency operations center. In fact, if I printed it all out, there would be a stack very high here. And the primary drivers for guidance are stakeholder need, perceived issues related to the virus itself, and what we are seeing as the situation evolves. So it is a very responsive-type process to what is happening on the ground.

So I would sum up by saying that it is probably the most responsive guidance machinery that I have ever seen at CDC.

Ms. FOXX. Well, thank you very much. And thank you for what you are doing, what you and your colleagues are doing, because we know you are focused on the health and safety of American workers.

And, Ms. Sweatt, I appreciate you emphasizing that in your first comment. I have another question for you. On April 8, OSHA issued a statement reminding employers that it is illegal to retaliate against workers because they report unsafe and unhealthful working conditions during the coronavirus pandemic. What protections do workers have under the OSHA Act against unlawful retaliation? And how is the agency responding to whistleblower complaints during the pandemic?

Ms. SWEATT. Thank you, Dr. Foxx. This is very important work at the agency. And we have 23 whistleblower statutes that we are in charge of. What we see with the COVID-19 is mostly 11(c), which is in the Occupational Safety and Health Act.

What I would like to say is that the agency and its whistleblower investigators have already achieved reinstatement of workers, they have seen letters of reprimand removed. Just based on a phone call as we initiate the investigation -- and in fact we have reports of businesses understanding and changing their structure so that they are not retaliating and that they are encouraging the reporting of safety and health concerns.

Ms. FOXX. Thank you very much.

Ms. SWEATT. Thank you, Dr. Foxx.

Chairwoman ADAMS. Thank you very much, Dr. Foxx.

I want to recognize now Ms. Jayapal.

Ms. Jayapal, unmute.

Ms. JAYAPAL. Thank you very much, Madam Chair. I hope you can hear me okay, and I very much appreciate this hearing. I think this is a very important hearing, and I appreciate the witnesses.

We are in an unprecedented time. We have lost over 100,000 American lives. That is almost more than we lost during the Vietnam -- during World War I, and it is more than all of the worst combined since World War II. So I think what we are talking about is something extremely unprecedented that requires our complete attention and devotion.

What happens when an agency fails the people it is supposed to protect? People suffer and people die. People like Tyson Fresh Meats beef-packaging worker, Guadalupe Olivera, who loved to travel to national parks with his wife; Amazon warehouse worker, Harry Sentoso, who died on his 27th wedding anniversary; 28-year-old mental health counselor, James Simpson, whose own experiences in foster care led him to work as a counselor for troubled teens; and transit worker and father of three, Scott Ryan, who coached his kids in baseball and wrestling. These workers lost their lives to COVID-19 after faithfully serving their communities during this pandemic. The loss of these workers' lives is an incredible tragedy and a preventable one.

OSHA is a division of the U.S. Department of Labor and is charged with that important responsibility of protecting workers. And I am glad to have a representative of OSHA here today to better understand what you have been doing to protect workers during this pandemic.

So, Ms. Sweatt, as the Principal Deputy Assistant Secretary of OSHA, how many workers in the United States have contracted COVID-19 in the workplace?

Ms. SWEATT. We have -- we have reports of worker injury related to COVID-19. And what we do instead have -- and better statistics -- are the fact that we have 5,000 COVID complaints right now. And our agency is working expeditiously -- expeditiously, excuse me, to close those complaints and figure out how to provide employers and workers the best information available to protect themselves.

Ms. JAYAPAL. So, Ms. Sweatt, are you saying that OSHA, which is the agency charged with protecting workers, is not tracking COVID-19 infections in the workplace? I mean, the U.K., for example, has been carefully tracking COVID-19-related deaths by occupation. Are you not tracking this? Are you incapable of tracking COVID-19 infections in the workplace separate from the complaints?

Ms. SWEATT. I would -- I could go into a description of record-keeping and the employer's responsibility under recordkeeping, but I think Dr. Howard might be the best person to talk about the way that COVID-19 is tracked.

Dr. HOWARD. Thank you, Loren.

Yes, at CDC, as I mentioned in my testimony, we have been getting better at tracking occupation and industry for COVID-19

cases. We have a new case report form that we are hoping that the States will start using, we asked them to start using it on the 15th of May, in which there are specific fields that can be filled out that delineate what the occupation and industry of that worker is.

We have done more in the area of surveillance for healthcare worker occupation, and we are beginning to do that for meat, poultry, and chicken processing workers also.

We have received funding from the Congress recently to modernize data collection at CDC for these types of things. And I am happy to go into more detail on that.

Ms. JAYAPAL. Thank you, Mr. Howard. I guess, you know, what I would say is May 15 is pretty late for beginning to track deaths and occupational deaths and cases.

Let me go back to Ms. Sweatt. Isn't it true that OSHA revised its previous enforcement policy for recording cases of coronavirus stating that under OSHA's recordkeeping requirements, coronavirus is a recordable illness and employers are responsible for recording cases of coronavirus? And, also, isn't it true that OSHA only revised this data collection policy on incidents of COVID-19 in the workplace on May 19, more than 2 months after President Trump declared a state of emergency?

Ms. SWEATT. So our first recordkeeping guidance or enforcement document really wanted to have folks -- sorry for the feedback -- focus on healthcare workers and for other employers to look at hygiene practices. And so there was never a rescission, if you will, of a requirement to put recordkeeping and COVID-related recordkeeping on their logs.

As America looks to reopen, we issued a new guidance document that reemphasizes the employer's obligation to examine COVID-19 work-relatedness and put that on their OSHA logs.

Chairwoman ADAMS. Thank you very much. Your time is up. Thank you.

Ms. JAYAPAL. Thank you, Madam Chair. I yield back.

Chairwoman ADAMS. Thank you, Ms. Jayapal.

Let me now recognize the gentleman from North Carolina, Mr. Walker.

Mr. WALKER. Thank you, Madam Chair.

There has been a lot of discussion today from my colleagues across the aisle pointing to an Emergency Temporary Standard as being the only solution to guarantee workplace protections, which completely overlooks the significant burden that would be placed on small businesses that are already struggling, as most of the country can see.

Small businesses in my district and across America have been shattered due to the extended closures because of COVID-19. I speak to small businesses literally every day who are hanging or trying to hang in there to make tough decisions just to keep their doors open. Imposing restrictive and duplicative regulations would simply create additional barriers.

My question, Ms. Sweatt, if I could start with you, you mention in your testimony that important work OSHA -- the important work OSHA is doing in conjunction with the CDC to issue industry-specific guidance to ensure worker safety. Just yesterday when I was looking through the CDC website, I was very encouraged to

find detailed guidance for various industries ranging from the retail to the airline industry.

Can you expand on why it is important to issue guidance tailored to address the unique challenges of each industry as opposed to a one-size-fits-all regulation covering all industry?

Ms. SWEATT. Thank you, Congressman. Yes, I think it is very important that we are able to take our general industry guidance and then put it into the specific industries because they are different. Construction can be outside and inside. Manufacturing is mostly inside. So there is a variety of social distancing issues that folks face.

And if I can comment briefly on the small business aspect of your question. We have an onsite consultation program that is available in all 50 States for small businesses to find a person who can help them implement safety and health. And there is a firewall between the OSHA enforcement side of the house. And we have seen dramatic improvement and results from small businesses utilizing our onsite consultation program.

Mr. WALKER. And using the right title, Dr. Howard, if I could ask you something. How often does the CDC and OSHA receive new data on COVID-19, given the constantly changing information? So hold that one question.

Let me say the second part is, what is the likelihood that a regulation published as soon as tomorrow would be applicable or relevant even 4 to 6 weeks from now?

Dr. HOWARD. Well, regarding the first question, you know, as I said, this is a highly evolving situation, and we get new data every day, not only from -- from the surveillance system that we have in place and the ones that we are developing, but also from a number of these industries that you are talking about. I can't speak to the issue of regulation because CDC does not do regulation.

Mr. WALKER. Yeah, I want to swing that part of it back over to Ms. Sweatt. Do you have anything to weigh in on the question?

Ms. SWEATT. I just would agree with Dr. Howard that this is rapidly evolving, and our folks are tracking this. They are working 24/7 to provide the best information available.

Mr. WALKER. Under the OSHA Act, once an ETS has been issued, it must be replaced with a permanent standard. I believe the timeline is within 6 months, using the customary rulemaking process, which includes gathering stakeholder input through public comment as well as hearings.

Ms. Sweatt, can you tell me what is the average amount of time it takes to gather the necessary data and evidence to publish a permanent standard?

Ms. SWEATT. According to a GAO report, OSHA takes 8 to 15 years to promulgate a new standard.

Mr. WALKER. So would you say that an abbreviated rulemaking process would require additional resources that could be used to enforce existing guidelines to protect workers in order to publish the rule within a 6-month timeframe?

Ms. SWEATT. I do think that we are working around the clock to provide the information available, to make information available and work towards protecting workers. And the other piece of the

rulemaking issue is we do find that it is very important to get the most robust comments during our rulemaking process.

Mr. WALKER. Well, I think it is clear for all of us that this is still a learning process. We want to be diligent. But I would hope that we can all agree that OSHA and the CDC resources are best spent on assisting American workers and businesses, maintaining safe workplaces, rather than complying with more bureaucratic demands.

With that, I yield back, Madam Chair.

Chairwoman ADAMS. Thank you, Mr. Walker.

Let me yield to the gentlelady from Pennsylvania, Ms. Wild.

Ms. WILD. Thank you, Madam Chair.

I would like to address some comments by my colleague across the aisle, Mr. Byrne. The problem with silencing witnesses on issues before this and other Committees is that we seem to be mired in lawsuits brought by both sides of the aisle, which could basically bring a halt to the very important work done by these Committees.

Also, it is usually on advice of counsel that a witness is instructed not to speak on a matter in litigation. This process just allows an administration witness to pick and choose which question she is willing to answer.

I would further like to comment on Mr. Byrne's remarks. H1N1 killed fewer than 13,000 people in a year. COVID has killed 100,000 in 4 months. To say that we should not have a standard on the basis of H1N1 is also a false comparator.

With that, Dr. Howard, I have a question for you. A large survey by the American Nurses Association indicates that where facilities are reusing and decontaminating respirators, 54 percent of nurses believe it is unsafe to use a decontaminated respirator N95 mask. A different survey by the National Nurses United found that a quarter, 25 percent of respondents had to reuse a so-called decontaminated respirator with confirmed COVID-19 patients.

Is there solid evidence that decontaminated N95 respirator masks are safe for healthcare workers to use? And are decontaminated respirator masks as protective as new ones in preventing infection?

Dr. HOWARD. Thank you for that fair question. I am aware of those surveys and I understand that being a healthcare worker myself. I think one of the issues that I would like to emphasize at the get-go is that decontamination of an N95 respirator is not the first step in optimizing the use of respirators for healthcare workers. It is literally the last step. Every other type of respirator that we recommend in healthcare, a PAPR, an elastomeric, et cetera, be used before you decide to decontaminate your supply of N95s.

The science about decontamination is relatively new, and I mean, very new. Manufacturers would take exception to the idea of decontaminating an N95. What we recommend in terms of a hospital that is planning to do this is to check with the manufacturer. There are over 500 models of the N95, and each of them are constructed a little differently, out of different material, and they have different configurations. And it is important that you identify with the manufacturer what do you think is going to happen to this particular

model that we are using if we use vapors, hydrogen peroxide as a decontamination method?

So, again, it is the last step in the hierarchy of controls. PPE is always the last step, and amongst PPE optimization procedures, it is literally the last step.

So take it very carefully, check with the manufacturer, and check with the companies that are planning to decontaminate your respirator. Have they done testing? One, does the respirator survive the elastic bands, et cetera? And two, does it kill the virus?

Ms. WILD. Thank you very much for that very complete answer. You have answered my other questions that I was going to ask you.

Ms. Sweatt, in your March 19 letter to Chairman Scott and Representative Adams, you stated that an Emergency Temporary Standard is not needed to protect healthcare workers or other workers because the healthcare industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers. But we know that close to 62,000 healthcare workers have been infected with COVID-19, and 291 are dead as of last count.

I suspect that some hospitals are safer than others -- would you agree with me on that -- for workers?

Ms. SWEATT. I don't have an opinion one way or the other on that.

Ms. WILD. Okay. You need to turn on your mike. But you don't have an opinion one way or the other.

I know that we have two excellent healthcare institutions in my Pennsylvania district that have taken worker safety very, very seriously. On the other hand, we have another hospital where employees have reached out to me with deep concerns about their lack of PPE, the need to reuse surgical masks, paper masks -- like the one I am wearing now -- over and over again. Wouldn't an OSHA standard ensure that all of our healthcare workers be kept safe while caring for the rest of us?

Ms. SWEATT. Well, I think if you are talking about respirators, respiratory protection is already required. And so it really becomes access to respirators.

And I think Dr. Howard could talk to some of the things that they are doing related to respiratory protection. But what we did early on was address the need to slow the burn rate. One of the requirements in our respirator standard is an annual fit test. We ensure that the fit test could occur while still protecting workers and not destroying the respirator, which is what the annual fit test would require otherwise.

And so we have been very concerned about that since day one. And we have issued five guidance documents related to respirators and their use in order to --

Ms. WILD. Excuse me. I would note that this is not responsive to the question I asked. But with that, we are out of time. Thank you.

Chairwoman ADAMS. Thank you. Thank you, Ms. Wild.

The gentleman from Virginia, Mr. Cline, you are recognized.

Mr. CLINE. Thank you, Madam Chair. I thank the witnesses for being here today.

Dr. Howard, you mentioned that at NIOSH, you have significantly increased work hours in order to more than triple the rate of respirator approval and denial decisions from 30 to over 100 decisions per month. That is a significant increase. And I appreciate the steps you are taking to expand your workload during this time.

And, Ms. Sweatt, thank you for outlining how OSHA has been responding to this virus and how frequently you are issuing guidance. It is imperative during a time like this that OSHA is able to remain responsive to the new discoveries through the ability to revise guidance. It is clear that OSHA is working hard to ensure employees are protected and that their guidance is accessible through things like COVID-19 Tip of the Day and a top 10 list of the actions employers and workers can take to prevent COVID-19 infection.

I would ask, Ms. Sweatt, back on April 16, OSHA issued an interim enforcement policy advising the agency's compliance, safety, and health officers to evaluate an employer's good-faith efforts to comply with safety and health standards during the coronavirus pandemic. Can you elaborate on this policy, including what kinds of factors OSHA will consider when evaluating an employer's efforts and how employers should document these efforts to comply?

Ms. SWEATT. Yes. Thank you very much for the question. And that was really focused on a lot of the medical removal issues and medical requirements and our existing standards. And a lot of the people who are providing these services to workers were no longer able to do that because of shelter-in-place issues. And so spirometry, iodometry, those things were not going to be available to the employer.

So as they look to reopen and they look to reschedule that, if and when an OSHA inspector comes on site, they need to explain what their plan is going forward to catch up on the requirements that they have to protect their workers under these standards.

Mr. CLINE. As OSHA continues to revise its guidance based on the newest information surrounding the coronavirus, how are you working to inform businesses about these changes? And moving forward, will OSHA consider industry-specific webinars and offer opportunities for industry to ask direct questions?

Ms. SWEATT. Thank you very much for the question. We have had a very active engagement with the unions and with stakeholders. Our folks have done a variety of webinars. Our compliance assistance individuals talk about almost 4,000 outreach activities that they have already done in the last 2 or 3 months. So we are actively engaged on all fronts of what the agency does. And as we continue our work through the summer and into the fall, our folks will be available, and we will give the best information that we can.

I think one of the most important things that we can see immediately is the dramatic increase to the number of people who have visited our website to look at our guidance documents. And so I think people are really, truly looking for answers.

Mr. CLINE. Thank you.

Dr. Howard, the FDA issued an emergency use authorization permitting the use of certain respirators certified under other -- under other country's safety standards during the pandemic. How

is NIOSH working with the FDA to ensure the efficacy of these respirators?

Dr. HOWARD. Thank you for that question. NIOSH works very closely with the center at FDA that is responsible for approving respirators. And we look with FDA to the standards that particular manufacturer in that country are using. There are some international standards that the EU has, for instance, that many Chinese manufacturers use. So we work with FDA to figure out which of the -- KN95s, they are called, coming from China, for instance, meet the international standards. And then they are included on the FDA's EUA.

Mr. CLINE. And you mentioned this earlier, but you had the opportunity to expand on it a little bit, beyond the issuance of formal guidance, what additional resources has NIOSH created for employers and workers to educate themselves about how to prevent COVID-19 in the workplace?

Dr. HOWARD. Well, one of the things that we do, we do field technical assistance visits with other centers at CDC. As I mentioned, we have done 34 sites for beef, pork, and chicken processing. And we have had excellent cooperation from the plant operators and from the companies involved, even though they are dealing with a very difficult situation.

As you know, a meat-processing plant is a very labor-intensive workplace. And our recommendations are fundamental on the issue of keeping people apart. That is extremely difficult to do in a very labor-intensive operation like meat processing.

So those field investigations have been educational for us and they have been educational also for the plant operator and the companies.

Mr. CLINE. Thank you.

Chairwoman ADAMS. Thank you very much.

I want to now recognize the gentlelady from Michigan.

Ms. Stevens, you are recognized.

Ms. STEVENS. Thank you, Madam Chair. And I join my colleagues in mourning the staggering loss of 100,000 Americans to this wretched disease.

Ms. Sweatt, it is known that you oversee an agency with a budget of \$552 million, is that correct, and you oversee about 2,300 employees?

Ms. SWEATT. About 2,000, yes, ma'am.

Ms. STEVENS. Okay, great. And are you currently working from home?

Ms. SWEATT. No.

Ms. STEVENS. You are going in every day. And how many -- I guess, how many calls or meetings do you take a day? I have to imagine it is quite a few.

Ms. SWEATT. Yes.

Ms. STEVENS. And are most of them just meetings that have been scheduled? Are they kind of reactive meetings? Are there specific calls or, you know, outreach that you are doing that is sort of unprompted?

Ms. SWEATT. I think my schedule is a combination of activities related to -- we have a weekly meeting with all of our senior staff

and regional administrators. I meet weekly with the directorate heads, as we are able to do that.

Ms. STEVENS. Have you spoken to any essential workers? Have you picked up the phone and called any or -- any employers that are deemed essential during your time?

I know as a Member of Congress, that it was sort of unprompted, but the first call I made when this pandemic was declared was to our grocery stores, because I just thought, holy smokes, you are now all of a sudden an essential service, just almost overnight, how are you getting prepared. Have you made any calls like that?

Ms. SWEATT. Yes. We have had calls with the unions. We have had calls with stakeholders. We have performed webinars. I have personally done these things myself, as has the staff. And, you know, we continue our --

Ms. STEVENS. You have an outreach office, right? You do, you have an external affairs outreach office?

Ms. SWEATT. Well, we have a communications office, but we also have a directorate of compliance and State programs. We have had every other week --

Ms. STEVENS. I would invite you anytime, ma'am, excuse me, I would just invite you anytime to call the incredible grocers in Michigan. We -- and nursing homes for that matter. I mean, these hardworking individuals, every single day, I know they would absolutely welcome a phone call from you at anytime.

And, Dr. Howard, thank you so much for your expertise and your testimony today. I think last month, you might have seen I introduced legislation to create an inner agency task force that would bring together experts from across our government to establish the scientifically-based guidance and recommendations to our industries, right? And I heard you in one of the previous responses that you -- you see the CDC changing almost on a weekly basis.

How is that being communicated? And how are you with NIOSH working on an inner agency basis to communicate these changing science-based facts that are coming out of our coronavirus?

Dr. HOWARD. Well, our chief method of communication is obviously through the CDC website on coronavirus. The interaction with other Federal agencies are chiefly OSHA. The Department of Agriculture, which we have had a much closer relationship with lately in the Food Safety Inspection Service, FSIS, as well as the Department of Transportation on airline, the FAA, for instance.

So wherever the particular workplace or industry is, we tend to reach out to that particular Federal agencies that are often regulators, that are responsible in that area, the stakeholders, the unions involved, and the employer associations that service that industry.

Ms. STEVENS. Great. Thank you, Dr. Howard.

And, Ms. Sweatt, Michigan has been pretty hard hit, and particularly in our nursing homes, by this coronavirus pandemic. I have heard complaints, as you were citing, from businesses in my district that have found OSHA's guidance sometimes confusing and vague.

So, for example, on page 10 -- and I read this report several times on the guidance on preparing workplaces for COVID-19. On

page 10, you state that employers should provide a face mask, if feasible and available, and ask a person to wear it, if tolerated.

Why did OSHA issue guidance like this? And why not just clearly state that masks can prevent the spread of COVID-19 when they are worn by workers?

Ms. SWEATT. I would point out that this was written in early March, and so the issue involving the thought process around face masks may have changed. But I do think that Dr. Howard can give you the more scientific issues around the use of face masks. Our concern here is often around respiratory protection and the use of respirators.

Ms. STEVENS. With that, I am out of time, but we thank our Committee Chair for holding today's hearing. And we will follow up on questions for the record.

Chairwoman ADAMS. Thank you, Ms. Stevens. Thank you, Ms. Sweatt.

I am going to recognize myself now for my questions. I did have to leave to go vote.

Ms. Sweatt, do you think that COVID-19 presents a grave danger to workers?

Ms. SWEATT. I think that you are asking questions around the Emergency Temporary Standard, and I can't answer that.

Chairwoman ADAMS. Well, I am not -- I am simply asking, is COVID-19, in your opinion, does it present a grave danger to workers? Yes or no?

Ms. SWEATT. I think that you are asking a question around the Emergency Temporary Standard.

Chairwoman ADAMS. Oh, okay. You are not going to answer that. All right.

Ms. Sweatt, at least 260 healthcare workers have already died of COVID-19. Tens of thousands have been infected. Is COVID-19 a grave danger to healthcare workers? Can you give me a yes or no?

Ms. SWEATT. Madam Chair, what I will tell you is that OSHA has prioritized healthcare workers and identified the issue of respirators since the very beginning of this pandemic. As I have said before, we issued five guidance documents in an attempt to ensure that the burn rate on respirators did not impact these workers.

Chairwoman ADAMS. Okay. But is it a grave danger, yes or no? You can't say yes or no --

Ms. SWEATT. Madam Chair, I am not going to answer yes or no questions.

Chairwoman ADAMS. All right. Let me move on. I don't want to use up my time like that.

Dr. Howard, would you try to answer yes or no for me, please? Do you think that COVID-19 presents a grave danger to workers?

Dr. HOWARD. Yes, I do.

Chairwoman ADAMS. All right. Let me ask you, Dr. Howard. Let's focus for a moment on the meat-packing workers. Is COVID-19, in your opinion, a grave danger for meat-packing workers?

Dr. HOWARD. Yes, I do.

Chairwoman ADAMS. What about healthcare workers?

Dr. HOWARD. Yes, I do.

Chairwoman ADAMS. All right. Ms. Sweatt, can you answer me honestly, if you were a worker in a meat-processing plant or a

nursing home, would you feel safer knowing that there was an enforceable OSHA standard and the agency stood ready to issue citations if safe working standards were being violated? Or would you feel safer knowing only that your employer just had to make a good-faith effort to comply with voluntary guidance?

Ms. SWEATT. What I can tell you is that the agency has focused on the meat-processing industry. We have over 58 complaints or inspections active currently. And we have had daily phone calls with FSIS and Dr. Howard's office to address the concerns around meat packing and --

Chairwoman ADAMS. Okay, ma'am. I just want to know, if you were a worker, would you feel safer knowing that there was an enforceable standard, OSHA standard, and that the agency stood prepared to issue citations if safe working standards were being violated? Or would you feel safer knowing that the only thing your employer had to do was just to make a good-faith effort? Can you give me a yes or no?

Ms. SWEATT. I think that I am going to tell you that the agency is doing everything it can related to this specific industry to provide the best available information.

Chairwoman ADAMS. Yes, ma'am. Let me move on.

So, Ms. Sweatt, despite voluntary OSHA and CDC guidance and the Presidential executive orders, conditions in meat plants are getting worse. Now, you can say yes or no to that, but we have got all of the data, comes on TV. Every day we see that people are not only coming down with the disease but that they are dying in these plants.

And over the past month, according to The Washington Post, the number of infections tied to three of the country's biggest meat processors -- Tyson Foods, Smithfield, and JBS -- have gone from just over 3,000 to more than 11,000. Worker deaths have tripled, surging from 17 to at least 63.

Now, given those numbers, would you say that your current strategy to ensure the safety of meat-processing workers is working?

Ms. SWEATT. I have to be very careful here because we do have open inspections and investigations in meat-packing facilities. So I think to answer your previous question at this time --

Chairwoman ADAMS. No, I don't want you to answer the previous question. Okay. That one, you can't give me a yes or no?

Ms. SWEATT. The answer is we stand ready if we find violations in our enforcement investigations --

Chairwoman ADAMS. Thank you, ma'am. I have got 50 seconds.

If the only way to accomplish social distancing in meat processing is to slow down the production lines, will OSHA be willing to order the plants to do so? Would you order the plants to do so?

Ms. SWEATT. Line speed is not within the jurisdiction of the agency, but what they can do is in our guidance.

Chairwoman ADAMS. Okay. That is fine. No, you wouldn't do it. Okay.

And how many meat or poultry process plants has OSHA done a physical inspection? How many physical inspections have you done?

Ms. SWEATT. Within the last week, I believe it is 10.

Chairwoman ADAMS. How many of those have been closed with no citations?

Ms. SWEATT. I believe most of those are still pending. We have 6 months to complete our inspection.

Chairwoman ADAMS. Okay. Dr. Howard, let me ask you. You said that -- your testimony discussed the inspections of 34 meat-packing facilities in 12 states. Given the difficulty of redesigning meat-packing facilities, would it be far more effective to keep the virus out of the plant by requiring regular testing of workers for COVID-19?

Dr. HOWARD. Well, this is -- testing is a complex issue, and right now, CDC doesn't have the establishment-wide guidance to give an employer who is interested in doing testing.

Now, we are thinking about that. We have a lot of information that we are putting together, and we may be coming out with more guidance on that issue. But right now, we don't have enough information to recommend establishment-wide. Now, those are asymptomatic workers --

Chairwoman ADAMS. My time is up, sir. I apologize. My time is up. I am going to have to now yield. Thank you, sir.

Mr. Guthrie of Kentucky, you are recognized, sir.

Mr. GUTHRIE. Thank you. I thank the Chair for the recognition. I appreciate it. Thanks again for being here today.

And my colleague from Michigan, Ms. Stevens, kind of talked about masks, and you said that was early in March. Things have changed. And I am on Energy and Commerce, Health, so we are -- and O&I, so we are following this, the information.

So businesses out there are trying to make -- they want their workers to be healthy and safe. They want to be. So as things change, how is OSHA being proactive in making sure businesses know these changes, and how does proactive business -- what is the best way -- if I am a businessperson in Bowling Green, Kentucky, trying to run a factory, what is the best way for me to know the best practices as these change every day, the updates?

Ms. SWEATT. Well, we can update our website very quickly, obviously. So as our documents go up, we put them out on the website. We push them out in as many social media platforms as we have available. And we have seen a dramatic increase in the traffic to our website, in addition to our newsletters. So we think employers and workers are seeking the best information possible.

A lot of our website also links to our Federal partners, NIOSH and CDC. They also have an abundance of guidance based on what they are finding scientifically and medically. So we are working as quickly as possible to provide the best information to everyone.

Mr. GUTHRIE. Okay, thank you.

And then, Dr. Howard, I know the FDA -- because I have oversight on FDA, my other Committee assignment, and did the emergency use order for the certain respirators that are certified in other countries for use. So how is your organization, NIOSH, working with FDA to ensure these are safe -- their efficacy is there and they are eligible to be used?

Dr. HOWARD. Well, thank you for that question. As I mentioned, you know, we work very closely with FDA on these emergency use authorizations that they publish. So our laboratory looks at the fit of the respirator and the filtration capability of the respirator.

Those are the two main attributes of a respirator that we are -- think are very important.

A lot of these international respirators are made internationally. And China, for instance, use ear loops. That doesn't give you the best fit, for instance. We have to look at both the filtration efficiency. And we have tested some of those respirators. They don't come to the 95 percent of filtration efficiency that an N95 is.

So we work with FDA. We get -- States, for instance, are buying respirators from China. They send it to us for evaluation. We perform the evaluation and give them the results. We also share that with FDA. The FDA decides what models they are going to put on their EUA based on our testing.

Mr. GUTHRIE. So you are saying the ear loops like this and the rest of us --

Dr. HOWARD. The ear loops versus the ties behind the head. The two big issues for protecting the lungs from atmosphere is the fit. How tight the fit is so you don't get any leakage. And that is hard with the ear loops, okay. You get less fit. And the other is the material itself that filters the particles. So filtering and fit, those are the two big things that we test for.

Mr. GUTHRIE. Dr. Bucshon, who is a surgeon in another Committee, we were talking, he says, yeah, people because they are wearing the mask a lot, they can cough without having to corrupt. And the problem is it can run out the sides, and it is probably -- it creates a moral hazard sometimes. You have to be careful with that.

So let me ask another question. I know that sometimes you get conflicting information, businesses do and employers do. And not in this, specifically. I don't have any examples. But I know there are other areas that if you comply with one agency, you are violating another agency. I have seen that before.

So, Ms. Sweatt and Dr. Howard, as more business are reopening -- and I have heard from employers in Kentucky on how critical to ensure the workplace safety guidance is consistent across the Federal Government and that agencies are not providing conflicting information -- can you both elaborate on how you work together and coordinate the public health agencies during the pandemic?

Dr. HOWARD. Well, I will take it first. We work very closely with OSHA to make sure that does not happen. That is the worst outcome that we as one government can make is to have conflicting information.

So any information that involves the workplace, we run by OSHA for their comments.

Mr. GUTHRIE. Okay.

Ms. SWEATT. I would say we have an excellent working relationship with our Federal partners, especially at NIOSH and CDC. I know our folks are on the phone with Dr. Howard's folks all the time. But I do believe that in the response to this pandemic, you have seen an all-of-government process here. And so anything that we put out has also been vetted to make sure that we are not in opposition with any of our other Federal partners.

Mr. GUTHRIE. Thank you. And I appreciate the hard work you guys are doing. And I know we are all concerned, both sides, that people show up in a place where they can be safe and to work. And

I know you are trying to put that out in an ever-changing environment. I know businesses are trying to figure out how to do it in an ever-changing environment. And we all need to work together and pull together to make this work. And thank you for your efforts. I appreciate it very much.

I yield back.

Chairwoman ADAMS. Thank you, Mr. Guthrie.

Let me recognize the gentleman from Connecticut.

Mr. Courtney, you are recognized.

Mr. COURTNEY. Thank you, Madam Chairwoman, for holding this hearing today.

This Saturday in New London, Connecticut, there is going to be a memorial service for Elva Graveline, who was a certified nurse's aide who worked at a local hospital there, 52 years old, mother of two, grandmother of three, who succumbed to COVID a couple of weeks ago.

And, again, there were stories in the human face of people who really are the good guys. She was a caregiver who treated her job as a CNA as a calling, not as a job, 23 years, described as kind-hearted. And, again, it just reinforces that this is not a theoretical academic issue. This is really about human beings who are doing right by all of us in terms of keeping this country going forward.

I just wanted to just touch base with both witnesses about the fact that this is not the first pandemic that OSHA has encountered. The AIDS/HIV pandemic in the late -- mid eighties, late eighties, and early nineties, OSHA acted, and it acted very swiftly to put into place real standards in terms of bloodborne pathogens.

My wife is a nurse practitioner. She worked at Bellevue back in the eighties there, and she still remembers the day where, again, you drew blood and used needles with no gloves. And there was no such thing as disposable needles.

OSHA created, with the standard, an enforceable standard, the regime that we now just sort of take for granted when we go into hospitals. Was OSHA wrong to institute a standard versus just operating with guidelines?

Ms. SWEATT. I believe OSHA followed the direction of this Committee through a statutory requirement to establish that standard.

Mr. COURTNEY. Correct. I mean, it was a prodding from Congress that they actually moved. And again, it wasn't a 5- to 20-year process. I mean, it happened in much swifter terms.

And, again, Dr. Howard, did OSHA do the right thing by implementing a standard to deal with AIDS/HIV?

Dr. HOWARD. I think so. And I would like to point out that they followed California's lead in that area.

Mr. COURTNEY. So, again, when we talk about having a standard put into place, this is not some wild, unprecedented sort of notion. I mean, the fact of the matter is it is just part of the reality every day when people walk into doctors' offices or hospitals.

Again, Dr. Howard, your description of how to safely disinfect N95 masks that you testified to earlier was, again, I think a learning experience for all of us about the fact that you have got to really actually do more than just throw it in the washing machine. You know, there is real issues that you got to do it the right way.

Why wouldn't that sort of, you know, standard be really something that would help guide a lot of employers?

And I will tell you, because this is relevant in Connecticut, which again has been very hard hit. Again, we have had tremendous, you know, donations from, you know, private individuals, as well as FEMA, in terms of getting masks, N95 masks. But some of them, as you point out, are different. They are not all the same.

So if you are a hospital or a nursing home trying to, you know, organize this, I mean, you need -- it sounds to me based on your testimony -- you know, more than just lumping them all together and disinfecting them in exactly the same fashion. So why wouldn't that be a good thing to have, you know, that more precise advice that you described out there so that employers really would know that you have got to do more than just treat them all the same?

Dr. HOWARD. Well, I certainly think that the more specification that you can provide an employer, the more helpful it is to that singular workplace. The problem is we can't do guidance that is highly specific to each establishment. So we have to do fairly general guidance and then look at the application, help employers -- both NIOSH, CDC, and OSHA, through their consultation service -- apply those guidelines to their specific workplace.

Mr. COURTNEY. But, again, having a standard, which just says you have got to look at the manufacturer's specifications when you are going to reuse, you know, N95 masks, that is just, like you pointed out, necessary to make sure that these workers when they reuse them are actually going to be protected.

And, again, I would just say, you know, one of my wife's good friends back home is a nurse at a local hospital who has been intubating COVID patients with reused N95 masks. I mean, they were basically reusing them over a period of 7 days. You could not get in a more high-risk situation than intubating a patient as a worker. And, you know, that just shows how life and death -- you know, having real standards out there so that people like Dawn are going to be safe in terms of doing, you know, just amazing work in terms of saving lives.

I yield back.

Mr. SCOTT. [Presiding.] Thank you.

Is the gentleman from Michigan prepared to ask questions?

Mr. LEVIN. Yes.

Mr. SCOTT. The gentleman from Michigan is recognized for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman.

Mr. SCOTT. Wait a minute. Excuse me, Andy. The other gentleman from Michigan, Mr. Walberg. I am sorry.

Mr. LEVIN. Oh, okay, I am sorry.

Hi, Tim.

I yield to my esteemed colleague from Michigan, Mr. Walberg. Sorry.

Mr. WALBERG. Andy, it is good to see you. I hope you are well. I just wondered what that guy was spraying or looking at in your basement or whatever. So it has been interesting to watch.

Mr. LEVIN. I will tell you later.

Mr. WALBERG. Okay.

Thank you, Mr. Chairman, for holding this hearing. And I would concur that we ought to do this regularly, have live hearings where we are here in the room. It is the best way to get the work done. And I think by now we should be capable of handling this. Plus, we have a lot to consider.

Loren, it is good to see you back.

Ms. SWEATT. Thank you, sir.

Mr. WALBERG. It seems strange that you are not sitting behind me and telling me what to say and what to do when I chaired this Subcommittee for 6 years.

Ms. SWEATT. I agree.

Mr. WALBERG. So you got me through well on that. And I am sure that you are giving it your best, best effort now where you are at. We appreciate that.

Having been away for votes, I probably missed some questions I might have asked. But there were a few that I really wanted to ask you as well, and it goes back to guidance. And as we wrestle with that whole idea, I know during the time we worked together, on what rules need to be in place and what laws had to be in place, and how you could work in a system that mandated you be loose on your feet, as it were, to deal with situations that came up, whether it was in a mining situation or a manufacturing situation or now, of course, the hospital situations that are going on.

Let me ask again why the agency believes it is better to issue guidance as opposed to a new regulation response to COVID-19 spread? And if you could also provide a real-world example of where your agency would have been delayed in this response if you had a hard-and-fast rule or law in place as opposed to guidance.

Ms. SWEATT. Thank you, Mr. Walberg. And I appreciate the kind words, and I share the sentiment.

But I think what we have seen over the last 3 months is, as I said, we are at 5,000 complaints related to COVID. And the agencies take in almost the same number of complaints that are in our, unfortunately, normal safety and health concerns.

So with the way this virus has changed and our understanding of it, our guidance documents have been able to address what we know today. We issued construction guidance just on Monday. We have more coming out maybe even as I speak. And, you know, we have gone from the idea of not wearing masks to now everyone, almost everyone in this room wearing masks. And that is a 2-month evolution of thought process.

So we are able to look at what is happening and respond and put that information out as expeditiously as possible through our website. And yet our folks are still, as I have said, 24/7 out there responding to COVID and, unfortunately, responding to other safety and health concerns. As people are returning to work, we are seeing a small increase in problems related to what I would call what we do on an everyday basis related to safety and health.

So this is a good opportunity, I think, to remind folks that all of their obligations exist under the OSH Act and that employers need to really be focused on those as they restart their businesses.

Mr. WALBERG. In a Committee-Democrat forum held on May 14, former Assistant Secretary for OSHA, David Michaels, who I worked with extensively back then, told Members that if he was in

charge of the agency during the COVID-19 pandemic, it would be doing inspections of high-profile workplaces and would be talking to the media to inform workers of their rights. Yet by all accounts, OSHA is doing just that.

Can you elaborate on the department's efforts in this regard? And are there any other misleading statements made by our friends on the other side of the aisle that their union allies -- and their union allies that you would like to clear up?

Ms. SWEATT. I would like to highlight one part of your question about whistleblowers. I think you could not get a better spokesperson for whistleblower protection than the Secretary of Labor at the White House. And he pointedly said, on April 9, that retaliation would not be tolerated. Our whistleblower investigators have tackled the almost 2,000 COVID complaints that we have received and the other 2,000 complaints that we have received from our other 23 or 22 statutes.

So we have seen success with reinstatement of whistleblowers. We have seen, as I said, letters of reprimand removed. And we have seen actual policy changes by businesses to ensure that workers have the right to express concerns about their safety and health in the workplace.

I am not really sure where people aren't seeing that message, but truly, the Secretary of Labor -- there is no higher authority, in my world, from the White House to determine and determinly say that this is not acceptable behavior.

Mr. WALBERG. I appreciate that. Thank you.

I yield back.

Mr. SCOTT. Thank you. The gentlelady from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you to the Chair and the Ranking Member, and also to our witnesses today.

We just, yesterday, in the United States passed 100,000 deaths. And those aren't just numbers, they are real people. And our thoughts and prayers are with their families. But we have to keep in mind that the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health have an obligation to prevent workers from hazardous conditions on the job, and they are falling short. Too many workers are facing risks at work.

In the absence of leadership from the agencies, I was proud to join Chairman Scott in introducing the COVID-19 Every Worker Protection Act, and I was pleased that it was included in The Heroes Act. And my thoughts are with those essential workers who are showing up every day despite the risks -- the nurses, the doctors, the grocery store workers, the firefighters, postal employees, childcare workers, health workers. They are the heart and soul of our communities right now, and they are going to help us get through this.

Dr. Howard, I want to ask you this, CDC recently changed its guidance allowing healthcare workers to use surgical masks rather than N95 respirators. After the CDC issued this guidance, and many hospitals denied healthcare workers access to N95s, news reports document cases of healthcare workers who objected to the CDC guidance and had their credentials challenged and were fired

for insubordination, and some tragically died of COVID-19 because they lacked access to prep or PPE, personal protective equipment.

So, Dr. Howard, was the change in the CDC guidance based on shortages in personal protective equipment or based on new scientific information?

Dr. HOWARD. Thank you for that question. The answer is unequivocally it was based on a crisis strategy that we have a global shortage of the supply of N95 respirators. The science has not changed. It is only our current situation of supply.

Ms. BONAMICI. Thank you.

Ms. Sweatt, you noted in your testimony that OSHA has the tools to protect workers from COVID-19 by enforcing the general duty clause and other existing OSHA standards. OSHA has received, as you noted, nearly 5,000 complaints and referrals related to COVID-19, and those range, it is my understanding, from outbreaks in the workplace to lack of access to PPE and insufficient physical distancing practices.

The majority of these cases have been closed without action. So Ms. Sweatt, how many COVID-19-related citations has OSHA issued under the general duty clause?

Ms. SWEATT. Sorry. At this point, we have issued one citation under an existing standard, and I would note that we still have 6 months to complete any investigation or enforcement action.

So I think relying on looking at citations is maybe not the best parameters here. What we are really trying to do is remove the worker from the hazard or remove the hazard from the workplace. And so our priority has been that. We have been proactively working on all of those issues when we receive these complaints. Employers get information, in case they are not fully aware, and they are able to change their work practice. Where we do not find an employer who is protecting their workers, we will enforce --

Ms. BONAMICI. Ms. Sweatt, I am going to reclaim my time because I have some more questions. How many COVID-19-related citations has OSHA issued under any existing standard during COVID-19?

Ms. SWEATT. As I said, we have had one within the last week, and, you know, there is still a very -- a substantial amount of time within our statute of limitations. These --

Ms. BONAMICI. I understand. But just one, and it is my understanding that was for a recordkeeping violation.

Ms. SWEATT. It was --

Ms. BONAMICI. And I understand the general duty clause citation could take more time, which is why it would be more efficient and effective for OSHA to issue an Emergency Temporary Standard. But in your testimony, you emphasize that OSHA's existing standards for respirators, PPE, and sanitations, can these citations be issued faster?

Ms. SWEATT. We have to build a legal case to defend our citations, and I do not believe that rushing to issue a citation is really the best effort. What our folks need to do and are doing is proactively inspect and investigate all complaints that we receive and build the appropriate legal case to defend those. To issue a citation that is not legally defensible would be irresponsible on our part.

Ms. BONAMICI. And I appreciate that, but in my home State of Oregon, Oregon OSHA has been more proactive. Their efforts have not been perfect, but I have been calling on them to do more to protect workers. Oregon OSHA recently issued a willful violation to a business in only 9 days. So what prevents Federal OSHA issuing citations in a similar time --

Ms. SWEATT. Nothing prevents that, but what I don't think you see related to our complaints is, when we provide the employer information to protect their workers and their practices change. And that is one of the key elements is to remove the worker from the hazard or remove the hazard.

So we think that there is positive action occurring when we have taken these complaints. And when we see an employer who is not moving to make appropriate changes, we can enforce.

Ms. BONAMICI. Well, I also want to note, Mr. Chairman, and colleagues, this committee received a letter from Dr. Rayfield, dated May 20, and with that letter, Dr. -- excuse me -- Redfield attached the table with the CDC available data on healthcare worker infection rates.

He also noted that it is likely an underestimate and not all cases are reported to the CDC. And I just want to note how challenging it is not only for you at OSHA and NIOSH to do your work but for us as policymakers to make good policy decisions without good data, so -- and I know my time is about to expire, or has expired. But I just want to note --

Mr. SCOTT. It has expired.

Ms. BONAMICI. -- that we really need good data, and we don't have it.

Thank you, Mr. Chairman. I yield back.

Mr. SCOTT. Thank you. The gentleman from Wisconsin, Mr. Grothman.

Mr. GROTHMAN. Yes. A couple questions. First of all, I think things are getting better. But part of the problem you are going to hear from employers is a lack of PPE. Okay? And in my district, we have some ability to make more masks, for example, which I think is one of the big things that employers are going to need. But I am wondering, are either of your agencies doing anything? It frustrates me, because I think we should have been weighing in harder, and the industry in my district is just doing yeoman's work in getting their new machines up and running quicker than they would under normal circumstances.

But I am a little bit frustrated, say, with regard to FEMA, who I think maybe could have waited a little bit more or done a little bit more. Are you guys doing anything in your agencies to make sure that PPE is available for the businesses, or keeping track of how much we need, or working in coordination with FEMA or something like that?

Ms. SWEATT. I will start very quickly, because I think Dr. Howard has a more robust responsibility in this area. One thing that OSHA has participated in over the last 3 months is the supply chain task force, and so our folks have been working with our Federal partners to determine how we can get more supply in.

And, again, I testified previously, the most important thing that we did was our five guidance documents to try and assure that

there was PPE respiratory protection available related to the burn rate within hospitals. And I will refer to Dr. Howard.

Dr. HOWARD. Thank you very much. We work at NIOSH with our partners at CDC. CDC is part of the National Response Coordination Center, which is run by FEMA. Currently, the SNS, the national stockpile, is purchasing 800 million respirators. On the supply side, 3M is now up to 90 million respirators per month. Honeywell is up to 20 million respirators per month. So we are seeing a change now from where we were 3 months ago. So the supply is increasing.

Now, I can't say the distribution of that supply in every corner of the United States is the same, but the supply pipeline is increasing.

Mr. GROTHMAN. Okay. How many masks a month do you think we need?

Dr. HOWARD. You know, that is a very difficult thing to figure out.

Mr. GROTHMAN. You can --

Dr. HOWARD. One of the things that the NRCC is doing is looking at, as Loren said, that supply chain, what is the utilization. And we have a PPE burn rate calculator, which is now an app, that individual hospitals can use to figure out their own burn rate of that PPE.

And we have a PPE monitoring system where we have about a hundred hospitals enrolled to date where we are developing that national system so we can figure out what is the inventory and what is the utilization rate.

Mr. GROTHMAN. Presumably you want some in places other than hospitals too. Aren't there other employers who you are going to want it for as well?

Dr. HOWARD. Sure. What we are talking about though right now is the N95 respirator, which is, as we talked about, used for aerosolized procedures in hospitals.

Mr. GROTHMAN. And what is your target? How many a day do you think you need? Do you have -- you must have an idea.

Dr. HOWARD. Well, we are talking in the billions in order to bring us --

Mr. GROTHMAN. Two million? Five million? What is your target?

Dr. HOWARD. For the national supply?

Mr. GROTHMAN. Correct.

Dr. HOWARD. Yeah, that number I don't know, but it is certainly in the billions.

Mr. GROTHMAN. Okay. Ms. Sweatt, thanks for being here again. I would like to ask you how OSHA helps employers determine worker risk of occupational exposure to COVID-19. I have a lot of manufacturing facilities in my district. Based on their specific operations, manufacturers may feel they fall into high-risk, medium-risk, low-risk. What is the biggest determining factor in the decision as to how close manufacturing workers are?

What is the biggest factor determining how close manufacturing workers can be to each other throughout the day, and what are other factors that go into the classification of high-risk, medium-risk, or low-risk?

Ms. SWEATT. Sure. It is the sustained contact issue. So I think we have put out manufacturing guidance to help folks work through the issues. It is really incumbent upon the employer to do an analysis of their work practices and determine if there are changes that they can make. And you know, we have our hierarchy of controls within there.

I know some folks find that to be maybe tedious, but I think that manufacturers have folks that are, you know, trained in this area, but it is really an important part of the agency as well, that we have compliance assistance specialists, and they are available.

Mr. GROTHMAN. I have one more quick question which just kind of popped into my head.

Ms. SWEATT. Sure.

Mr. GROTHMAN. There was a feeling among some medical professionals that eventually regardless of what we do, this COVID is going to go through the population, that we should maybe protect the vulnerable, but it is inevitable that it will go through the population as a whole. The only question is how long that is going to take. Do you believe that or not? Five years from now, assuming we don't get a vaccine, is everybody going to be touched by it or not? What do you think?

Ms. SWEATT. I think that is outside of my jurisdiction at OSHA, and I would refer to Dr. Howard.

Chairwoman ADAMS. Thank you very much. We --

Dr. HOWARD. Do you want me to respond?

Chairwoman ADAMS. Briefly.

Dr. HOWARD. Yeah. There is no timeline. As Dr. Fauci has said at NIH, we are talking about 12 to 18 months, perhaps, at the outside for a vaccine. We hope for it being sooner. That would certainly be great. The issue about everybody in the population getting COVID-19, the issue is, do they all show up in the same emergency room at the same time? That is the issue, is protecting the healthcare system.

Mr. GROTHMAN. Do you believe it is inevitable over 5 years?

Dr. HOWARD. I don't believe it is inevitable, but I do think that if everybody gets it all at once, you are going to end up crashing your healthcare system.

Chairwoman ADAMS. Thank you very much. Thank you very much.

Let me recognize our distinguished Chair of Education and Labor Committee, the gentleman from Virginia, Mr. Scott. You are recognized.

Mr. SCOTT. Thank you, and thank our witnesses for being with us today. Ms. Sweatt, you have indicated that you are not responding to questions involving the Emergency Temporary Standard. I agree with the gentleman from Alabama that no good lawyer likes his client talking about issues under litigation, but as the Chair has indicated, you need a legal basis for that claim. Are you claiming a legal privilege, and if so, which specific privilege are you claiming?

Ms. SWEATT. I have been advised by Department counsel not to answer questions on ETS.

Mr. SCOTT. Can you provide for the record -- apparently you don't know which privilege they are using. If you could provide for the

Committee exactly which legal privilege you are relying on, in order not to answer questions.

Ms. SWEATT. [Nonverbal response.]

Mr. SCOTT. And you have indicated in your testimony that OSHA considers retaliation against workers unacceptable. How many complaints of retaliation has OSHA received, and how many businesses have been sanctioned for retaliation?

Ms. SWEATT. We have, as of May 26, 1,374 whistleblower complaints for COVID, and there is no statute of limitations on the investigations of those. So while investigations are ongoing, I can tell you in certain circumstances, we have seen resolution almost immediately when the whistleblower calls to initiate the investigation and --

Mr. SCOTT. Well, by "resolution," do you mean the worker got their job back?

Ms. SWEATT. Yes, sir.

Mr. SCOTT. Well, that is not a sanction. They shouldn't have been fired to begin with. How many businesses have been sanctioned?

Ms. SWEATT. At this juncture, I don't believe we have issued any sanctions per se.

Mr. SCOTT. So the --

Ms. SWEATT. We have seen back pay -- reinstatement and backpay. And I think one of the more important issues is the change of approach by some of these businesses about how they address safety and health.

Mr. SCOTT. So people have been fired in retaliation for making a complaint, and the businesses really show no -- there is no deterrence for that action?

Ms. SWEATT. They reinstate, and they have to pay backpay.

Mr. SCOTT. Okay. At which they owed the pay to begin with, and the person shouldn't have been fired to begin with, but there is no sanction.

We know that there are many deaths in nursing homes, meat-packing plants, as well as healthcare facilities. The general duty clause is generally used after a death or serious injury, not for prevention. How many site visits have been conducted by OSHA, proactively for prevention, rather than in response to a death or some kind of complaint?

Ms. SWEATT. I would say everything that we do is proactive, and we have issued nursing home guidance. And I would also point back to everything that we have done to try and protect the respirator supply for individuals in --

Mr. SCOTT. But I asked you, how many have been proactive and not in response to a death or a complaint? In your response to questions in writing that you responded, you said all of OSHA's inspections are initiated through unprogrammed activity, those were either opened as a fatality inspection, catastrophe inspection, response to employer reports of hospitalized workers or initiated in response to complaints. None were proactive prevention.

Ms. SWEATT. I would say that if you look at what we have done in previous natural disasters or other emergency situations where we have suspended enforcement, we proactively chose to not suspend enforcement in this area, and so, in fact, we have proactively

pursued complaint inspections and investigations and done onsite

--

Mr. SCOTT. Proactively in response to complaints, that is not proactive. Is OSHA bound by the policy of eliminating two rules in order to establish a new rule?

Ms. SWEATT. The Department as a whole is, yes.

Mr. SCOTT. So you can't establish an Emergency Temporary Standard without repealing two other rules?

Ms. SWEATT. I think that is a question that you are trying to get on the Emergency Temporary Standard area. The two-for-one is larger than just the agency.

Mr. SCOTT. Okay well --

Ms. SWEATT. And so --

Mr. SCOTT. I have a question for Dr. Howard. You formerly worked in California. Does California have an airborne transmissible disease standard, and what should Congress consider in drafting legislation to protect workers from airborne infectious diseases?

Dr. HOWARD. Well, certainly California does have an aerosol transmissible disease standard. But I will leave the legislating to people who do that for a living.

Mr. SCOTT. How long has it been in effect?

Dr. HOWARD. I think it was 2013, somewhere around there. It was in development for a number of years before that.

Mr. SCOTT. Thank you, Madam Chair.

Chairwoman ADAMS. Thank you. Thank you, Mr. Scott.

The gentleman from Kentucky, Mr. Comer, you are recognized.

Mr. COMER. Thank you, Madam Chair. Ms. Sweatt, we have heard untrue claims that the Trump Administration did not act soon enough to prevent coronavirus from entering our country. Can you give some detail about the actions taken by your agency prior to COVID-19 being declared a pandemic by the World Health Organization on March 11th to ensure that healthcare workers and other essential businesses were prepared to respond to unprecedented workplace safety challenges?

Ms. SWEATT. Thank you, Congressman, for the question. OSHA had started as early as January of this year putting information on our website, through a safety and health topics page, to inform individuals about the pandemic, which at that point was an unknown novel coronavirus. We have pursued updating our safety and health topics page.

We outlined what standards we thought employers should be aware of, that they should be in compliance with, and we have subsequently provided general industry guidance, along with almost 20 actual individual industry guidance documents to help employers respond to this pandemic.

Mr. COMER. Dr. Howard, the poultry and beef cattle industries are major industries in my congressional district, and I have four major poultry processing facilities located in my district. Two of those have been significantly affected by minor COVID-19 outbreaks. You testified that NIOSH has been on the ground in dozens of meat-packing and meat-processing facilities across the country, conducting site visits, and providing recommendations to employers based on your observations. Can you explain some of the workplace

safety challenges you have observed in these facilities and how businesses are implementing measures to address these challenges?

Dr. HOWARD. Sure. As I said, you know this -- whether it is beef or pork or chicken, these are very labor-intensive activities. And people are extremely close together on a production line, and if the fundamental principle for protecting workers from COVID-19 is to separate people, it is really a feasibility challenge in these meat-processing plants.

So we have come up with a number of different recommendations. In fact, they fill about 15 pages of our joint CDC/OSHA guidance, to try to help employers figure out how they can do that and still be able to produce the food the country needs. And that is a real challenge.

Mr. COMER. I think we have learned as a public -- I am an agriculture guy, a former Commissioner of agriculture, so I knew this already, but a lot of Americans are figuring out that employees at food processing facilities are very essential workers. So I appreciate what you are doing there.

There have been a few local hotspots in my congressional district, very few. I have 35 counties, I have probably had four counties that have had any, you know, measurable activity as far as being a hotspot in my congressional district. I am very thankful for that. And in Kentucky, businesses are slowly -- and I can't say this enough in Kentucky -- very slowly reopening.

Every employer wants safety, that I know of. The CDC now recommends that everyone should wear a mask in public settings. This would apply to businesses and their employees as they return to the workplaces. Dr. Howard, are there any circumstances in which an employer should not have their employees wear a mask?

Dr. HOWARD. Well, there are. There are some folks that have preexisting respiratory conditions. Things that are over their mouth make it difficult for them to breathe. They already have a difficult time breathing, so putting a mask on their nose and mouth can make it more difficult. So certainly those folks may not be able to wear a respirator, and they may complain to the employer. They just can't tolerate it. So some workers are going to be in that category.

Mr. COMER. What about the recommendation that some States are implementing, I think based on CDC recommendations, with respect to youth sports, that young people wear masks, for example, playing baseball this summer? My son's on a tribal baseball team, and, you know, the temperature gets up in the hundred-degree weather and they are outside, they are spread out pretty good, but our governor came out and said that those kids need to wear masks.

Is that something that should be of a concern for the children, 11, 12 years old or younger, wearing masks outside in hundred-degree weather?

Dr. HOWARD. You know, CDC is just getting into the area of sports, both professional, amateur, and children's sports. So we don't have a lot of guidance on that area, but these are the kind of issues that we are all going to face as we approach the summer in terms of reopening.

Chairwoman ADAMS. Thank you, sir.

Dr. HOWARD. So these are the things that we are thinking about.

Mr. COMER. Thank you.

Chairwoman ADAMS. Thank you.

All right. Thank you very much. I would like to recognize the gentleman from Michigan. Mr. Levin, you are recognized, sir.

Mr. LEVIN. Thank you so much, Madam Chairwoman, and thanks for holding this very important hearing. Earlier I think perhaps in the discussion with Mr. Courtney, Dr. Howard, you said that during the AIDS crisis, Congress required and OSHA implemented a mandatory standard to protect workers during the AIDS crisis. Is that correct?

Dr. HOWARD. Yes. I think it was actually Ms. Sweatt that referred to the congressional mandate at that time.

Mr. LEVIN. Okay. But so that happened then. And then some of my colleagues mentioned that, quite extensively, that the Trump Administration has acted similarly to the Obama Administration during the SARS outbreak, and so that this is an appropriate response.

Ms. Sweatt, are you aware of how many Americans died during the SARS outbreak?

Ms. SWEATT. I don't have those figures in front of me, no.

Mr. LEVIN. Well, let me share them with you from the CDC website. In the United States of America, eight persons were laboratory confirmed as SARS cases, and there were no SARS-related deaths in the United States. Would you consider that to be a comparable situation to what we are going through now?

Ms. SWEATT. I can tell you from the place that I sit at the occupational safety -- excuse me?

Mr. LEVIN. I think that is a yes or no question. Ma'am, I am sorry I am not in the room with you, but that is a yes or no question.

Ms. SWEATT. I have to tell you, from where I sit at the Occupational Safety and Health Administration, we are at almost 5,000 complaints on COVID, and we are responding as rapidly as we can.

Mr. LEVIN. Okay. I am going to move on. I have got to move on with my questions. So NPR just reported this morning that we have had close to 300 United States healthcare workers alone killed by COVID-19. And obviously we have had a hundred thousand Americans who have passed away from COVID-19. Ms. Sweatt, given --

Ms. Sweatt, more than three-quarters of OSHA's COVID-19-related inspections have been fatality investigations. To put it bluntly, OSHA is stepping in only once someone has died. Every day I get calls from workers who are terrified that they will become sick in their workplaces. Many worry not for their own lives but for the lives of sick or elderly family members that they reside with and support. What should I tell those frightened workers and those vulnerable workers about the fact that OSHA refuses to issue any mandatory standards in the greatest workplace healthcare crisis in our history?

Ms. SWEATT. As I have said before, OSHA has existing standards to address a variety of aspects of this virus, and we are enforcing where we find failure to comply.

Mr. LEVIN. Ma'am, you have issued one citation in the greatest crisis. You say you are acting proactively, but in fact, what you are doing is the definition of reactive. You are refusing to act proactively and issue a mandatory standard of any kind during the greatest healthcare crisis in the workplace in modern history.

If your agency inspects workplaces only after a worker has died, you are not preventing worker infections. I would suggest that your agency could be acting strategically, looking proactively at industry sectors, determining the worst actors, identifying infection vectors, and protecting workers from being put in situations of unnecessary and cruel risk. But your agency is waiting for the worst possible outcomes before taking action. This is simply unconscionable.

Let me ask a question of Dr. Howard. Sir, how long have you been in this field of occupational medicine yourself?

Dr. HOWARD. Since 1981.

Mr. LEVIN. And, sir, have you ever seen a comparable situation of the scope and scale of health risk in American workplaces during your long and distinguished career?

Dr. HOWARD. The only comparison I can make is in the 1980s with the human immunodeficiency virus.

Chairwoman ADAMS. Thank you very much. You are out of time. Thank you.

I want to recognize now the gentleman from Pennsylvania, Mr. Smucker.

Mr. SMUCKER. Thank you, Madam Chair. Ms. Sweatt, thank you so much for rebalancing OSHA's mission to ensure compliance assistance is a priority. As a former construction business owner, I know how important that can be. Employers really do want to do the right thing. They care about their employees. They want to keep employees safe. And feeling like they can ask OSHA for assistance to ensure they are doing things correctly is absolutely critical.

It appears to me my colleagues on the other side of the aisle are looking to pin OSHA as the scapegoat and place blame for the spread of a global pandemic on employers. And I will just, food for thought, that may seem like a pro-worker stance right now, but it won't be very pro-worker when their misguided targeting causes them to lose all their jobs due to business closures.

So a question for you, my colleagues on the other side of the aisle seem to think the guidance you put out is optional and that employers can choose to follow them. They will argue that this is why we need to pass more onerous laws that will end up in a legal spider web that do not meet the needs of all industries.

Do you think that rhetoric could ultimately be more dangerous for workers if employers are misled to believe that they don't legally need to follow your guidance?

Ms. SWEATT. Well, I definitely think it is problematic, but I think what we need to say here is employers do need to know and understand their obligations under the Occupational Safety and Health Act. They need to make a plan. They need to determine what they need to do to protect their workers, and the time to do that is now before a dramatic reopening.

I know we have talked a lot today about essential workers, and, you know, we have looked at a lot of these essential worker cat-

egories and have tried to provide the best updated scientifically accurate guidance that we can, and you know, we will continue to do our work.

And if I could respond briefly to the previous question that I received. You know, OSHA has responded to almost 5,000 COVID complaints, and what we are trying to achieve every day is removing the worker from the hazard or removing the hazard from the workplace.

Mr. SMUCKER. So can you tell me a little bit more about that process, the screening process, when you do get a complaint? How does it get evaluated? How long does it take? How is it determined that OSHA will open an investigation, and if so, what does the investigation entail?

Ms. SWEATT. Thank you. The investigation entails the employer being put immediately on alert that we understand there could be a problem in their workplace. They have to respond to us. They have to tell us what they are doing to resolve the complaint. If we find the resolution that they have proffered inappropriate or not protective of the worker, we can convert to an inspection and, you know, work to our enforcement.

But again, it is removing the worker from the hazard or removing the hazard from the workplace. These are really the goals that we need to be focused on to protect workers and not just issuing citations.

Mr. SMUCKER. Thank you. I am going to go to Dr. Howard. I would like to thank you for the work that your agency is doing to produce the guidance that all Americans are relying on to make safe decisions as they navigate the threat of COVID-19. We appreciate all the long hours that both you and your team at NIOSH, as well as the team folks at OSHA are putting in to ensure that guidance is there. It really is needed for employers to safely reopen.

I know NIOSH has played a central role in finding ways to overcome the global shortage of PPE. And we have heard from hospitals in our district that it has been difficult to find sources. Just what information can you share to help them address PPE shortages and also employers as well? How do they find appropriate and safe PPE?

Dr. HOWARD. Well, as I mentioned before, the supply of filtering facepiece respirators, like N95s, is increasing. I pointed out that domestic manufacturers, like 3M and Honeywell, have doubled, tripled their production capabilities. 3M is making 90 million N95s per month. Honeywell is making 20 million N95s per month.

Mr. SMUCKER. I want to get in one additional question. I know that CDC collects data on instances in which COVID exposure could have happened in the workplace. How can we truly determine if someone's exposure did indeed occur in the workplace?

Dr. HOWARD. Well, thank you for that question. That is a very difficult question to answer, to tease out what is true occupational exposure from what is community exposure that is then carried into the workplace. Remember, this virus doesn't have wings or feet. It has to have a person carry it around.

So distinguishing between occupational transmission and community transmission is a topic that is involving some very smart epidemiologists at CDC currently.

Chairwoman ADAMS. Thank you very much. You are out of time. Let me recognize now the gentle lady from Florida, Dr. Shalala. You are recognized.

Ms. SHALALA. Thank you very much. Ms. Sweatt, you told Representative Bath to look at the regulatory agenda for the status of the OSHA infectious disease standard. That standard is languishing on a long-term agenda -- after a hundred thousand deaths and thousands of worker deaths, how can you not be working on that particular standard?

Ms. SWEATT. Thank you for the question, Dr. Shalala. Because at this juncture, we are working on responding to the COVID pandemic, and I am putting the regulatory agenda aside. The work of this agency has been focused on protecting workers and, again, removing them from the hazard. And that is, you know, our primary mission and goal right now is to execute that work.

Ms. SHALALA. I didn't understand that answer, but let me go on to Dr. Howard because I am interested in data. The CMS has issued regulations that require that all long-term care facilities and nursing homes that receive Medicare and Medicaid funding report the number of infections and deaths among residents and staff members, PPE supplies, staffing shortages, and testing -- CMS has said that these facility reports will be publicly available.

Wouldn't it make sense to add the requirement for hospitals to report healthcare worker COVID-19 infections and deaths to the existing reporting requirements? I looked at the CDC new requirements for the States. CMS is going to collect better data, and I would think that after they set out the nursing home and long-term care facilities data that they wanted, that they ought to extend it to hospitals and other healthcare institutions. Could you react to that?

Dr. HOWARD. Sure. And I think that is up to CMS, but on the CDC front, we are moving in data modernization to taking the beginning of the pipeline for disease surveillance data, which is the healthcare facility, and then the State health department and then to CDC, we are looking at electronic data modernization, and we thank the Congress for the additional funds that are available there.

In the here and now, we have redone our case report form which includes specific sections about healthcare workers, as well as workplace exposures. So we are hoping that new form, which the States now are getting up to speed on, will improve our ability to know exactly where the occupational -- industry and occupations are in the American workforce.

Ms. SHALALA. Let me follow up on that. As you know, the CDC has had trouble getting States to use uniform standards for information so that you couldn't compare it nationally. Will this particular standard be the same for every State, or will they be able to vary it as they have in the past?

Dr. HOWARD. Thank you for that question. Excellent question. We are trying to move to a uniform national surveillance disease reporting system. So that is the goal. With the cooperation of the States, we hope that -- and the States have challenges. Some States have some IT support challenges in getting there, but hope-

fully we are going to be much better off than we have been in terms of national disease surveillance.

Ms. SHALALA. It includes nursing homes, I assume?

Dr. HOWARD. Yes. It includes any kind of institution that is reporting disease that, as you well know, having been Secretary of HHS, the CSTE and CDC have agreed to collaborate on reporting that particular condition to the Federal Government.

Ms. SHALALA. Thank you. I yield back.

Chairwoman ADAMS. Thank you very much.

I want to yield now to the gentleman from Kansas, Mr. Watkins. You are recognized.

Oh, I am sorry.

Mr. WATKINS. Thank you, Madam Chair.

Chairwoman ADAMS. Oh, just a minute, I am sorry. Mr. Meuser, you are recognized. I apologize, Mr. Watkins.

Mr. WATKINS. No apology necessary. Thank you, Madam Chair.

Mr. MEUSER. Well, thank you, thank you both for being here very much, being present and answering our questions.

So getting our economy open, getting people back to work is just about a top priority, right above all else, as well as getting our schools open, come September. So maybe I could ask a couple questions about that as well.

But what is crucial, of course, is that businesses open with a high level of health and safety workplace standards. And I am a firm believer that our businesses need to open, but we need to in a very responsible manner. And I don't think that this is going to be over the short-term. Businesses need to prepare for a longer term, evolving, always improving health and safety work environment.

So from OSHA's standpoint, I know, Ms. Sweatt, you have been putting out -- OSHA has been putting out guidance for a while now, I think as many as 26 or 27 different forms of workplace guidance. I assume that is going to continue to evolve and -- I haven't read them all, my apologies -- but are you offering the essentials behind social distancing -- and again as guidance -- PPEs, the masks, when it is appropriate to wear gloves? Is OSHA's guidance getting that specific?

Ms. SWEATT. Our guidance is pretty comprehensive, yes. And I think as folks look to returning to work, employers should start to plan now about how they are going to protect their workers. They can do that by examining work practices, and our guidance speaks to a variety of different work practices.

So, yes, for example, our meat-packing guidance discusses social distancing as well as carpooling. So I think that it is robust guidance to provide information to employers and workers.

Mr. MEUSER. Okay. Are businesses, are you finding, asking for any additional funding or some sort of support to set themselves up with plexiglass and everything else? Who knows, maybe even building another annex, so all workplace areas can be six feet apart? Are you getting any requests such as that?

Ms. SWEATT. I am not getting funding requests, but our compliance assistance specialists, and our compliance assistance program has received almost 5,000 requests for information, so I think people are looking to the agency for answers.

Mr. MEUSER. Okay. And Dr. Howard, are you involved as well in putting out guidance for workplace? I read some of your background.

Dr. HOWARD. Yes. That is an understatement. We have reams of guidance available in very specific situations.

Mr. MEUSER. Okay. Is CDC, is OSHA adopting it? Are you finding it to be practical and useful?

Dr. HOWARD. A lot of the guidance that relates to workplaces specifically and workers are reviewed by OSHA folks before they are issued by CDC, so there is a collaborative effort.

Mr. MEUSER. Okay. Is OSHA finding high level of compliance? I spend a tremendous amount of time talking with businesses throughout my district and visiting them, even under today's circumstances, because they are working, and so we go out. Are you finding a high level of compliance, Ms. Sweatt?

Ms. SWEATT. I think there is a mixture of results, but I do think that employers are attempting to achieve the best protection that they can. And again, where we fail to see that, our enforcement folks will be right there.

Mr. MEUSER. Okay. I would -- do you offer any models? Do you use any companies as examples? There are many throughout my district if you are interested in those that not only have made their workplace very comfortable and very safe, but the records show it. Many of them have had no COVID cases with over 500 employees, and they have been following strict guidelines, that they get the feedback from their workers, which is smart, for how to achieve this. Are you gaining such information on a regular basis and offering models?

Ms. SWEATT. We are very fortunate that people are providing some of their return-to-work practices, and so we can review that in the context of our standards, and you know, we are actively participating in webinars with a variety of stakeholders, and the union folks have been talking to us.

So we are engaged, we are open, we are listening, and we will adapt our guidance documents to what we are learning.

Mr. MEUSER. Well, it is very important, obviously not a higher priority than finding a vaccine and correcting the virus itself. Lastly, are you providing any information for restaurants and -- for the actual opening? Are you planning ahead for what restaurants can do in order to open safely?

Ms. SWEATT. There is CDC guidance available already, yeah.

Dr. HOWARD. CDC has guidance on restaurants and bars.

Mr. MEUSER. Right. But it needs to evolve. That guidance doesn't necessarily include people sitting down and operating --

Dr. HOWARD. Yes. The current guidance has all of those issues, but I also mentioned that all of our guidance is evolving. And so additional information may be available.

Chairwoman ADAMS. Thank you.

Mr. MEUSER. Thanks for the answers. I yield back. Thank you.

Chairwoman ADAMS. Thank you very much. Let me yield now to the gentleman from Texas, Mr. Castro. You are recognized.

Mr. CASTRO. Thank you, Chairwoman, and thank you all for your testimony today. On April 28, President Trump announced that he would issue an executive order that would use the Defense Produc-

tion Act to force meat-packing plants to remain open, leaving tens of thousands of workers in unsafe conditions.

The actual executive order did not do that, because it turns out there is no authority under the DPA to force plants to stay open. Instead, the order left meat-packing plants without any protection for workers, letting tens of thousands of workers get sick, and over 20 meat-packing plants to close down.

Ms. Sweatt, after President Trump issued his executive order, you and Solicitor of Labor Kate O'Scannlain issued a statement stating that before issuing citations, quote, OSHA will take into account good-faith attempts to follow the joint CDC/OSHA meat-processing guidance.

So my question, my first question to you is, what motivated the issuance of this statement? Who directed you and the Solicitor to issue it, and can you explain what you mean in the statement by "good-faith attempts"?

Ms. SWEATT. So to start with the good-faith effort, it is to look at the guidance that we have issued jointly with CDC, and we have seen employers in this area already instituting a lot of the guidance in the information here. So there has been some, you know, proactive measures taken. OSHA is working with Dr. Howard's office and FSIS. We are having daily phone calls to examine the issues surrounding what they are seeing on the ground and what we are seeing.

We have active enforcement efforts, and we have been into these plants for inspections, and we will continue to do that.

Mr. CASTRO. How many plants have you all inspected?

Ms. SWEATT. We have, I think, almost 58 meat-packing compliance -- sorry -- enforcement activities right now. And I think we have been into about 10 within the last week.

Mr. CASTRO. And there have been, in the last count I saw, about 11,000 folks infected because of meat-packing plants. Many folks have died. Many of the workers have died. So if an employer shows good faith, is it the case that there will be no OSHA citation? Is that right?

Ms. SWEATT. Well, good faith and other standards are two different things. So I would hesitate to comment on a strawman if you will. Enforcement is going to be based on the specifics of what we find in a plant.

Mr. CASTRO. Well, I don't think it is a strawman. I mean, I think people's lives are literally on the line. People are getting infected here. These standards are not mandatory standards. We can agree on that, right?

Ms. SWEATT. We have existing standards for other activities, sanitation being one of the key, I think, in this area. I would like to say for a moment, you know, the people that work at OSHA are dedicated to protecting workers and preventing illness, injury, and fatalities. So --

Mr. CASTRO. Well, let me -- I don't question that. Let me ask you, do you think these standards that have been discussed recently when the pandemic hit, do you think these standards should be mandatory?

Ms. SWEATT. I think that what we have provided in this guidance is a roadmap to helping protect these workers. It is one element

of the response that the government has had. CDC and NIOSH have gone into these plants and done wall-to-wall epidemiological surveys, and we have access to that information as well.

And so I think there is a variety of people across the government who are working to improve the safety and health in these --

Mr. CASTRO. Well, but you have got 11,000 people that have gotten sick. You have got a lot of people that are dead now. The meat-packing plants, along with nursing homes and cruise ships, have been the places where this thing has spread very rapidly, and yet you don't believe that these standards should be mandatory?

Ms. SWEATT. I think that people should comply with the law, and if we can continue to put the best practices in place, we will eventually and hopefully, you know, soon, as in tomorrow, eradicate this problem, but it is a challenge, and our folks continue to tackle it.

Mr. CASTRO. And I also think that the good-faith standard is problematic here because can you tell me anywhere else in the OSHA enforcement program, aside from equipment shortages, where good faith gets an employer out of an OSHA citation?

Ms. SWEATT. I can tell you that upon implementation of the silica standard, we implemented the good-faith policy for approximately 30 days as employers learned and tried to figure out how they were to comply with the new silica standard. So it is not novel, if you will, and we have seen dramatic compliance with silica now.

Mr. CASTRO. Thanks for your testimony.

The Trump Administration has been woefully inadequate in setting standards, mandatory standards, that will save people's lives, even as more and more people have become infected and the President has forced these plants to stay open. And that is an incredible failure of the Federal agencies and of the Trump Administration. I yield back.

Chairwoman ADAMS. Thank you very much. We are going to recognize now the gentleman from Kansas, Mr. Watkins. You are recognized, sir.

Mr. WATKINS. Thank you, Madam Chair, and thank you, Mr. Byrne. Thanks to the panelists for coming today. It is my belief and most people in eastern Kansas' belief that the President and associated agencies have taken decisive action amid this incredible pandemic.

And in fact, it is during this time the response warrants not only just a whole-of-government approach but really a whole-of-America approach, and now is the time when we should be looking past partisan politics and come together in order to respond in an appropriate and proportionate manner. And I believe that largely we have done that, and I know, Dr. Howard, you have brought up how conditions and guidance is evolving, because we are a learning organization.

And I also know that, Ms. Sweatt, you have pointed out that the guidance is just that, because the, you know, decision-making authority, in my opinion, ought to be pushed down to more local levels where it could be adopted to a community because they can see their health situation and what applies to them.

You know, what might be true in New York City might not be true in Topeka, Kansas. And in fact, what might be true in Topeka,

might not be true in a small town called Iola, Kansas. They might know how many hospitals they have, how many -- what PPE situation is and all. And so I applaud you for your efforts, and I know it is a very challenging time.

Ms. Sweatt, getting back to the increased number of employers and employees who have reached out to you, has there been any particular industry that has reached out more than the other industries?

Ms. SWEATT. No. I would say we have seen across the board from industries looking for information and guidance, and we have provided as many people from the agency as possible to talk to folks, either webinars or, you know, answering other questions. And, you know, again, by and large, we do think that employers are trying to do their best to respond to this. And the agency will be there to help give them the best information that we can.

Mr. WATKINS. Thank you. And Dr. Howard, as the economy regains its strength, you know, most of us agree that the biggest fear and threat here is a deflationary spiral going past these economic lines that we can't return back from.

And so obviously we want to return back to work. We all think many of us believe that to be the best stimulus. We can't simply just print money in hopes that saves us. And so that makes the CDC and its guidance so incredibly, incredibly important. Does the CDC have specific guidance for companies that the workers aren't simply allowed to practice social distancing perhaps by nature of how closely they are required to stand?

Dr. HOWARD. Well, I think the paradigmatic type of business that we are familiar with, having done now a number of field investigations in these workplaces, is meat processing, where it is extremely labor-intensive. People are shoulder to shoulder oftentimes on these production lines. There is nothing closer than that type of workplace.

We have also seen in nursing homes, in hospitals, you have to be close to the patient. You can't do your work 10 feet away from the patient. So there are a number of workplaces in which congregate working situations are significant.

Mr. WATKINS. And in eastern Kansas we have actually, in my district, we have had a hog slaughtering business that has had a number of cases. What should I, as a policy maker, what should I know as I approach those business leaders?

Dr. HOWARD. What I would do is take a copy of the CDC/OSHA guidance on meat and poultry processing for workers and employers, all 10 pages. Those are our recommendations for solving the problem.

Mr. WATKINS. Excellent. And this question is generally for both of you. Would you say that we are generally trending up or trending down in our capacity to deal with this pandemic?

Dr. HOWARD. Well, if you look at the case numbers, other than some notable hotspots, the general numbers in new cases, day over day, as well as new fatalities day over day, are going down. As the CDC Director has pointed out, there may be a second wave in the fall, coupled with our normal seasonal influenza, so we can't rest until we take care of the whole problem.

Mr. WATKINS. Thank you. That does it for my time. Thank you for coming. I appreciate your professionalism and hard work.

Madam Chair, I yield.

Chairwoman ADAMS. Thank you very much. I want to recognize the gentleman from Pennsylvania, Mr. Keller.

Mr. KELLER. Thank you, Madam Chair, and I would like to thank both our testifiers for being here today. We do know that the job that you do is very important and appreciate the work you do, and I know the employers that you help appreciate keeping their employees safe.

Because as an employer myself prior to being elected to office, I understand that the most important asset that we have is the people that go to work every day in our businesses, and we want to make sure they are safe.

Ms. Sweatt on May 19, OSHA updated an interim enforcement response plan to increase the use of on-site inspections for all types of workplaces, not just healthcare facilities and emergency responders as OSHA had previously prioritized. Can you explain OSHA's rationale for initially focusing on healthcare and emergency responder cases for onsite inspection, and why the agency is now expanding the use of onsite inspections in other workplaces?

Ms. SWEATT. Thank you. As the pandemic began, our frontline healthcare providers were clearly in the, you know, the most challenging position to address the pandemic.

So we put all of our -- not all -- but we put a majority of our resources into helping with those kinds of complaints, working with our guidance documents to ensure respirators were available to them.

As the pandemic has changed and as the country looks to return to work, we thought our posture should change as well, and so we have gone from places where employers were not actually open, which would have also changed our resources, to looking at where people are going to be opening and encouraging folks to, you know, plan. And our people will be out.

We have protocol for how our inspectors will work onsite, and our folks are to do job hazard analysis before they go do inspections so that they can protect themselves as well.

Mr. KELLER. Okay. Thank you. I appreciate that. And Dr. Howard, I think we touched on this a little bit, but I will just sort of say this. As the economy regains its strength, businesses will continue to take steps to return to full operating capacity. This could be difficult, however, because there are areas and tasks in workplaces where social distancing is simply not feasible. Does the CDC currently have guidance that provides safe alternatives where social distancing is not possible, and if not, would the agency consider providing such guidance to employers and employees?

Dr. HOWARD. Yes. We have -- a lot of our guidance does create a default physical distancing, but then when physical distancing is not feasible, we recommend other things, such as the wearing of cloth facial coverings.

Mr. KELLER. The other question I guess I would have, as we see and as we move forward, and as employers start to open up their businesses and start to, you know, get to more operating capacities and increase that, the guidance that they need, as it is updated,

how readily available, or how are we communicating that to our employers so that they have the most up-to-date information?

Should we find a better way to protect our employees or a more efficient way of going about it? Is that something that is pushed out by OSHA and CDC, or do the employers have to go someplace to look for that?

Ms. SWEATT. Our information is available on our website, and we have seen a dramatic increase in the use of our website and our guidance documents. We link to a lot of CDC guidance, but we are also using all of the social media platforms available. So we are trying to reach as many folks as possible. We have a newsletter that has gone from approximately 230,000 to 280,000 subscribers over the last month and a half, so I think people are looking to the agency for information. And we are updating it as quickly as possible when we learn of changes or other things that we need to be doing.

Dr. HOWARD. I would just add, one of the other channels that we are using are webinars that are specifically sponsored by employer associations in particular areas.

I have done several, the Iron Workers International, for instance, three for the National Safety Council. So webinars are a good way to get information out and then for the attendees to ask questions of government officials.

Mr. KELLER. Yeah. I would say, as we experience things in different parts of the country, there might be a best practice or somebody that is -- two similar manufacturers or processors or what have you, but somebody may have figured out a best practice.

Are we able to share that readily across industry? Is that something that we push out a notice to anybody? Can they sign up for, like, an alert if something changes, or how does that work?

Dr. HOWARD. Sure. And I think one of the issues is our guidance, CDC guidance, evolves based on what we learn from employers and workers in the particular workplace, how they are making their workplace safer. So we include all of that learning into our next version of guidance on the particular industry or occupation.

Chairwoman ADAMS. Thank you very much. Time is up.

Mr. KELLER. Thank you. I yield back.

Chairwoman ADAMS. Thank you.

Let me recognize the gentleman from South Dakota, Mr. Johnson. You are recognized, sir.

Mr. JOHNSON. Thank you, Madam Chair. My line of questioning will be for Dr. Howard. Dr. Howard, last month, the President announced that CDC, OSHA, others, should do everything they can to keep meat-packing facilities open given the critically important role they play in the food-supply chain.

I was just hoping you could walk us through a bit what the technical advice, guidance, and work your agency has done in continuation of that mission?

Dr. HOWARD. Well, as I mentioned, we have a 10-page guidance that we have done with OSHA, and it is really jam-packed with a lot of very specific information for processing in beef, pork, and chicken. One of the challenges as I have mentioned --

Mr. JOHNSON. If you could highlight maybe the top two or three best practices and findings.

I just know, particularly in South Dakota, this is an area of high interest because of the Smithfield plant, and I think folks watching at home on the internet, they may be interested to know the best recommendations.

Dr. HOWARD. So we start out with the basic recommendation of physical distance between employees. But as you well know, coming from South Dakota and the Smithfield plant and other plants like that, it is very difficult. It is a very labor-intensive process. So what can you do in lieu of that physical distancing? You can try to separate people. Maybe you can put a partition between them so that they are not shoulder to shoulder. Or you can protect their breathing zone by the use of a cloth face mask with a face shield, et cetera.

One of the things that we have noticed in these plants, and I will mention this because to me it is a very important best practice, these plants are very, very noisy. And one of the things we have seen, even if you keep individuals separated as much as you can and you keep a cloth face mask and a shield, they sometimes have to speak to each other or a supervisor and off comes the shield, down comes the mask, and they are shouting at each other, you know, mouth to ear.

That kind of interaction is a possible transmissive event. So if we can prevent that from happening, that is a best practice that we think would really help. It is not one that a lot of people know about because people are more knowledgeable about separating the line in terms of employees.

The other thing is ventilation in the workplace to make sure that you are moving a lot of air. In a workplace like these plants, you know, the temperature is kept very low, which actually helps the virus. So it is a challenge. The temperatures are low because of food safety issues.

So each time you look at one of these best practices, you have to put it into the context of the production facility itself. It is a very challenging thing for us to make recommendations and to get them to be feasible, technically, within that workplace, a very challenging thing.

Mr. JOHNSON. I mean every relocation, obviously, is different. I mean, we talk a bit about the role of the screens as people go into the workplace. The last time I was at Smithfield, I examined the -- what appeared to be rather rigorous process they have for people to get into the plant with temperature checks and screening questions. Has that proven to be effective? Is that a key best practice?

Dr. HOWARD. Sure. When you look at the hierarchy of controls, the first step is hazard elimination. Well, the hazard is actually the virus. It just happens to be carried along by people who may not know they are infected. They may be asymptomatic. Or they may have a little fever, but a lot of people don't really notice they have a fever.

So those checks prior to entry: Do you have any symptoms? Symptom questioning. Are you around somebody? Have you been in contact with anybody who has Covid-19? The issue about doing a temperature check. And then some companies are starting actual testing. But testing for the virus is only a snapshot in time. It is

not -- it is not the -- it doesn't answer the whole thing as you go through time. It gives sometimes workers a false sense of security.

So together with those entry checks, then you go into the workplace and you look at engineering controls, administrative controls, and PPE, if necessary.

Mr. JOHNSON. So obviously, humankind is very good at fighting the last battle. And it does seem that there is high awareness, and packing plants are on high alert. But that is obviously not the only critical portion of the food supply chain. What is the next place? What is the next weakness within the food supply chain that we should be attuned to?

Dr. HOWARD. Well, when you look at the food when it gets to the grocery store and the interaction in that setting, not between workers, between workers and their customer -- and oftentimes you see now the same kind of physical distancing, engineering controls happening with Plexiglas between the clerk and the customer.

So we are seeing the same fundamental principal, i.e., physical distancing being used in a lot of creative ways depending on the specific workplace that you are in.

Mr. JOHNSON. Thank you, Dr. Howard.

And thank you, Madam Chair.

Chairwoman ADAMS. Thank you very much.

I want to remind my colleagues -- let me thank the witnesses very much -- I want to remind my colleagues that pursuant to Committee practice, materials for submission for the hearing record must be submitted to the Committee Clerk within 14 days following the last day of the hearing. So by the close of business on June 10, preferably Microsoft Word format.

The materials submitted must address the subject matter of the hearing. Only a Member of the Subcommittee or an invited witness may submit materials for inclusion in the record. Documents are limited to 50 pages. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Clerk within the required time frame. But recognize that years from now, that link may no longer work.

Pursuant to House Resolution 965 and the accompanying regulations, items for the record should be submitted electronically by emailing submissions to edandlabor.hearings@mail.house.gov. Member offices are encouraged to submit materials to the inbox before the hearing or during the hearing.

At the time the Member makes the request, the record will remain open for 14 days for Committee practice for additional submissions after the hearing.

Again, I want to thank the witnesses for your participation today. What we have heard is very troubling. Members of the Subcommittee may have some additional questions for you, and we ask the witnesses to please respond to the questions in writing.

The hearing record will be open -- held open for 14 days in order to receive, receive those responses.

I want to remind my colleagues that pursuant to Committee practice, witness questions for the hearing record must be submitted to the Majority Committee staff or Committee Clerk within 7 days. The questions submitted must address the subject matter of the hearing.

I now want to recognize the distinguished Ranking Member for his closing statements.

Mr. BYRNE. Thank you, Madam Chair. Before I get started, I ask unanimous consent to place in the record letters from the American Hospital Association, The Coalition for Workplace Safety with 58 additional organizations, and the National Association of Manufacturers providing their views on today's hearing topic.

Chairwoman ADAMS. So ordered.

[The information follows:]



Washington, D.C. Office
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 Washington, DC 20001-4956
 (202) 638-1100

May 27, 2020

The Honorable Bobby Scott
 Chairman
 House Education and Labor Committee
 2176 Rayburn House Office Building
 Washington, DC 20515

The Honorable Virginia Foxx
 Ranking Member
 House Education and Labor Committee
 2176 Rayburn House Office Building
 Washington, DC 20515

The Honorable Alma Adams
 Chairwoman
 Workforce Protections Subcommittee
 House Education and Labor Committee
 2176 Rayburn House Office Building
 Washington, DC 20515

The Honorable Bradley Byrne
 Ranking Member
 Workforce Protections Subcommittee
 House Education and Labor Committee
 2176 Rayburn House Office Building
 Washington, DC 20515

Dear Chairman Scott, Ranking Member Foxx, Chairwoman Adams and Ranking Member Byrne:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to provide you with information on actions taken by hospitals and health systems in response to the COVID-19 pandemic in conjunction with the House Education and Labor Committee's Workforce Protections Subcommittee Hearing, "Examining the Federal Government's Actions to Protect Workers from COVID-19." The AHA also provided [comments](#) on provisions of the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (H.R. 6800), which was recently passed by the House of Representatives.

The U.S. has experienced more than 1.5 million cases and nearly 100,000 deaths due to COVID-19. The pandemic has swept across the country and entire globe at a pace so rapid that hospitals and other providers have had to make extraordinary efforts to access needed resources, such as personal protective equipment (PPE), and have worked every day to be good stewards of such scarce resources. Hospitals and other providers have, at the same time, worked with all levels of government to increase testing capacity for COVID-19.



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Hospitals and health systems have a long history of establishing and supporting infection control programs to maintain an environment safe for patients and workers. Hospitals already adhere to Centers for Medicare & Medicaid Services (CMS) rules based on science-based guidance from the Centers for Disease Control and Prevention (CDC). In order to participate in the Medicare and Medicaid programs, hospitals and health systems are required to meet specific infection control planning and training requirements as set forth by the conditions of participation (CoP). These conditions include requirements that hospitals have an active program for the prevention, control and investigation of infections and communicable diseases. CDC closely follows scientific evidence as it develops and provides critical guidance as more becomes known about emerging pathogens. Hospitals, working with CDC, other government agencies and health care stakeholders, continue to take steps to analyze and improve their infection control practices through a variety of different avenues, including new construction and renovation, quality improvement projects, technology and staff training.

The adequate supply of PPE is a monumental concern for all involved in patient care. N95 respirators and surgical masks remain in short supply as demand far exceeds available product. Due to significant shortages across the supply chain, hospitals and health systems continue to assess the availability of needed PPE and are following CDC guidelines to conserve PPE, including using Food and Drug Administration authorized methods to decontaminate and sterilize existing PPE to extend its use, cohorting patients and constructing physical barriers when appropriate to reduce the need for PPE. Because N95 masks are in significant short supply, they must be reserved for only those procedures in which they are absolutely needed, such as aerosol generating procedures. For other care tasks, CDC and the World Health Organization recommend the use of medical-grade face masks.

CDC has the ability to provide timely guidance based on current scientific study and has done so throughout the pandemic. Hospitals have worked to follow several recent issuances of important guidance such as:

- Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance); updated April 30, 2020;
- Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19); updated May 3, 2020;
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance); reviewed May 2, 2020;
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings; updated May 18, 2020; and
- Strategies to Optimize the Supply of PPE and Equipment; reviewed May 18, 2020.

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In addition to adhering to updated CDC guidance, hospitals and health systems have taken the initiative to protect health care workers in new and different ways. The 100 Million Mask Challenge was originally launched by Providence, a health care system headquartered in Washington State, where they experienced a tremendous outpouring of support from individuals, community organizations and local manufacturers. Providence entered into an important collaboration with a local manufacturer that is now producing much needed PPE for health care workers. The AHA then expanded the 100 Million Mask Challenge nationwide and is calling on manufacturers, the business community and individuals working in their own homes to rapidly produce needed PPE on a large scale.

The AHA also has launched a call to action to increase production and distribution of PPE through an innovative effort with Point A, where leading global companies, startups and academic institutions come together to solve complex supply chain challenges. Through this unique partnership manufacturers who have been forced to close their facilities or are exploring how to reconfigure their facilities can access engineering and innovation experience to produce much needed PPE.

The AHA also leads the development of a coalition of private and non-profit organizations banded together to launch the Protecting People Everywhere initiative supporting a national exchange matching PPE donors with the hospitals in greatest need. HealthEquip™ is a smart app that tracks donations, manages shipping of donated supplies through UPS, and ensures shipping is paid for by the receiving hospital. It matches donations with the hospitals in the area based solely on demand. It also ensures that the individual or organization donating PPE will receive a donation receipt.

This long history of hospitals' support for providing a safe environment for patients and workers together with the ongoing struggles for this nation to produce sufficient supplies leads us to conclude that now is not the time to enact a new temporary and permanent worker protection standard. The provisions included in the HEROES Act would require the Secretary of Labor to promulgate an emergency temporary standard (ETS) within seven days of enactment to protect from occupational exposure to SARS-CoV-2 employees of the health care sector and emergency responder employers, as well as others with employees at occupational risk. While the legislation requires the Secretary of the Labor to consult with CDC and the National Institute for Occupational Safety and Health, there is no guarantee that forthcoming standards would align with existing guidance that can be updated regularly to keep pace with existing science. These provisions would be extremely difficult to implement in the midst of a global pandemic and could result in a confusing array of regulations and guidance.

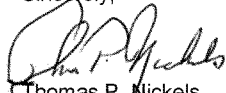
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The legislation also requires the new standard to provide protections no less than the most restrictive state plan. Resulting federal standards then might not be based on the most appropriate national science and guidance but rather on what a particular state requires and suggests that the federal government is surrendering its responsibility to appropriately regulate the nation to a state government agency without consideration of whether that state's decisions are appropriate for implementation anywhere and everywhere. Additionally, it includes a requirement for hospitals to develop comprehensive infectious disease exposure control plans with the input and involvement of employees or representatives of employees that does not recognize hospitals' long history of establishing such plans and compliance with Medicare CoPs and The Joint Commission standards. Even with some enforcement discretion on the part of the Secretary of Labor, this provision fails to recognize the ongoing global lack of supplies, equipment and testing capability. For these reasons, and as noted in our May 14, 2020, letter on the HEROES Act, we strongly oppose these provisions.

Additionally, the AHA has proposed several important initiatives to provide support for those on the front lines of health care delivery. These include child care; housing and transportation vouchers; expanded liability protections for health care workers; ensuring coverage of any health care costs not covered otherwise; daily free testing for exposure to COVID-19; education loan pay-down; supportive services to help preserve mental health and wellbeing; and bonus pay rewarding extraordinary actions during the pandemic. We urge Congress to consider and approve these provisions as quickly as possible.

Thank you for providing the opportunity to examine this important issue and provide comments on pending legislation. America's hospitals and health systems are working constantly to meet the challenge of the COVID-19 pandemic and protect every health care hero each and every day.

Sincerely,



Thomas P. Nickels
Executive Vice President



May 28, 2020

The Honorable Alma Adams
Chairwoman
U.S. House Subcommittee on Workforce Protections
Washington, D.C.

The Honorable Bradley Byrne
Ranking Member
U.S. House Subcommittee on Workforce Protections
Washington, D.C.

Dear Chairwoman Adams and Ranking Member Byrne:

On behalf of Coalition for Workplace Safety (“CWS”) and the 58 undersigned organizations, thank you for holding today’s Workforce Protections Subcommittee hearing, “Examining the Federal Government’s Actions to Protect Workers from COVID-19.” We write to advise against requiring the Occupational Safety and Health Administration (“OSHA”) to issue an Emergency Temporary Standard (“ETS”) at this time in response to the coronavirus pandemic. Such a requirement is included in the COVID-19 Every Worker Protection Act of 2020 (H.R. 6559, included as Division L, Title III in H.R. 6800). OSHA should instead continue with its current approach of issuing industry-specific guidance based on the latest information from the Centers for Disease Control and Prevention (“CDC”). This approach provides a more nimble and effective solution than issuing a rigid, one-size-fits-all standard.

The Coalition for Workplace Safety (“CWS”) is composed of associations and employers who believe in improving workplace safety through cooperation, assistance, transparency, clarity, and accountability. Workplace safety is a top priority for CWS members, and we strongly believe that employers should take steps to ensure that employees are protected. Improving safety can only happen when all parties—employers, employees, and OSHA—have a strong working relationship. CWS members are dedicated to ensuring employers and employees have the latest and best information about workplace safety in the face of the COVID-19 crisis.

CWS and the undersigned organizations believe an ETS would be far less agile at adapting to the nation’s evolving understanding of COVID-19 and the societal response to the crisis. The argument for rushing to issue such a standard is based on two false premises: 1) employers have no current, enforceable obligation to protect their employees from exposure to COVID-19; and 2) a new OSHA standard will help employers protect their employees from potential exposure. The Occupational Safety and Health Act’s General Duty Clause (“GDC”) already requires employers provide employees with a safe and healthful workplace and to eliminate, to the extent possible, known hazards using known methods of mitigation or avoidance. The GDC is enforceable by OSHA, and Secretary Scalia has said explicitly that the agency will not hesitate to bring enforcement actions where appropriate.

Furthermore, the GDC functions in conjunction with guidance to provide industry with situation-specific steps employers should take to protect their employees. An employer can be cited for violating the GDC if OSHA determines it has not implemented the appropriate guidance on protecting workers.

OSHA's current GDC-plus-guidance approach provides the agility needed in this crisis, where employers and employees are seeking the most accurate, up to date information regarding safe practices in the face of:

- a rapidly evolving understanding of COVID-19;
- changes in how industry delivers goods and services in response to the crisis; and
- differing restrictions imposed by state and local authorities.

The GDC-plus-guidance process allows new information to be disseminated to employers and workers and incorporated into OSHA's enforcement policies quickly and effectively. OSHA has been diligently issuing industry- and situation-specific guidance in order to provide timely and tailored information to employers, employees, and OSHA enforcement officers. A rigid ETS would make it far more difficult for OSHA, employers, and employees to quickly make these adjustments.

We are also concerned that H.R. 6559 would require OSHA to issue a new standard *prior* to the National Institute for Occupational Safety and Health ("NIOSH") and CDC collecting data and conducting research on workplace COVID-19 cases. This is exactly the reverse of how good workplace safety policy should be made. Data is a critical component in the consideration and development of any workplace safety regulation.

CWS members are determined to protect their employees from exposure to COVID-19 to the maximum extent possible. Employers and employees alike are far better served by an approach that focuses on disseminating the latest information available and tailoring safety guidance to reflect the rapidly evolving understanding of this public health emergency than a rigid standard that would limit our collective ability to quickly adjust to changing circumstances.

Again, thank you for holding this important hearing.

Sincerely,

Agricultural Retailers Association
 Air Conditioning Contractors of America
 American Bakers Association
 American Coke and Coal Chemicals Institute
 American Composites Manufacturers Association
 American Council of Engineering Companies
 American Feed Industry Association
 American Foundry Society
 American Hotel and Lodging Association

American Mold Builders Association
American Pipeline Contractors Association
American Road & Transportation Builders Association
American Trucking Associations
Asian American Hotel Owners Association
Associated Builders and Contractors
Associated General Contractors
Associated Wire Rope Fabricators
Distribution Contractors Association
Equipment Dealers Association
Flexible Packaging Association
Global Cold Chain Alliance
Heating, Air-conditioning, & Refrigeration Distributors International
HR Policy Association
Independent Electrical Contractors
Industrial Fasteners Institute
International Association of Amusement Parks and Attractions
International Foodservice Distributors Association
International Franchise Association
International Warehouse Logistics Association
Leading Builders of America
Mason Contractors Association of America
Motor & Equipment Manufacturers Association
National Association of Manufacturers
National Association for Surface Finishing
National Association of Electrical Distributors
National Association of Home Builders
National Association of Landscape Professionals
National Association of Wholesaler-Distributors
National Community Pharmacists Association
National Demolition Association
National Federation of Independent Business
National Grain and Feed Association
National Lumber & Building Material Dealers Association
National Ready Mixed Concrete Association
National Restaurant Association
National Retail Federation
National Roofing Contractors Association
National Tooling and Machining Association
National Utility Contractors Association
North American Die Casting Association
Plastics Industry Association
Power and Communication Contractors Association
Precision Machined Products Association
Precision Metalforming Association
PRINTING United Alliance

Tree Care Industry Association
Truck Renting and Leasing Association
U.S. Chamber of Commerce



Robyn Boerstling

Vice President

Infrastructure, Innovation and Human Resources Policy

May 28, 2020

The Honorable Alma S. Adams
Chair, Subcommittee on Workforce
Protections
Committee on Education and Labor
U.S. House of Representatives

The Honorable Bradley Byrne
Ranking Member, Subcommittee on
Workforce Protections
Committee on Education and Labor
U.S. House of Representatives

Dear Chair Adams and Ranking Member Byrne:

As our nation begins to re-open during the ongoing COVID-19 pandemic, manufacturers highest priority remains the health and safety of workers, their families and their communities. Since the onset of this public health emergency, most NAM members have remained operational to produce the critical supplies necessary for health care workers, first-responders and the general public. Under the guidance of the Centers for Disease Control and Prevention and the Occupational Safety and Health Administration, manufacturers are continuing to take the necessary steps to safeguard their operations and provide workers with facilities free from known hazards.

Our nation faces a severe shortage of a range of personal protective equipment and related supplies to support a safe return to work, school and other pursuits. Congress should enact proposals that support manufacturers in the effort to ramp up production so that our nation has an adequate supply of masks and other kinds of protective wear as well as cleaning supplies to keep Americans safe at home, work and while going about their daily lives.

As Congress examines the federal government's actions to protect workers, the NAM believes that the most effective role CDC and OSHA can play is to provide employers with thorough and timely guidance on how COVID-19 spreads and what can be done at individual facilities to safeguard employees. It is critical that the federal government continue to issue guidance on employers' role in protecting employees as new information comes available in this ever-changing environment.

The NAM commends OSHA and CDC for their recent joint guidance for manufacturing workers and employers.¹ Collaborations such as this are an example of effective cross-agency communication that provide clear support for companies. The recent guidance highlights the fact that each manufacturing facility is unique, and a one-size-fits-all mandate will not provide businesses with the flexibility needed to implement safety procedures at their respective workplaces.

Since the beginning of the COVID-19 outbreak, the NAM has held dozens of webinars and presentations to share best practices with members and connect government officials with businesses of all sizes, all under the umbrella of operating safely during the COVID-19 pandemic. The NAM recently released an [operational guide](https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html) of practices to consider in the time

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html>

of COVID-19 which is a collection of shared procedures to assist manufacturers in meeting or exceeding federal guidelines while also reducing operational and business risks².

Manufacturers will continue to lead America's recovery from the pandemic by producing essential products and keeping their workforce safe. The NAM appreciates the Subcommittee's attention to safeguarding Americans and we look forward to working with Congress to support this essential undertaking.

Sincerely,



Robyn M. Boerstling

² <https://www.manufacturingleadershipcouncil.com/report-new-operational-practices-to-consider-in-the-time-of-covid-19/>

Mr. BYRNE. Thank you.

I want to thank the witnesses. That was outstanding. You provided this Committee and the public with an enormous amount of very important information, and we are grateful to you for it.

Sometimes you were asked questions and said it is a yes or no, unfortunately, this topic does not lend itself to a lot of just simple yes or no answers.

A lot of Members said that this is very important. And they are right. This is extremely important. And that is why 20 of us -- I am updating my count from my opening -- 20 of us decided to be here in person, 13 Republicans and 7 Democrats. We felt strongly enough about it to be here in person. But so did millions of Americans today show up for work and do their jobs in person, because that is what we are supposed to do.

When I started preparing for this hearing, I have looked at it from a point of view from my prior life as a lawyer representing employers that have to comply with OSHA law. And so I said, okay, if one of my clients called me, what kind of advice would I give them? So I went online to see what you guys had put out. And it took me a long time because you have put out a lot of stuff.

The benefit of that to both the employers and employees is this. This is a confusing time. And just getting good quality information is about 99 percent of what we need to do. And good quality information hasn't been exactly easy to come by in this environment.

So the guidance you have put out has been extraordinarily important to employers trying to comply with the law, but more importantly do what they want to do which is to protect their employees. And you have given that to them. And you are working with them to help them to understand it.

The experts have sort of been all over the place about this disease. Early on, oh, it is not a big problem. Oh, no, now it is a big problem. Early on, don't wear a face mask. Now you are supposed to wear a face mask. We got some experts saying today we shouldn't have shut down. The other experts saying we had to shut down.

So it has been difficult for all of us to try to figure out, all right, what should we do? And what you all have tried to do and have done, I believe, is work through this in good faith to try to distill this down, understand it for the rest of us so that we can implement it. And I know it is a changing situation. So you are going to have to change your guidance as we go along. And I appreciate that about what you are doing.

We made some mistakes in Washington. Some of the stuff we have done has gone too far, and we have hurt our economy. But we based it on the advice we had at the time from public health experts who were dealing with limited information on their part. Some of the projections we got were wildly off the mark. And we are just having to deal with it as best we can.

I don't see how it helps anything for us to turn to you guys, who have this very important obligation in this very difficult time, to keep the workplace safe, for us to say stop and go through all of the legal mumbo jumbo of doing the standard.

There is a difference between keeping people safe and issuing a standard. Issuing a standard in and of itself doesn't keep anybody

safe. We have a standard right now, it is called general duty clause. Every employer in America has an obligation under the OSHA general duty clause to keep their workplaces safe. There is no question about that.

The questions on this environment, what is that duty? The guidance helps describe the duty. And if enforcement is necessary, you use the guidance to determine this employer did not comply with the general duty clause.

When I saw the AFL-CIO filed the lawsuit, I was really disappointed. If there ever was a time for us not to be filing frivolous lawsuits, this would be it. Particularly, a lawsuit against the very departments of the government that we rely upon to keep the workplace safe. We don't need you to be taking time off from that job of keeping the workplace safe, to go sitting down with a bunch of lawyers, and trying to decide what we got to do to respond to this lawsuit. That is inhibiting workplace safety, not helping it.

And here in Congress, we passed a bill out of the House a couple of weeks ago -- it is not going anywhere, it is not even going to be taken up in the Senate because of the way it was done and because it has got stuff in it that is just not acceptable -- but it attempted to deal with this issue, and not once do we have a hearing on it in this Committee, the Committee of jurisdiction, not once did we bring that bill in this Committee to have a markup, the Committee of jurisdiction on that topic, not once. If this is so important, why didn't we do it before we passed the bill?

Look, we have worked together in this Congress on this disease. We passed almost \$3 trillion in spending bills in a very short period of time with huge bipartisan majorities. That is the only way to act in this situation is with a bipartisan commitment to the American people. We need to work together. Like our constituents are having to do.

We shouldn't be having partisan hearings. We should show up for work like our constituents do. We should take this seriously, like our constituents do. And we should understand at the end of the day, it is all of our job to work for a safe workplace.

What I said before, the most important part of the American economy, the working men and women of the United States of America. Thank you for what you do every day. We are grateful to you. We are grateful for your presence.

And with that, Madam Chairwoman, I yield back.

Chairwoman ADAMS. Thank you, Mr. Byrne.

I now recognize myself for the purpose of making my closing statement. I want to again thank Deputy Assistant Secretary Sweatt and Director Howard both for joining us for this important discussion. I want to thank all of my colleagues who have been here today, those who are physically here, and those who are virtually here.

I do want to emphasize that the ETS and The Heroes Act is not a rigid or inflexible one-size-fits-all standard that fails to accommodate changing scientific knowledge.

The text of The Heroes Act calls for an ETS to require an infection control plan based on the hazards in that specific workplace. It requires assessment of risks in that workplace and a plan tai-

lored to the particular workplace. The development of the plan should involve employees. This is not a required rigid standard.

Second, California OSHA has an airborne transmissible standard. It applies to Covid and healthcare and has not been a one-size-fits-all.

Let me just say that what we heard today is that in the middle of this global health emergency that is causing more deaths in less time than any other workplace crisis that OSHA has faced in its 50-year existence, OSHA stubbornly refuses to use its authority to protect this Nation's workers.

The failure to act is a stunning act of abdication by the senior leaders in the Department of Labor. When workers are demanding strong standards and enforcement of those standards. Instead, we get voluntary guidance that employers can choose to comply with if it is convenient. And the best OSHA can offer is threats to use a largely toothless general duty clause.

When OSHA inspections do occur, they happen too often after the bodies are in the morgue, rather than when the prevention can make a difference. When employers need clear standards so that they know when they have met their obligation to make their workplaces safe, instead they get vague, generic suggestions. This is not how the architects of the Occupational Safety and Health Act envisioned OSHA's response during a workplace crisis.

The Act tells us that OSHA shall issue an Emergency Temporary Standard if it determines that workers are exposed to a grave danger or from new hazards, and that a standard is necessary to protect workers from that hazard.

Not only do the large numbers of sick and dying tell us that there is a grave danger, but it is clear that the limited actions taken by OSHA are not sufficient. Not only is OSHA refusing to act on the emergency authority, but the agency won't even resume work on a large awaited permanent standard that would address the hazard that this Nation is facing.

So as the economy reopens, the key to preventing an even more devastating second wave will be protecting workers and the millions of workplaces that present exposure hazards. Yet, we have no mandatory standard, no cop on the beat to enforce safe working conditions that will be the key to preventing that second wave.

And it is deeply disappointing that OSHA, the only Federal agency with the authority to enforce safe working conditions, is missing in action. And I am not only disappointed, but I am saddened for the workers of this country who continue to lack adequate protections on the job, and when they go home, they will infect their families. And I am upset about the future of this country that OSHA's inaction foreshadows.

And I can only hope that you and Secretary Scalia will wake up before it is too late and choose to fulfill OSHA's mission to assure safe working conditions for every man and for every woman in this country.

If there is no further business or without objection, the Committee stands adjourned.

Thank you.

[Additional submissions by Chairwoman Adams follow:]

ROBERT C. "BOBBY" SCOTT, VA
Chairman

MAJORITY – (202) 225-3725
FAX – (202) 225-2350



COMMITTEE ON EDUCATION
AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

VIRGINIA FOXX, NC
Ranking Member

MINORITY – (202) 225-4527
FAX – (202) 225-9571

January 30, 2020

The Honorable Eugene Scalia
Secretary
U.S. Department of Labor
200 Constitution Ave., NW
Washington DC 20210

Dear Secretary Scalia:

The sudden emergence of the 2019 Novel Corona Virus (2019-nCoV) has prompted us to write to urge you to prioritize the Occupational Safety and Health Administration's (OSHA) work on its Infectious Diseases standard. We welcome OSHA's continuing collaboration with the Centers for Disease Control and Prevention (CDC) and other federal health authorities concerning this possible pandemic, as well as the materials recently released on OSHA's website.

However, we are very concerned that OSHA's Infectious Diseases standard continues to languish on the agency's "Long-Term Actions" since being placed on its regulatory agenda almost ten years ago (May 2010). This standard would make compliance with CDC infection control guidelines mandatory for health care facilities.

The Small Business Regulatory Enforcement Fairness Act (SBREFA) panel and report were completed in 2014. The next step would be a Proposed Rule; however, the Administration's Spring 2017 regulatory agenda relegated the Infectious Diseases standard to "Long Term Actions," where it has languished with no scheduled date for the issuance of a Proposed Rule.

The potential danger to health care workers is real. Similar to the Severe Acute Respiratory Syndrome (SARS) virus pandemic of 2003-2004, front-line health care workers are at high risk of infection with the 2019-nCoV. As of January 29, 2020, 15 health care workers in China were confirmed to have contracted the virus from caring for infected patients, although most experts think that figure is significantly understated. During the SARS epidemic, 8,098 cases occurred during the SARS outbreak, and 774 (9.6%) persons died, according to the World Health

The Honorable Eugene Scalia
January 30, 2020
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Organization. Healthcare workers accounted for 1,707 (21%) of the cases overall¹, and in Canada, 43 percent of all SARS cases were health care workers.

OSHA currently has only one standard that addresses protection of workers from infectious diseases: the bloodborne pathogens standard. This standard has been one of the most successful standards in OSHA's history, changing the way health care was practiced and saving the lives of hundreds of health care workers every year. CDC infection control guidelines can effectively protect healthcare workers, but OSHA has no mechanism to enforce compliance with these precautions, aside from use of the legally burdensome General Duty Clause. Health care workers whose employers are not in compliance with CDC guidance are thus left vulnerable to infection with such diseases as Tuberculosis, pandemic influenza, Methicillin-resistant *Staphylococcus Aureus* (MRSA), SARS, Middle East Respiratory Syndrome (MERS), and now 2019-nCoV.

While health care institutions in the United States have made significant advances in infection control since the bloodborne pathogens standard was issued 30 years ago and from lessons learned from experience with H1N1, SARS and Ebola, there is evidence that significant risk to health care workers still exists in health care institutions.

- Recent literature reviews have shown inconsistent compliance with basic infection control procedures in emergency rooms and other areas of the hospital, particularly in the areas of respiratory and contact precautions.²
- In 2016, CDC conducted "mystery patient" drills in the emergency departments (EDs) of 49 New York City hospitals, sending in 95 patients pretending to have symptoms of measles and MERS. Almost 40% of the hospitals failed one of the drills, and only 36% of health care staff washed their hands. The study did not consider the effect of overcrowding on the EDs' ability to apply proper infection control measures.³

Our nation's hospitals are not the only workplaces where health care workers are at risk. Health care workers may also face increased risk of exposure to potentially infectious people in emergency response, ambulatory care facilities, correctional facilities, homeless shelters, drug treatment programs, schools, and other occupational settings. Finally, it is not just workers who are at risk in health care institutions. The general public is also at risk. As the experience with SARS in Canada showed, infected health care workers can spread disease to the wider community.⁴

¹ Kent A. Sepkowitz and Leon Eisenberg, Occupational Deaths among Healthcare Workers, *Emerg Infect Dis.* 2005 Jul; 11(7): 1003–1008.

²IC in Care Series: The Emergency Department," *Infection Control Today*, June 2, 2017 <https://www.infectioncontrolday.com/emergency-department/ic-care-series-emergency-department>; Stephen Y. Liang, MD, et. al., "Infection Prevention in the Emergency Department," *Annals of Emergency Medicine*, Volume 64, no. 3 : September 2014, <https://bit.ly/2Gtz9Xs>; Rogers, Bonnie, et al. "Development of Competencies for Respiratory Protection for Health Care Workers." *Workplace Health & Safety*, vol. 67, no. 2, Feb. 2019, pp. 56–67, doi:10.1177/2165079918798857; Wizner, Kerri, et al. "Exploring respiratory protection practices for prominent hazards in healthcare settings." *Journal of occupational and environmental hygiene* 15.8 (2018): 588–597.

³ Mary M.K. Foote, et.al. "Assessment of Hospital Emergency Department Response to Potentially Infectious Diseases Using Unannounced Mystery Patient Drills — New York City, 2016" *Morbidity and Mortality Weekly Report*, Vol. 66 / No. 36 September 15, 2017, <https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6636.pdf>

⁴ SARS Commission. "SARS Commission Executive Summary: Volume One—Spring of Fear." (2006).

The Honorable Eugene Scalia
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OSHA must take swift action to protect health care workers, and by extension, the American public. Even if the 2019-nCoV is controlled without a major impact in the United States, the outbreak has illustrated the urgent need for an OSHA Infectious Diseases standard. Recent worldwide and American outbreaks of novel infectious diseases have shown that we can expect more nation-wide threats to the nation's health and our front-line health care workers. The Infectious Diseases standard should immediately be put on the active regulatory agenda and all available resources should be dedicated to moving it to the proposal stage and then final promulgation.

Unfortunately, even if OSHA prioritizes this standard, it will be years before it is issued. While it is currently too early to determine the virulence of 2019-nCoV or the rate of transmission, there is a high potential for it to become a grave danger to health care workers. If 2019-nCoV proves to be highly communicable, virulent, and easily transmissible in a health care setting, OSHA will need to take immediate and decisive action by:

1. Issuing an Emergency Temporary Standard (ETS).

Section 6(c)(1) of the Occupational Safety and Health Act provides only two conditions for issuing an ETS:

(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and

(B) that such emergency standard is necessary to protect employees from such danger.

While it is still too early to issue an ETS, a widespread epidemic of a virulent novel airborne virus would clearly satisfy those conditions and OSHA should be prepared to issue an ETS.

2. Issuing a Compliance Directive.

Although OSHA has standards covering respirators and personal protective equipment, until a final Infectious Diseases standard (or an ETS) are issued, OSHA's primary enforcement tool to ensure appropriate protections for health care workers is the General Duty Clause⁵. Because application of the General Duty Clause is a lengthy and legally burdensome process, a compliance directive would provide important guidance for OSHA's Compliance Safety and Health Officers in enforcing safe working conditions in the nation's health care workplaces. OSHA has issued compliance directives for previous infectious disease outbreaks, including Bloodborne Pathogens⁶ (prior to issuance of the Bloodborne Pathogens Standard), Tuberculosis⁷ and H1N1⁸.

⁵ Occupational Safety and Health Act, Section 5(a)(1)

⁶ OSHA Instruction CPL 2-2.44, January 19, 1988.

⁷ Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, CPL 02-02-078, 2015,

https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-02-078.pdf

⁸ Enforcement Procedures for High to Very High Occupational Exposure Risk to 2009 H1N1 Influenza CPL-02-02-075, 2009,

https://www.osha.gov/OshDoc/Directive_pdf/CPL_02_02-075.pdf

The Honorable Eugene Scalia
January 30, 2020
Page 4

The safety of America's front-line health care workers and, by extension, the health of the entire nation will depend on OSHA's ability to ensure the safety of the nation's health care infrastructure. Absent timely action, OSHA will be failing frontline health care workers, its mission, and the nation.

Please provide the Committee with OSHA's response to our requests and plan to address this problem by February 15, 2020.

Thank you for your attention to this matter. Contact Jordan Barab with the House Committee on Education and Labor at jordan.barab@mail.house.gov with any questions. Please send all official correspondence relating to this request to tylease.allli@mail.house.gov.

Sincerely,



ROBERT C. "BOBBY" SCOTT
Chairman



ALMA S. ADAMS
Chairwoman
Subcommittee on Workforce Protections

cc: Loren Sweatt, Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

MAR 18 2020

The Honorable Robert C. "Bobby" Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Scott:

The Department of Labor received your letter regarding the Occupational Safety and Health Administration's (OSHA) response to the recent outbreak of Coronavirus Disease 2019 (COVID-19), as well as OSHA's infectious disease rulemaking activity. The President and his administration are taking aggressive action to protect public health. As you know, the President signed a bipartisan spending bill making \$8.3 billion in funding available to help fight COVID-19. He also has supported legislation passed by the House to, among other things, make medical testing more widely available and affordable and to support employee paid leave and unemployment insurance payments. And, on March 13, he issued the "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease Outbreak." These actions are part of a far broader effort by a number of federal departments and agencies as the government works to monitor, contain, and mitigate the spread of the virus. OSHA takes the virus's potential risk to workers very seriously and is actively participating in the overall federal response to this emerging threat.

Presently, the U.S. Centers for Disease Control and Prevention (CDC) is recommending that healthcare workers follow standard and transmission-based infection control precautions for suspected cases of COVID-19. The CDC's interim guidelines are frequently updated and already include recommendations for worker protection that incorporate the lessons learned from prior outbreaks of pandemic influenza, severe acute respiratory syndrome, Middle East respiratory syndrome, and Ebola. For example, the interim recommendations already refer to OSHA's personal protective equipment (PPE) standards (29 CFR 1910 Subpart I), the Respiratory Protection standard (29 CFR 1910.134), and the General Duty clause (Section 5(a)(1) of the Occupational Safety and Health Act of 1970), as well as links to the OSHA respiratory protection training videos.

Moreover, OSHA has a number of existing enforcement tools it is using to help address worker protections for COVID-19. As noted, OSHA's PPE standards already address exposure issues of workers to require the use of gloves, eye, and face protection, as well as respiratory protection. The Bloodborne Pathogens standard applies to occupational exposure to human blood, certain body fluids, and other potentially infectious materials; and the provisions of the standard offer a framework that will control some transmission of the virus. And, the General Duty clause authorizes enforcement action in cases involving "recognized hazards that are causing or are likely to cause death or serious physical harm"—which could include improper exposure to

COVID-19. OSHA can and will use enforcement, as necessary, to ensure the protection of workers exposed to COVID-19.

OSHA is also working proactively to assist employers seeking information to protect workers from illness. The agency recently issued a guidance document, "Guidance on Preparing Workplaces for COVID-19," which details steps employers can take to reduce workers' risk of exposure. OSHA also recently created a Coronavirus Safety and Health Topics page on its website at <http://www.osha.gov/SLTC/> to help assure the safety and health of America's workers. OSHA will continue to update this website as new information becomes available.

And, following President Donald J. Trump's March 11, 2020 memorandum on the availability of respirators during the COVID-19 outbreak, OSHA issued new temporary guidance aimed at ensuring healthcare workers have full access to needed N95 respiratory protection in light of anticipated shortages.

In your letter, you inquired about OSHA's regulatory activity with respect to an infectious disease standard. OSHA believes that the healthcare industry fully understands the gravity of the situation and is taking the appropriate steps to protect its workers while responding to the public health emergency. The CDC guidelines, for instance, are universally distributed, and public awareness of COVID-19 is high. We believe that working on a formal rulemaking at the same time that the healthcare industry is responding to the COVID-19 public health emergency is counterproductive to both the public health response and robust stakeholder engagement. For example, the efforts employers would take to document compliance with such a standard would distract them from other vital response activities. OSHA can best meet the needs of America's workers by being able to rapidly respond in a flexible environment.

We note that OSHA is able to issue an Emergency Temporary Standard (ETS) when there is a minimum level of workplace safety practice that is necessary to protect workers, but is not being followed by employers. For the reasons identified above, however, we currently see no additional benefit from an ETS in the current circumstances relating to COVID-19. OSHA is continuing to monitor this quickly evolving situation and will take the appropriate steps to protect workers from COVID-19 in coordination with the overall U.S. government response effort.

Thank you for your shared commitment to occupational safety and health. For further assistance, please contact the Office of Congressional and Intergovernmental Affairs at (202) 693-4600.

Sincerely,



Loren Sweatt
Principal Deputy Assistant Secretary

Lee Saunders
President

Elissa McBride
Executive Director

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 Indianapolis, IN
 Mary E. Sullivan
 Albany, NY
 Braulio Torres
 San Juan, PR
 Anthony Wells
 Chicago, IL

The Honorable Alma Adams
Chairwoman, Subcommittee on Workforce Protections
Committee on Education and Labor
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Adams:

On behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFCME), I applaud you for holding a hearing on “Examining the Federal Government’s Actions to Protect Workers from COVID-19” and request that this letter be included in the hearing record.

AFSCME members work on the front lines as nurses, health care workers and EMS (Emergency Medical Services) personnel caring for people sick with COVID-19. As most of our nation shelters in place, AFSCME members who are bus drivers, home care workers, child protective service workers, correction officers, sanitation workers, group home staff and others, are on the job. They deserve respect because they ensure that essential services continue without disruption and protect vulnerable individuals – even as those workers face an elevated risk of infection because of their jobs.

The Occupational Safety and Health Administration (OSHA) is the only federal agency with the authority to issue a national emergency temporary standard to protect at-risk workers from COVID-19. OSHA should have issued a temporary emergency standard at the beginning of the pandemic, but it has ignored the urgent need for a standard, and not just guidance. Currently health care workers and others at elevated risk are working in a wild west of makeshift instructions and dwindling levels of protection due to lack of protective equipment and no firm standard. OSHA's failure to issue a standard has and continues to harm our nation's essential workers. OSHA's failure to protect workers also harms all of us because protecting front-line workers also protects public health by reducing the spread of the coronavirus.

AFSCME supports “COVID-19 Every Worker Protection Act of 2020” (H.R. 6559) and a similar provision in the recently passed HEROES Act for two important reasons. First, both bills give OSHA a firm deadline to issue a temporary emergency standard on COVID-19 infectious disease. Secondly, both bills define employer so that standard would apply to both private and public sector front-line workers no matter where they live. Currently, state and local government workers are not covered by OSHA standards in: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, West Virginia and Wisconsin. Enacting H.R. 6559 or the provisions in the HEROES Act would protect both public and private workers no matter where they live.

American Federation of State, County and Municipal Employees, AFL-CIO

TEL (202) 429-1000 **FAX** (202) 429-1293 **TDD** (202) 659-0446 **WEB** www.afscme.org 1625 L Street, NW, Washington, DC 20036-5687

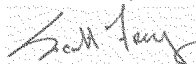
We honor and mourn these proud AFSCME Members who have died because of COVID-19 even as we celebrate their lives of service:

Abernathy, Michelle, Residential Services Supervisor, Local 2081, *Park Forest, IL*
 Ali, Timanjin, LPN, Local 1199C, *Philadelphia, PA*
 Baker, Correan, Retired, AFSCME Retiree Subchapter 153 President, *Las Vegas, NV*
 Bates II, Monroe, Maintenance Assistant, CSEA, *Alfred, NY*
 Bautista, Buenaventura "Ben," CNA, Local 3354, *Newark, NJ*
 Beaubien, Ketty, Day Hab Aide 1, CSEA, *Brooklyn, NY*
 Blakeley, Donnell, Operator/ Street Sweeper, Local 725, *Indianapolis, IN*
 Boone, Delores, Administrative Assistant 1, CSEA, *Bronx, NY*
 Brandenberger, Robert, Groundskeeper 1, CSEA, *Lindenhurst, NY*
 Burton, Alice, Retiree, Local 9999, *Brooklyn, NY*
 Campos, Angel, Comm. Assc., Local 371, *Jamaica, NY*
 Canon, Rodney, Maintenance Mechanic, Local 1542, *Miami, FL*
 Carlisle, Lorraine, Office Assistant 2, CSEA, *Bronx, NY*
 Cisneros, Esequiel (Zeke), LPN, Local 782, *Medical Lake, WA*
 Clark, Rhonda, Secretary, Local 2250, *Oxon Hill, MD*
 Cognato, Christopher, JOS, Local 371, *Staten Island, NY*
 Culetsu, George, Maintenance Worker, Local 2493, *Warren, OH*
 Daniels, James, Developmental Treatment Aide Trainee, CSEA, *Staten Island, NY*
 Dawson, John, Corrections Officer, OCSEA, *Marion, OH*
 Dickson, Dennis, Custodian, Local 1597, *Brooklyn, NY*
 Doronila, Daisy, RN, Local 1199J, *Newark, NJ*
 Evans, Faith, Administrative Assistant III, Local 2946, *Chicago, IL*
 Fleisher, Carl, Retiree, Local 9999, *Pompano Beach, FL*
 Forster, Paul, Neighborhood Safety Officer, Local 1600, *Flint, MI*
 Francis, Devin Dale, Radiology Technologist, Local 1363, *Miami, FL*
 Head, Michael, HSC, Local 2805, *Chicago, IL*
 Holder, Ed, Dev Assnt 2, CSEA, *Brooklyn, NY*
 Hughes, Troy, Social Worker, Local 2187, *Philadelphia, PA*
 Ji, Peter, LPN, CSEA, *Thiells, NY*
 Kama, Sakinah, Direct Support Assistant, CSEA, *Amityville, NY*
 Kane, Patrick, ICU RN, Local 875, *Flint, MI*
 King, Curwin, Nursing Assistant 2, CSEA, *Brooklyn, NY*
 Lee, Cephus, Support Service Worker, Local 2645, *Park Forest, IL*
 Lidell, Roger, Supply Distribution, Local 2650, *Flint, MI*
 Louis, Mirvil, Direct Support Assistant, CSEA, *Thiells, NY*
 Martinez, Carmen, Parent Coordinator, Local 372, *Bronx, NY*
 McBride, Sean, Information Specialist II, Local 3309, *Detroit, MI*
 McDowell, Edwin "Ebo," Street Dept Supervisor, CSEA, *Hempstead, NY*
 McKethan, Kalema, Supervising Motor Vehicle Representative, CSEA, *Jamaica, NY*
 Nelson, Edward, Carpenter, Local 1603, *Flint, MI*
 Onouah, Richard, LPN, Local 2216, *Newark, NJ*
 Payne, Bernadette, Supervising Motor Vehicle Representative, CSEA, *New York, NY*

Petitti, Josephine, Data Entry Clerk II, CSEA, *Yonkers, NY*
 Phillip, Keith, Secure Care Treatment Aide, CSEA, *Chester, NY*
 Quinn, Wendell, Public Safety Officer, Local 814, *Flint, MI*
 Reeves, Tina, LPN, OCSEA, *Blacklick, OH*
 Ricketts, Kenneth, Mental Health TH Aide, CSEA, *Jamaica, NY*
 Shannon, Robert "Robbie," Dispatcher, CSEA, *Ballston Spa, NY*
 Smith, Linda, Sr Clerk, CSEA, *New York, NY*
 Snorton, Nancy, CTT, Local 150, *Newark, NJ*
 Taylor, Michael, Utility Worker, Local 123, *Houston, TX*
 Thomas, William, Mental Health TH Aide, CSEA, *Manhattan, NY*
 Thomson, Goldie, Case Manager, Local 371, *Brooklyn, NY*
 Tolliver, Myrtel, Juvenile Detention Specialist, Local 409, *Detroit, MI*
 Veloz III, Jose, Support Service Coordinator, Local 2645, *Park Forest, IL*
 Washington, Earl A., Medical Security Officer, Local 2222, *Trenton, NJ*
 Whitted, Jr., Curtis L., Youth Division Aide 2, CSEA, *Highland, NY*
 Yeung, Kong, Maintenance Custodian, Local 1488, *Renton, WA*
 Zack, David, Retiree, Local 9999, *Franklin Square, NY*

We will never know if these health care and public service workers would still be alive if OSHA had issued and enforced an emergency temporary standard on COVID-19 and if the administration had made sure all essential workers had needed personal protective equipment (PPE). We do know that workers' lives can be saved if Congress and the administration take needed action to protect workers and provide them with the necessary PPE. We urge you to do so without delay and to fund the front lines to help states and localities provide workers with equipment, help them navigate this public health crisis and alleviate its accompanying economic fallout.

Sincerely,



Scott Frey
 Director of Federal Government Affairs

SF:LB:rf



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

May 20, 2020

The Honorable Robert Scott
U.S. House of Representatives
Washington, DC 20510

Dear Chairman Scott:

Thank you for your recent letter regarding the Coronavirus Disease 2019 (COVID-19) pandemic and available information related to healthcare workers. The Centers for Disease Control and Prevention's (CDC) goal is to get as complete a picture as possible of the overall situation in the U.S. and share findings with the American public.

CDC is leveraging our available surveillance systems to monitor COVID-19 and protect healthcare workers who are working on the frontlines of the pandemic response. While COVID-19 is a reportable disease, healthcare provider status is not required to be provided to CDC and reporting of this information to CDC varies across states. While CDC does not currently have complete data from states on healthcare worker status, many states publicly report data on cases in healthcare personnel on their health department websites.

CDC collects healthcare worker status as part of COVID-19 surveillance through the case report form (www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html). Public health departments report COVID-19 cases to CDC using a standardized case report form that captures information on the individual, including pre-existing medical conditions. As you noted, the case report form has been updated to include added questions about workplace exposures in critical infrastructure as well as categories for healthcare worker status and if there was healthcare-associated contact with a patient, visitor or co-worker.

Reporting of this information to CDC is voluntary. CDC requested that states implement this new report form by Friday, May 15, 2020, however, we expect state implementation to happen over time as states onboard the new form into their reporting systems. Prior to this change, the only occupational question on the case report form was indication of whether the case was a U.S. healthcare worker.

We have enclosed a table with CDC's available data on healthcare worker infection rates, and percentage of total infections reported by state and U.S. territory. Healthcare worker status has been included on approximately 18 percent of case report forms from states. Nationally, as of May 13, 2020, CDC has reported 43,738 healthcare worker cases of COVID-19 across the United States, however, given the considerations noted above, this is likely an underestimate. It is also not clear how many of these infections occurred as a result of occupational exposure, and not all cases are reported to CDC.

Information included in this table comes from case-level data reported directly to CDC via two systems. The National Notifiable Diseases Surveillance System (NNDSS), a nationwide collaboration that enables all levels of public health to share notifiable disease-related health information, and the Data Collation and Integration for Public Health Event Response (DCIPHER), a data integration and

Page 2 – The Honorable Robert Scott

management system for use in outbreak responses, are the only sources for case-level information such as healthcare worker status. Case count data from these systems do not match cases reported on CDC's website as information on cases are collected directly from state health department websites and validated by the states themselves. Data reported to CDC through NNDSS and DCIPHER are preliminary and may be updated by health departments over time. Critical data elements, such as healthcare worker status, might be missing at the time of initial report as public health departments are under time limitations to collect and report case information.

State health departments work to get complete information on every case, including sex, race, ethnicity, and other demographics such as healthcare worker status, but given the constraints they may be facing during this response, health departments may not be able to gather all the case-specific information. Data collection begins on the front lines of this public health emergency with a clinician or laboratory worker requiring time to complete information about individuals. Similarly, at this time, they may be limited in the amount of data they can provide.

CDC is actively working to address the issue of capturing occupational data, particularly for healthcare workers, as it relates to COVID-19 cases. To address missing data in case report forms and other data gaps, supplementary surveillance systems are being developed to better capture key demographic or clinical information. Special studies and enhanced surveillance platforms will continue to improve data collection on this issue. In April, summarized healthcare worker data was published in CDC's *Morbidity and Mortality Weekly Report, Characteristics of Health Care Personnel with COVID-19 reported to CDC from February 12–April 9, 2020* (www.cdc.gov/mmwr/volumes/69/wr/mm6915e6.htm).

CDC continues to collaborate with hospitals, academic institutions, and state public health partners to gather and report more demographic data, such as healthcare worker status. These collaborations will allow CDC to obtain additional data to learn more about information reflected in preliminary data. These data can help inform improvements in clinical management of patients, allocation of resources, and targeted public health information.

Thanks to support from Congress, CDC received resources in Fiscal Year 2020 to invest in modernizing the public health data system, which will help solve this issue. Among the priority investments in CDC's Public Health Data Modernization Initiative is an effort to scale up electronic case reporting—that is, digitally automating the provision of COVID-19 case reports from electronic health records to public health without placing extra burden on healthcare workers. This electronic reporting provides more consistently complete data than manual reporting so public health can have a comprehensive view of the pandemic's impact in near real-time. The electronic reporting seamlessly captures patient occupation when the information is included in the electronic health record.

In this fast-moving pandemic, CDC and its federal partners are providing regular briefings for Congressional members and staff to keep policy makers informed on these rapidly evolving developments. In addition, the CDC Washington Office is sending daily updates to Congressional staff with case counts and information about new guidance for key stakeholders and other important updates. We understand that you and your constituents have ongoing concerns about COVID-19. Please contact Nancy Tourk in our CDC Washington Office at (202) 245-0600 or NTourk@cdc.gov when you have further questions.

Page 2 – The Honorable Robert Scott

Thank you, again, for the work you do to protect the American people and for your interest in this ongoing response. We appreciate your support, and that of Congress, as we all work together to fight COVID-19. CDC remains committed to protecting the American public in the face of this pandemic. A copy of this letter has been sent to Representative Adams.

Sincerely,

A handwritten signature in black ink, reading "Robert R. Redfield". The signature is fluid and cursive, with the first name "Robert" and last name "Redfield" clearly legible.

Robert R. Redfield, MD
Director, CDC

Enclosure

Enclosure

	Healthcare Worker Cases	Total Cases by State & U.S. Territory	HCW Cases as Percentage of Total
U.S. Total	43,738	1,094,157	4%
Alaska (AK)	21	95	22%
Alabama (AL)	0	10,148	0%
Arkansas (AR)	442	4,233	10%
Arizona (AZ)	1	10,770	0%
California (CA)	7,498	71,159	11%
Colorado (CO)	240	1,258	19%
Connecticut (CT)	0	1	0%
Washington, DC (DC)	0	2	0%
Delaware (DE)	1	5,899	0%
Florida (FL)	3	145	2%
Georgia (GA)	0	21,479	0%
Guam (GU)	17	115	15%
Hawaii (HI)	1	645	0%
Iowa (IA)	969	7,465	13%
Idaho (ID)	0	2,041	0%
Illinois (IL)	5,137	83,241	6%
Indiana (IN)	10	47	21%
Kansas (KS)	398	7,497	5%
Kentucky (KY)	38	3,980	1%
Louisiana (LA)	1,744	18,210	10%
Massachusetts (MA)	8,015	81,196	10%
Maryland (MD)	0	14,292	0%
Maine (ME)	3	1,353	0%
Michigan (MI)	0	47,842	0%
Minnesota (MN)	1,502	12,711	12%
Missouri (MO)	3	79	4%
Northern Mariana Islands (MP)	0	13	0%
Mississippi (MS)	25	182	14%
Montana (MT)	7	518	1%
North Carolina (NC)	1,110	15,816	7%
North Dakota (ND)	39	241	16%
Nebraska (NE)	0	4,258	0%
New Hampshire (NH)	3	3,212	0%
New Jersey (NJ)	1,603	129,757	1%
New Mexico (NM)	1	4,757	0%
Nevada (NV)	7	101	7%
New York (NY)	3,638	169,883	2%
New York City (NYC)	1	189,290	0%
Ohio (OH)	3,382	15,233	22%
Oklahoma (OK)	2	4,765	0%
Oregon (OR)	0	2,814	0%
Pennsylvania (PA)	4,066	58,699	7%

Page 2 – The Honorable Robert Scott

Puerto Rico (PR)	0	1	0%
Rhode Island (RI)	248	1,088	23%
South Carolina (SC)	2	5,817	0%
South Dakota (SD)	5	50	10%
Tennessee (TN)	1,227	16,452	7%
Texas (TX)	1	4,909	0%
Utah (UT)	336	6,134	5%
Virginia (VA)	0	24,473	0%
U.S. Virgin Islands (VI)	0	4	0%
Vermont (VT)	2	1,035	0%
Washington (WA)	1,904	17,337	11%
Wisconsin (WI)	4	10,691	0%
West Virginia (WV)	23	214	11%
Wyoming (WY)	59	510	12%
*Data as of May 13, 2020			
**Data Sources: CDC's National Notifiable Diseases Surveillance System (NNDS) and the Data Collation and Integration for Public Health Event Response (DCIPHER)			



**COMMITTEE ON
EDUCATION AND LABOR**
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
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JEFFERSON VAN DREW, NEW JERSEY

May 15, 2020

Dr. Robert Redfield, MD
Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333.

Dear Dr. Redfield,

We are writing to request updated information on COVID-19 infections among health care workers, that was first reported by CDC in the Morbidity and Mortality Weekly Report "Characteristics of Health Care Personnel with COVID-19 — United States, February 12–April 9, 2020".¹

At that time, CDC reported 9,282 U.S. COVID-19 infections and 27 related deaths among health care personnel (HCP). The report indicated that information on HCP occupational status was included only in 16% of the case reports from the states, with wide variability among the states. It was made clear that the number of HCP cases in that report must be considered a lower bound, because additional cases likely have gone unidentified or unreported by the states through the case reporting system.

Since then the Committee received information that there have been 43,738 total reported cases of COVID-19 infections among health care workers and 191 deaths, according to reports received from CDC.

¹ Characteristics of Health Care Personnel with COVID-19 — United States, February 12–April 9, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e6.htm>

Dr. Robert Redfield, MD
May 15, 2020
Page 2

In order to understand more fully the extent and distribution of COVID-19 infections among HCP, we request the following information, nationally and for each individual state and territory reporting to CDC for the week ending May 15, 2020 on the following:

1. The cumulative total number of HCP with COVID-19 infections and deaths.
2. The percentage of HCP infections as a percentage of total infections reported, with an indication on the percentage of the case reports from each state affirmatively indicating HCP status.
3. How many of the HCP infection cases reported a health care contact to a confirmed or probable COVID-19 patient, visitor, or co-worker?
 - a. In addition, we understand that the CDC has improved its case reporting form (Human Infection 2019 Novel Corona Virus Case Report Form) to include more information on occupational exposure as well as other sources of infection. Is reporting of information on the fields for health care workers information mandatory or discretionary?
 - b. On what date was this revised case reporting form required for states to use in their case reporting?

While we understand this is short notice, we urge you to provide the requested information by COB May 18, 2020, so this information is available prior to the May 20, 2020, Subcommittee hearing on *Examining the Federal Government's Actions to Protect Workers from COVID-19*.

This data may be provided in an email format Tylease.Fitzgerald@mail.house.gov. If you have any questions, please contact jordan.barab@mail.house.gov.

Thank you



ROBERT C. "BOBBY" SCOTT
Chairman



ALMA S. ADAMS PH.D.
Chair
Subcommittee on Workforce Protections

Cc: Dr. John Howard, MD, Director, National Institute for Occupational Safety and Health.

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

May 26, 2020

The Honorable Robert C. "Bobby" Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Scott:

The Department of Labor received your letter regarding the Occupational Safety and Health Administration's (OSHA) response to the SARS-CoV-2 virus and the COVID-19 pandemic. The President and his Administration are taking aggressive action to protect public health; OSHA is working with a number of federal departments and agencies as the government works to monitor, contain, and mitigate the spread of the virus. OSHA takes the virus's potential risk to workers very seriously and is actively participating in the overall federal response to this pandemic.

Your letter includes a series of questions you raised with me, and I provided real-time responses for, during a May 8, 2020 briefing call with Members of Congress. During that call you requested my responses in writing. I have done so below. However, you may note the below list of questions and answers omits your question regarding the issuance of an Emergency Temporary Standard (ETS). As you know, I previously provided a written response to your inquiry about an ETS in my letter dated March 18, 2020. A copy of that letter is enclosed. However, the Department is now in litigation on this issue and, thus, cannot provide any further comment. In addition, I will soon be participating in a hearing before the Education and Labor Committee's Workforce Protections Subcommittee. In preparation for that hearing, I am providing written testimony. This testimony provides additional information regarding guidance OSHA has issued.

Questions and Answers:

How many COVID-related citations has OSHA issued under the General Duty Clause and in what industries?

While OSHA has not yet issued any citations related to COVID-19 under the general duty clause, nearly all of the inspections the agency has opened related to the pandemic remain open. Under the Occupational Safety and Health Act any citation must be issued within six months following the occurrence of any violation. *See* 29 U.S.C. 658(c). OSHA has responded to thousands of COVID-19 complaints. This information can be found here: <https://www.osha.gov/enforcement/covid-19-data>.

How many COVID-related citations has OSHA issued under any other standards (e.g., PPE or Respirators)? In what industries?

As of May 18, OSHA has issued one citation related to COVID-19 (concerning work-related hospitalizations reported to OSHA within 24 hours). Nearly all of the inspections the agency has opened related to the pandemic remain open. As noted above, any such citations must be issued within six months following the occurrence of any violation.

How many on-site COVID inspections has OSHA initiated? In what industries?

OSHA held an agency-wide webinar to familiarize agency staff who may conduct on-site inspections with training and PPE requirements related to COVID-19. The agency has initiated more than 4,000 complaint investigations since the beginning of February, including on-site inspections for those investigations converted into inspections. The agency conducts on-site inspections as appropriate in the industries within its jurisdiction.

Of the complaints you have “closed,” how many of them were closed through on-site inspections and how many through “Rapid Response” or “Phone and Fax?”

The vast majority of the complaints OSHA has received have been successfully addressed using OSHA’s phone/fax/email process. When a complaint is not successfully addressed, the agency can undertake an inspection. Since February 1, 2020, and through May 21, 2020, OSHA has opened 34 inspections as a result of COVID-19 complaints. Of the 34 inspections opened as a result of complaints, 32 remain open.

What percentage of COVID-related OSHA inspections are in response to deaths or illnesses, and what percentage are pro-active—conducted before a worker gets sick or dies? In other words, is OSHA conducting any Programmed COVID-related inspections?

All of OSHA’s inspections related to the COVID-19 pandemic are initiated through unprogrammed activity.

Since February 1, 2020, and through May 21, 2020, OSHA has opened 358 COVID-19 related inspections. Of those, 268 were opened as fatality inspections, four were opened as catastrophe inspections involving three or more hospitalized workers, and nine were opened in response to employer reports of hospitalized workers. The remaining 77 inspections were initiated in response to complaints, referrals, or other unprogrammed activity.

What effect does [OSHA’s recordkeeping guidance] have on an employer’s ability to identify problems in the workplace and how does it help OSHA to know where to focus its inspections? Do you think that many work-related COVID-19 cases will not be recorded due to this change in OSHA policy?

At the start of the pandemic, OSHA exercised its enforcement discretion to help employers in some non-critical industries focus their efforts on mitigating COVID-19’s

effects, rather than on making difficult work-relatedness decisions in circumstances where there was community transmission. As the virus's spread began to slow in certain areas of the country and workplaces in non-critical industries in those areas began to reopen, OSHA revised its previous enforcement policy on May 19, 2020. Under OSHA's recordkeeping requirements, coronavirus is a recordable illness, and employers are responsible for recording cases of the coronavirus, if the case:

- Is confirmed as a coronavirus illness;
- Is work-related as defined by 29 CFR 1904.5; and
- Involves one or more of the general recording criteria in 29 CFR 1904.7, such as medical treatment beyond first aid or days away from work.

Under this policy, OSHA will enforce the recordkeeping requirements of 29 CFR 1904 for employee coronavirus illnesses for *all* employers. Given the nature of the disease and community spread, however, in many instances it remains difficult to determine whether a coronavirus illness is work-related, especially when an employee has experienced potential exposure both in and out of the workplace. OSHA's guidance emphasizes that employers must make reasonable efforts, based on the evidence available to the employer, to ascertain whether a particular case of coronavirus is work-related.

Has OSHA required any health care employers to reinstate nurses or others who have spoken up about their hospital's policies? If so, how many?

As of May 21, 2020, OSHA has received 119 complaints from employees working in the healthcare industry. A number of these cases have been resolved, with and without reinstatement agreements. The remaining cases are being investigated, and the agency is actively pursuing resolution.

Thank you for your shared commitment to occupational safety and health. I welcome the opportunity to respond to additional questions raised by you and your fellow members of the Workforce Protections Subcommittee at its upcoming hearing.

Sincerely,



Loren Sweatt
Principal Deputy Assistant Secretary

cc: The Honorable Virginia Foxx, Ranking Member

Enclosure

United States Senate
WASHINGTON, DC 20510

May 27, 2020

Scott S. Dahl
Inspector General
Office of Inspector General
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC. 20210

Dear Mr. Dahl:

We are writing to request that your office conduct an audit of the Occupational Safety and Health Administration's (OSHA) handling of inspections and citations during the coronavirus disease 2019 (COVID-19) pandemic, and the Department of Labor's (DOL) decision not to issue an OSHA Emergency Temporary Standard (ETS) to address the heightened risks for frontline workers during the pandemic.

Since President Trump's March 13, 2020 declaration of a national emergency,¹ the number of OSHA-issued citations has dropped by nearly 70%, and the inspection rate has also dropped dramatically.² An OSHA spokesperson reported the agency has not issued a single citation related to the COVID-19 pandemic.³

During this same period, thousands of essential workers have become sick, and many have died after being exposed to coronavirus at their workplaces. We are writing to seek an audit of OSHA's response to the pandemic, including an explanation for why citation and inspection numbers have dropped so dramatically during this national emergency, and whether DOL's refusal to issue an ETS is not in compliance with the law.

The Occupational Safety and Health Act (OSH Act) mandates that DOL "shall provide... for an emergency temporary standard to take immediate effect" if the Secretary of Labor "determines (A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and (B) that such emergency standard is necessary to protect employees from such danger."⁴ Essential workers continue to fall

¹ White House, "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," proclamation, March 13, 2020, <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

² Politico, "OSHA enforcement dwindles as workers fall ill," Rebecca Rainey, May 1, 2020, <https://www.politico.com/newsletters/morning-shift/2020/05/01/osha-enforcement-dwindles-as-workers-fall-ill-787270>.

³ Politico, "Clash over government role in worker safety intensifies as businesses reopen," Rebecca Rainey, May 18, 2020, <https://www.politico.com/news/2020/05/18/clash-over-government-role-in-worker-safety-intensifies-as-businesses-reopen-265888>.

⁴ 29 USC 655 (c).

ill and die due to workplace coronavirus exposure. More than 9,000 health care workers fell ill with coronavirus between February 12 and April 9;⁵ dozens of grocery store workers have died due to COVID-19;⁶ and in New York City alone, more than 80 transportation workers have died.⁷ This is just a small sampling of the thousands of workers spanning dozens of industries who have become sick – often gravely so – on the job. It is beyond dispute that coronavirus constitutes a new hazard which poses grave danger to employees, and that current safety standards are inadequate to protect workers from this hazard.

Despite the growing numbers of sick and deceased essential workers, DOL has refused to issue an ETS. In response to a letter from a group of Senators requesting OSHA issue an emergency standard, DOL wrote:

OSHA is able to issue an Emergency Temporary Standard (ETS) when there is a minimum level of workplace safety practice that is necessary to protect workers, but is not being followed by employers. ... at this time, we see no additional benefit from an ETS in the current circumstances relating to COVID-19.⁸

OSHA's rationale is plainly faulty. There is no evidence that employers are sufficiently protecting workers—in fact, there is an abundance of evidence to the contrary. State and local governments have had to close essential businesses after they have failed to prevent and mitigate coronavirus outbreaks among employees. The city of Worcester, Massachusetts ordered a Walmart store to close on April 29, 2020, after more than 20 employees tested positive for coronavirus⁹ – the first of whom tested positive on April 8, 2020; now, more than 80 workers have tested positive.¹⁰ Kentucky Governor Andy Beshear ordered Amazon to close a warehouse in Shepherdsville after multiple employees tested positive for coronavirus.¹¹ Smithfield Foods did not suspend operations at their Sioux Falls facility, where more than 850 workers have

⁵ CDC, “Characteristics of Health Care Personnel with COVID-19 — United States, February 12–April 9, 2020,” *Morbidity and Mortality Weekly Report*, April 17, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e6.htm>.

⁶ The Washington Post, “‘It feels like a war zone’: As more of them die, grocery workers increasingly fear showing up at work,” Abha Bhattarai, April 12, 2020, <https://www.washingtonpost.com/business/2020/04/12/grocery-worker-fear-death-coronavirus/>.

⁷ Politico, “With death toll hitting 83, the MTA contemplates a memorial for its Covid fallen,” Dana Rubenstein, April 22, 2020, <https://www.politico.com/states/new-york/albany/story/2020/04/22/with-death-toll-hitting-83-the-mta-contemplates-a-memorial-for-its-covid-fallen-1279032>.

⁸ Letter to Senator Elizabeth Warren from Department of Labor Deputy Assistant Secretary Joe Wheeler, April 10, 2020, on file with the office of Senator Elizabeth Warren.

⁹ WVCB, “State corrects number of Worcester Walmart employees with COVID-19 to 23,” May 1, 2020, <https://www.wcvb.com/article/worcester-walmart-store-ordered-closed-after-41-employees-test-positive-for-coronavirus/32321303>.

¹⁰ Boston Herald, “81 coronavirus cases at Worcester Walmart, city says,” Sean Philip Cotter, May 2, 2020, <https://www.bostonherald.com/2020/05/02/81-coronavirus-cases-at-worcester-walmart-city-says/>.

¹¹ WDRB, “Amazon plans April 1 restart for Kentucky warehouse with COVID-19 cases,” Chis Otts, March 26, 2020, https://www.wdrb.com/in-depth/amazon-plans-april-restart-for-kentucky-warehouse-with-covid-/article_43e34850-6f71-11ea-afc6-d37215a4cc4c.html.

become ill,¹² until South Dakota Governor Kristi Noem and Sioux Falls, South Dakota Mayor Paul TenHaken requested the facility close for 14 days.¹³

Furthermore, OSHA has largely abdicated its investigation and enforcement responsibilities for even *existing* standards. As of May 18, OSHA has only opened 310 COVID-19-related inspections, despite the agency receiving more than 3,990 COVID-19-related complaints.¹⁴ OSHA inspections dropped from on average 217 a day to 60 a day after the national emergency declaration, and the number of OSHA citations has decreased by nearly 70% compared with the prior two years.¹⁵ Stunningly, OSHA stated in an April 13, 2020 enforcement memo (which the agency recently announced will be rescinded¹⁶) that, in most cases, all workplaces other than healthcare and emergency response should not even receive on-site inspections in response to COVID-19-related complaints, but rather only a non-formal phone/fax inspection.¹⁷ While OSHA needs to ensure that its own inspectors are safe during this pandemic, the agency cannot do so by abdicating its mission to “to assure so far as possible every working man and woman in the Nation safe and healthful working conditions.”¹⁸

Additionally, OSHA stated in an April 16, 2020 memo that it may issue a citation in the case that “the employer cannot demonstrate any efforts to comply” with OSHA mandates, but urged Area Offices to take “attempts to comply in good faith ... into strong consideration in determining whether to cite a violation.”¹⁹ A former OSHA official cautioned that these efforts erode enforcement efforts, potentially allowing employers off the hook for violations based on efforts as minimal as a phone call to seek protective equipment.²⁰ And despite a requirement for

¹² Associated Press, “Some meat plants reopen, but Trump order may not be cure-all,” Stephen Groves, May 1, 2020, <https://apnews.com/6c6711b16d68ebde1b2cd8060f431774>.

¹³ Washington Post, “Thousands of OSHA complaints filed against companies for virus workplace safety concerns, records show,” Peter Whoriskey, Jeff Stein, and Nate Jones, April 16, 2020, <https://www.washingtonpost.com/business/2020/04/16/osha-coronavirus-complaints/>.

¹⁴ Politico, “Clash over government role in worker safety intensifies as businesses reopen,” Rebecca Rainey, May 18, 2020, <https://www.politico.com/news/2020/05/18/clash-over-government-role-in-worker-safety-intensifies-as-businesses-reopen-265888>.

¹⁵ *Id.*

¹⁶ OSHA, “Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19),” memo, May 19, 2020, <https://www.osha.gov/memos/2020-05-19/updated-interim-enforcement-response-plan-coronavirus-disease-2019-covid-19>.

¹⁷ OSHA, “Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19),” memo, April 13, 2020, <https://www.osha.gov/memos/2020-04-13/interim-enforcement-response-plan-coronavirus-disease-2019-covid-19>. (“Complaints received during the initial months of the outbreak describe concerns related to lack of personal protective equipment (PPE), such as respirators, gloves, and gowns. OSHA has also received complaints expressing concern about a lack of training on appropriate standards and about possible COVID-19 illnesses in the workplace. In most cases, Area Offices should process complaints from non-healthcare and non-emergency response establishments as “non-formal phone/fax,” following the non-formal complaint and referral procedures in the Field Operations Manual (FOM), CPL 02-00-163, September 13, 2019, at www.osha.gov/enforcement/directives/cpl-02-00-163.”)

¹⁸ 29 USC 651 (b).

¹⁹ OSHA, “Discretion in Enforcement when Considering an Employer’s Good Faith Efforts During the Coronavirus Disease 2019 (COVID-19) Pandemic,” memo, April 16, 2020, <https://www.osha.gov/memos/2020-04-16/discretion-enforcement-when-considering-employers-good-faith-efforts-during>.

²⁰ Kaiser Health News, “OSHA Probing Health Worker Deaths But Urges Inspectors To Spare The Penalties,” Christina Jewett and Shefali Luthra, April 22, 2020, <https://khn.org/news/osha-probing-health-worker-deaths-but-urges-inspectors-to-spare-the-penalties/>.

employers to report on workplace deaths, “former OSHA leaders say the agency has not openly reminded hospitals and nursing homes to file such reports in recent weeks.”²¹

OSHA did release revised enforcement policies on May 19, 2020 announcing the agency is “increasing in-person inspections at all types of workplaces” and “enforc[ing] the recordkeeping requirements of 29 CFR 1904 for employee coronavirus illnesses for employers.”²² While we are hopeful that these changes, which went into effect on May 26, 2020,²³ will lead to increased coronavirus-related inspections and enforcement activity, we believe it is critical to audit OSHA’s efforts to date, and what impact the updated guidance may have.

Due to our grave concerns that OSHA is failing to meet its core mission of protecting worker health and safety during the COVID-19 pandemic, and failing to meet legal requirements to adopt an ETS to prevent additional, unnecessary worker illnesses and deaths, we ask that you open an audit of OSHA’s actions and decisions during the pandemic expeditiously. Thank you for your work and your consideration of this request.

Sincerely,

Elizabeth Warren
United States Senator

Tim Kaine
United States Senator

Bernard Sanders
United States Senator

Tammy Baldwin
United States Senator

Robert P. Casey, Jr.
United States Senator

Tammy Duckworth
United States Senator

²¹ *Id.*

²² OSHA, “U.S. Department of Labor Adopts Revised Enforcement Policies for Coronavirus,” press release, May 19, 2020, <https://www.osha.gov/news/newsreleases/national/05192020-0>.

²³ *Id.*



**Statement of the National Safety Council
U.S. House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections
Hearing on,
"Examining the Federal Government's Actions to Protect Workers from COVID-19"
Thursday, May 28, 2020**

Thank you for allowing the National Safety Council (NSC) to submit this statement for the record. NSC appreciates the Education and Labor Workforce Protections Subcommittee leading this hearing to better understand what actions the federal government is taking to protect workers.

NSC is a mission-based organization, focused on eliminating the leading causes of preventable death and injury. We focus our efforts and thought leadership on impacting safety through three strategic pillars: Workplace, Roadway and Impairment. Our more than 15,000 member companies represent employees at nearly 50,000 U.S. worksites. Throughout the coronavirus pandemic, NSC has focused on supporting worker safety and health and giving employers resources to do so. NSC guidance and recommendations have changed with the evolving public knowledge about this novel virus, but our focus on safety and health has not.

The manner in which we return Americans to their traditional work environments and routines will define our national response to this pandemic that has upended our lives and forever changed how our nation approaches workplace safety. NSC believes the goal of reopening the country should not simply be to restart the economy. If employers are not sure they can bring employees back safely, they should consider whether it is the right time to bring them back. Ensuring a sustainable and lasting economic recovery means keeping workers available, healthy and safe.

Employers face myriad challenges and questions to operating safely during the pandemic. With some workers never stopping their shifts, some returning to workplaces now, and some working from home or other locations they never expected to be, employers need help navigating information sources, and they need to be able to trust the information they receive. To help tackle some of these issues, NSC joined with large and small companies, nonprofits, legal experts, public health professionals, medical professionals and government agency representatives to launch the [SAFER](#) (Safe Actions for Employee Returns) task force.¹

The SAFER task force has released "one stop" playbooks that provide information, resources and tips for employers on topics including:

- Physical safety
- Medical issues
- Mental health and stress
- Employment, Legal and Human Resources (HR)

¹ www.nsc.org/safer

- Communications with employees
- External factors

Playbooks also cover different work settings such as:

- Office operations
- Closed industrial
- Open industrial
- Public interactions (e.g. retail)

These playbooks also include checklists so that employers can understand, for example, what to do when one of their employees has a confirmed case of COVID-19 and how to manage workplace hygiene. While large employers may already have these plans in place, many mid-sized and small businesses do not have the resources to develop plans and procedures to safely return their employees to work.

The resources produced by the SAFER initiative provide clear, expert guidance where it is needed. NSC urges the federal government to use these resources to govern the return-to-work decisions it is making for its workforce and as a basis for external communications to workplaces.

Even as employers safely bring employees back to the workplace, they must not lose focus on avoiding a second wave of COVID-19 infections. Employers must work with public health authorities to prioritize three key issues that will help prevent another shut down: testing, contact tracing and mental health.

Testing and Contact Tracing

Businesses can be important partners in conducting more widespread COVID-19 testing. In April, NSC and over 70 other organizations wrote a [letter](#) to Vice President Pence, as the Chair of the White House coronavirus task force, asking that he prioritize testing equipment to businesses after the healthcare sector.² NSC appreciates Congress recognizing the need to support testing for businesses through the Paycheck Protection Program and Health Care Enhancement Act.³ This law provides funding to the states for testing and calls out that the workforce and employers are necessary partners of a more complete testing protocol and an important part of keeping workers safe and healthy. NSC asks Congress to ensure its directions are followed in this regard, and we are ready to work with states as these business testing protocols are developed and implemented. The federal government must also work with states, local governments, public health officials and employers to provide adequate and validated testing resources.

Containing any communicable disease effectively requires adequate and diligent tracing. NSC believes participation in contact tracing by workplaces is a key component to stop the spread of coronavirus. Workplaces may inadvertently provide locations for virus transmission, and contact tracing among co-workers is key to prevent further spread. We encourage employers to share relevant information on employee contacts with the public health officials when an employee tests positive for COVID-19.

If employers are to fully participate in screening and testing employees, there are considerations to keep in mind. Currently, there are strong laws in place to protect the privacy of healthcare information

² <https://www.nsc.org/in-the-newsroom/nsc-and-partners-call-for-coronavirus-tests-for-all-us-businesses-worksites>

³ P.L. 116-139

and prevent discrimination. Agencies such as the U.S. Department of Health and Human Services (HHS), the Equal Employment Opportunity Commission (EEOC), the Occupational Health and Safety Administration (OSHA) and others have relaxed some of the laws through temporary emergency orders to help fight the spread of coronavirus. NSC believes these agencies should consider the following measures for the duration of the pandemic:

- Continue to allow healthcare screening of employees, contractors and visitors to facilities. This includes temperature and symptom screenings. If screenings are conducted by a third party, results of screenings that could impact the health of other workers should be confidentially shared with the employer.
- Continue to allow COVID-19 testing of workers, contractors and visitors to workplaces.
- Provide clear validation of testing equipment through the Food and Drug Administration process.⁴
- Allow sharing of positive worker (employee or contractors) COVID-19 test results by the testing entity with employers to make appropriate [notifications](#)⁵ to other workers in proximity to the positive worker.

Mental Health

The coronavirus crisis has impacted mental health in both clear and unseen ways and will continue to do so as the crisis evolves. Because employees may not realize the impact stress has on their mental health and wellbeing, every return to work strategy must include assistance for employees to address mental health. That means leveraging employee assistance programs (EAPs), providing employees with contact information for mental health services, and openly acknowledging and discussing the impacts of COVID-19 on mental health.

Before this pandemic, the U.S. was in the midst of an overdose epidemic, and opioid overdoses were the leading cause of overdose deaths. For nearly a decade, NSC has been [working with employers](#)⁶ to help them understand the positive role they can play to help those with a substance use disorder (SUD) to find and receive treatment and return to work.

Opioid overdose related fatalities were beginning to decline in the U.S. before the coronavirus pandemic. However, as of June 2020, over 20 states have reported increases in opioid-related deaths.⁷ Further, much of the fallout from the coronavirus has triggered SUDs and other [mental health](#) issues.⁸ Extended isolation increases the risk for substance misuse and development of SUDs, increases risk for relapse, negatively impacts sleep quality and cognitive function, increases the risk of depression and other negative mental health impacts, and can cause suicidal thoughts. Mental health impacts may be prolonged or delayed and manifest differently in each employee—sometimes taking weeks, months, or even years to do so.

⁴ <https://www.google.com/url?q=https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations%23coronavirus2019&sa=D&ust=1589484095845000&usg=AFQjCNF1gZZduRenKB8jvSrPINbdJ1evzg>

⁵ See: https://www.nsc.org/Portals/0/Documents/NSCDocuments_Advocacy/Safety%20at%20Work/covid-19/safer/qh-confirmed-case-notification-protocol.pdf?ver=2020-05-29-132909-503

⁶ <https://safety.nsc.org/rxemployerkit>

⁷ <https://www.ama-assn.org/system/files/2020-06/issue-brief-increases-in-opioid-related-overdose.pdf>

⁸ https://www.nsc.org/Portals/0/Documents/NSCDocuments_Advocacy/Safety%20at%20Work/covid-19/safer-playbooks/mental-health.pdf?ver=2020-05-14-180954-763

Employers with short- and long-term response plans will be the best equipped to help their workers. Some key factors for workplaces should incorporate into their strategy include:

- Build a culture of mental health safety in workplaces, including training leadership and supervisors
- Establish resources and benefits to provide treatment and access to help needed
- Think about and shift language used in human resources and other documents to describe SUDs and mental illnesses to ensure it is non-stigmatizing
- Lead education and awareness opportunities for all staff so that they can protect themselves from the mental health and stress related to COVID-19 and practice safe coping mechanisms
- Communicate frequently with employees to ensure they know that they are supported in seeking any help they need

NIOSH and OSHA

The National Safety Council has been a longtime supporter of the U.S. National Institute for Occupational Safety and Health (NIOSH) and OSHA. This year, NSC led a request for increased funding for both agencies because of the critical missions they execute. We have requested \$677.4 million for OSHA and \$354.8 million for NIOSH, including a restoration of funding for the Agriculture, Forestry and Fishing and Education and Research Centers programs.

NIOSH has been a great resource for workers and employers during this time. NIOSH experts have shared information in a timely manner to promote safe workplaces. NSC has incorporated much of this information and used it as a basis for recommendations as part of the SAFER initiative. However, NIOSH is not a regulatory agency.

Unlike NIOSH, OSHA is empowered with the authority to issue emergency temporary standards when quick action is needed to protect workers' safety and health. The coronavirus pandemic is such a time. NSC believes OSHA should exercise its emergency authority to issue a temporary emergency standard to protect workers from occupational exposure to COVID-19. This action should remain in place for the duration of the current COVID-19 pandemic and its possible reemergence to limit the spread of the virus in workplaces, protect worker safety and health, and provide clear rules for workplaces. Without this action, states will act. That will create a patchwork of requirements instead of what employers and workers need – one level of safety that is clear and understandable to everyone.

Thank you for holding this hearing. Businesses should follow federal guidance, but it is the floor – not the ceiling. Employers must go beyond this guidance, because now is not the time for minimum. Additionally, it is clear that to ensure a sustainable and lasting economic recovery, workers must be safe and healthy. NSC is working toward this end, and we welcome an opportunity to partner with this Committee and Congress to make this a reality.

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March 5, 2020

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The Honorable Eugene Scalia
Secretary
U.S. Department of Labor
200 Constitution Ave., NW
Washington DC 20210

Dear Secretary Scalia:

In light of the COVID-19 epidemic and its rapid spread worldwide, we wrote you on January 30, 2020, asking the Occupational Safety and Health Administration (OSHA) to put its Infectious Disease Standard back on the active regulatory agenda and to dedicate all available resources to move to final promulgation. That letter also requested that OSHA prepare an Emergency Temporary Standard (ETS) to protect workers against COVID-19 in the event that conditions further deteriorated in the United States.

We requested a response to our letter by February 15, 2020, but as of the date of this letter, we have received no reply. In addition, Committee staff has reached out to the Department on several occasions seeking a response to the letter and OSHA's plan of action, but as of this date, no response has been received.

As we stated in our January 30 letter, Section 6(c)(1) of the Occupational Safety and Health Act provides only two conditions for issuing an ETS:

(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and

(B) that such emergency standard is necessary to protect employees from such danger.

We noted that at that time, over a month ago, it was still too early to issue an ETS, but that a widespread epidemic of a virulent novel airborne virus would clearly satisfy those conditions and "OSHA should be prepared to issue an ETS."

The Honorable Eugene Scalia
 March 5, 2020
 Page 2

Based on current and anticipated conditions, it is clear that the time for OSHA to issue an ETS to protect workers from COVID-19 has arrived. Since the end of January, this country has seen widespread community transmission of COVID-19. Hundreds of health care workers have been exposed and some have been infected¹. The number exposed and infected is undoubtedly higher than has been detected at this time because of the non-symptomatic nature of some infections, the limited availability of test kits, and restrictive criteria initially set by the Centers for Disease Control and Prevention (CDC) for testing.

Legally, the conditions to justify an ETS in the Occupational Safety and Health Act have been met. Health care workers are clearly exposed to "grave danger" from exposure to the SARS-CoV-2 virus.

If health care workers are quarantined in large numbers, or get ill or die, or fear coming to work due to the risks, it's not just a personal or workplace problem, it's a national public health disaster.

OSHA is the only agency in the federal government authorized to enforce safe working conditions for the nation's workers—including those in health care facilities. As we enter into what is likely to be the greatest infectious disease crisis this country has faced in over a century, it is in the national interest that OSHA be on the forefront of protecting workers essential to the country's health care system. For that reason, I reiterate my call for OSHA to put the infectious disease standard back on the active regulatory agenda and to issue an Emergency Temporary Standard to protect health care workers from COVID-19.

Please provide the Committee with OSHA's written response and its plan to address this crisis no later by March 15, 2020. We also request an immediate briefing on your plans.

Thank you for your attention to this matter. Contact Jordan Barab with the House Committee on Education and Labor at jordan.barab@mail.house.gov with any questions. Please send all official correspondence relating to this request to tylease.allii@mail.house.gov.

Sincerely,



ROBERT C. "BOBBY" SCOTT
 Chairman



ALMA S. ADAMS PH.D.
 Chair
 Subcommittee on Workforce Protections

cc: Loren Sweatt, Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor

¹ "First responders and medical staff test positive for coronavirus. UW doctors not getting masks"
<https://www.kuow.org/stories/first-responders-and-medical-staff-test-positive-for-coronavirus/?hclid=twAR0VzbrWfu5Qluc0C0YzskRLooyMAGIBzsYjsD7rjN5y7-4N5EKJ8cUsQ>



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May 29, 2020

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Loren Sweatt
Principal Deputy Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Dear Ms. Sweatt:

During the May 28, 2020, hearing before the Subcommittee on Workforce Protections entitled *Examining the Federal Government's Actions to Protect Workers from COVID-19*, you declined to answer any questions with regards to an OSHA Emergency Temporary Standard (ETS) in light of litigation against the Department by the AFL-CIO.

Specifically, you stated: "I have been advised by Department counsel not to answer questions on ETS."

I asked you at that time whether there was a legal basis upon which you are refusing to answer such questions, and to provide the specific privilege that you are claiming. Since you were unable to provide an answer to that question at that time, I am following up with this letter.

Please identify which specific legal privilege you are claiming in order not to answer questions regarding an OSHA Emergency Temporary Standard.

Please provide a written answer to this question no later than close of business Thursday, June 4, 2020.

Please direct this reply to Tylease.alli@mail.house.gov. If you have any questions, please contact Jordan.barab@mail.house.gov.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chair

Cc: Hon. Alma Adams Chair, Subcommittee on Workforce Protections
Hon. Virginia Foxx, Ranking Member, Committee on Education and Labor
Hon. Bradley Byrne, Ranking Member, Subcommittee on Workforce Protections



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

June 10, 2020

The Honorable Robert C. "Bobby" Scott
U.S. House of Representatives
Washington, DC 20515

Dear Representative Scott:

Thank you for your letter to the Secretary of Health and Human Services regarding the Coronavirus Disease 2019 (COVID-19) pandemic and protections for healthcare workers and emergency responders. I am responding on behalf of the Secretary.

We share your urgency to ensure that we prioritize the safety of healthcare personnel (HCP) and first responders during this pandemic. HCP and first responders use personal protective equipment (PPE) to protect themselves, patients, and others when providing care and it is critical that they have these supplies. PPE helps provide protection from potentially infectious patients and materials, toxic medications, and other potentially dangerous substances used in healthcare delivery. PPE shortages are currently posing a tremendous challenge to the U.S. healthcare system because of the COVID-19 pandemic. Healthcare facilities are having difficulty accessing needed PPE and are having to identify alternate ways to provide patient care.

CDC's evidence-based guidelines are designed to protect patients and healthcare personnel, encourage safe practices, improve health outcomes, and save lives. The guidelines are based on systematic evidence reviews that consider efficacy in model systems and real-world effectiveness. CDC also incorporates feedback and input from public health partners. CDC continues to adjust its response and guidance as conditions change, and as we learn more about this emerging infectious disease. CDC would like to reiterate that guidance for alternatives to the use of N95 respirators is only to be used when facilities and HCP are not able to obtain N95s or when healthcare facility supplies are critically low. When supplies are critically low, CDC guidance includes strategies and options to optimize supplies of disposable N95 respirators in healthcare settings. Use of appropriate PPE, including N95 or higher-level respirators, is recommended for HCP who have been medically cleared, trained, and fit-tested, when supplies are available and in applicable circumstances.

The Federal Emergency Management Agency (FEMA) is responsible for setting criteria to assess the priority for the distribution of PPE. FEMA is best positioned to address PPE supply issues. However, CDC has developed optimization strategies for PPE to offer guidance when PPE supplies are stressed, running low, or absent. Contingency strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have enough supplies now but are likely to run out soon. Crisis strategies can be considered during severe PPE shortages and should be used with the contingency options to help stretch available supplies for the most critical needs. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices. CDC also has provided the following guidance for HCP:

Page 2 – The Honorable Robert C. “Bobby” Scott

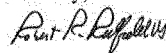
www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html, and *Strategies to Optimize the Supply of PPE and Equipment*, www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

CDC recognizes that during the COVID-19 pandemic, more needs to be done to ensure the health and safety of healthcare workers who use PPE such as N95 respirators. CDC's National Institute for Occupational Safety and Health (NIOSH) has expedited respirator approval decisions for products to improve supply during COVID-19. Before the pandemic, approximately 30 decisions were made per month. Since January, a total of 365 respirator approval decisions have been made. This includes, 35 new filtering facepiece respirators and 23 new powered air purifying respirator approvals, 676 new elastomeric respirators, and 9,354 extensions have been issued by NIOSH to allow modifications. Please see *Strategies for Optimizing the Supply of N95 Respirators*, www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html. We also have the guidance *Using Personal Protective Equipment*, www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html. Please regularly visit our COVID-19 website www.cdc.gov/ncov for CDC's latest and most up-to-date information, resources, and guidance.

In this fast-moving pandemic, CDC and its federal partners are providing regular briefings for Congressional members and staff to keep policy makers informed on these rapidly evolving developments. In addition, the CDC Washington Office is sending daily updates to Congressional staff with case counts and information about new guidance for key stakeholders and other important updates. We understand that you and your constituents have ongoing concerns about COVID-19. Please contact Jane Bigham in our CDC Washington Office at (202) 245-0600 or jbigham@cdc.gov with questions.

Thank you, again, for the work you do to protect the American people and for your interest in this ongoing response. We appreciate your support, and that of Congress, as we all work together to fight COVID-19. CDC remains committed to protecting the American public in the face of this pandemic. A copy of this response has been sent to Representative Adams.

Sincerely,



Robert R. Redfield, MD
Director, CDC



June 10, 2020

The Honorable Alma Adams
Chair
Subcommittee on Workforce Protections
Education and Labor Committee
U.S. House of Representatives
Washington DC 20515

The Honorable Bradley Byrne
Ranking Member
Subcommittee on Workforce Protections
Education and Labor Committee
U.S. House of Representatives
Washington DC 20515

Dear Chairwoman Adams and Ranking Member Byrne:

Thank you for holding the May 28, 2020 hearing on "Examining the Federal Government's Actions to Protect Workers from Covid-19." This is a topic of great importance to the 1.3 million members of United Food and Commercial Workers International Union (UFCW) who are on the frontlines of this pandemic.

UFCW is America's largest food and retail union representing 1.3 million hard-working men and women. Our members work in grocery stores, meatpacking, food processing, health care, chemical plants, retail, and senior care facilities. We have members in every state and congressional district.

Our country's food processing workers are working tirelessly during this outbreak to ensure families get the meat and poultry they need. These brave men and women are providing an essential service despite enormous risk to their own health and the health of their families. We need these workers to stay healthy more than ever and protecting them is essential to our communities and the food supply.

The guidance issued by the Centers for Disease Control and Prevention and the Occupational Health and Safety Administration is a step in the right direction, but meat and poultry workers need mandatory and enforceable regulations to protect workers from contracting and spreading COVID-19.

UFCW represents nearly 250,000 meat packing and food processing workers and we are long-time leaders on worker health and safety standards especially in meat processing. Despite the assertions of OSHA Principal Deputy Assistant Secretary Loren Sweatt, the Occupational Safety and Health Administration (OSHA) has not been regularly consulting with the union about worker safety in the meat and poultry processing plants. Unions affiliated with the AFL-CIO, which includes the UFCW, reached out to Deputy Assistant Secretary Sweatt early in the pandemic in order to speak with the agency about our concerns. Subsequently, UFCW participated in two calls with OSHA, one about worker safety concerns in the health care industry and one about worker safety concerns for all other non-health care industries. The calls were strictly cut off at 60 minutes. OSHA never followed up with the unions after either of these calls.

Anthony M. Perrone, *International President*
Shaun Barclay, *International Secretary-Treasurer*

United Food & Commercial Workers International Union, AFL-CIO, CLC
1775 K Street, NW • Washington DC 20006-1598
Office (202) 223-3111 • Fax (202) 466-1562 • www.ufcw.org

Honorable Alma Adams
Honorable Bradley Byrne

June 10, 2020

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In her testimony Deputy Assistant Secretary Sweatt stated that there are 58 open OSHA inspections, many in the meatpacking industry. None of these inspections are on-site inspections. All inspections involved only phone calls. OSHA is currently not going into the workplace to evaluate for hazards and risks to workers. Being on site is critical to observing, evaluating, and verifying workplace hazards and conditions.

OSHA is required to contact a union representative, if there is a union, when an inspection or investigation takes place. Often the union representing workers in the plants which are being "inspected" are unaware of these investigations taken place or have had no contact with an OSHA inspector.

Unfortunately, OSHA has fallen down on its job to protect workers. The policies that will ensure the safety of the food for consumers and workers are outlined below. Congress should:

- Require OSHA to issue an emergency temporary standard (ETS) to protect workers from infectious disease, which includes COVID-19.
- **Require food processing and slaughter businesses to implement social distancing protocols in the plants without eliminating any positions.** Companies must reconfigure and redesign the workplace to make it possible for workers to practice physical and social distancing in the plant, even if this means production slows down.
- **Slow down the lines and halt all line speed waivers.** As the pandemic raged, the USDA continued to approve regulatory waivers for meat processing plants to increase their maximum line speed. These waivers guarantee more workers are put at risk of either catching or spreading the virus. The USDA must cease granting any new waivers and suspend all existing waivers that allow plants to operate at faster speeds.
- **Ensure that any federal stimulus funds go to food processing companies that respect workers' rights,** pay living wages, provide a safe workplace, and treat their workers with dignity.
- **Require the USDA and companies to provide PPE to meat and poultry slaughter and processing workers.** Though social and physical distancing are essential to preventing the spread of COVID-19, workers still need access to personal protective equipment (PPE), such as masks and gloves. Meatpacking workers need a continuous supply of personal protection equipment to do their job safely and reduce the risk of exposure.
- **Prioritize Food Workers for Testing.** Meatpacking and food processing workers must be prioritized for testing if we are going to protect workers in the workplace from contracting COVID-19, protect the food supply and limit these plant closings.
- **Allow Workers to Quarantine with Pay.** It is critical to identify and isolate workers who have tested positive or who exhibit symptoms of COVID-19.

Honorable Alma Adams
Honorable Bradley Byrne

June 10, 2020

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These workers should be allowed to quarantine at home, with pay and job protections.

- **Protect Workers From Retaliation:** The UFCW believes that strong, anti-retaliation protections must be in place in order to ensure that workers who feel ill, or who are suffering from COVID-19, can remain at home, in quarantine for the full period of time recommended by the CDC, until it is safe to return to work. Workers must be encouraged to report any symptoms of illness, or of COVID-19, while at work, as well as any other safety and health hazards, and not suffer any negative consequences for doing so.

Uniform protections for food workers, including redesigning the workplace to allow for social distancing and providing personal protective equipment will benefit consumers by helping to prevent COVID-19 outbreaks in the workplace. While there is no evidence that COVID-19 spreads through food, workers getting COVID-19 at food processing plants will lead to food supply disruptions. Even at current line speeds it is difficult for federal inspectors and quality control workers to properly check meat for contamination that could make consumers sick. In order for workers and inspectors to be six feet apart, the line needs to be slowed down.

The UFCW International and UFCW Local Unions have been negotiating with employers across the country for PPE and increased benefits for food workers who are working to provide necessary food and supplies to their communities during the coronavirus pandemic. These employer by employer efforts are not enough and millions of food processing workers will be put at risk if uniform and enforceable standards are not implemented.

Like other first responders, food workers are on the front lines of this crisis. These workers have been exposed to health hazards, many have fallen ill, and too many have died, and this is not what they signed up for. Congress must do everything it can to protect food processing workers.

Sincerely,



International President

[Additional submission by Mr. Byrne follows:]

The Washington Post

By Letters to the Editor
April 30, 2020 at 4:18 p.m. EDT

The April 26 front-page article "[Plants' push to maintain meat supply led to illness](#)" claimed that the Occupational Safety and Health Administration (OSHA) had said it would not enforce workplace safety requirements in connection with the novel [coronavirus](#). The article quoted a former Obama administration official asserting that OSHA has "decided to bury its head in the sand" and told workers, "You're on your own." These statements are patently false.

During the coronavirus pandemic, OSHA has addressed thousands of complaints, published five guidance documents aimed at expanding the availability of respirators for health-care workers and conducted targeted outreach to high-risk industries to help employers comply with OSHA's workplace safety standards.

OSHA has a number of enforcement tools available to protect workers from the coronavirus and will use those tools where appropriate. The labor secretary, moreover, spoke on national television to warn, "We will not tolerate retaliation."

The article was a disservice to America's workers for misrepresenting OSHA's position, efforts and resources.

Loren Sweatt, *Washington*

*The writer is principal deputy
assistant secretary of the Occupational
Safety and Health Administration.*

[Questions submitted for the record and their responses follow:]

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June 18, 2020

MINORITY MEMBERS
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Mr. John Howard, MD, MPH, JD, LLM, MBA
 Director
 National Institute for Occupational Safety and Health
 395 E Street SW
 Washington, D.C. 20024

Dear Dr. Howard:

I would like to thank you for testifying at the May 28th Workforce Protections Subcommittee hearing entitled *"Examining the Federal Government's Actions to Protect Workers from COVID-19."*

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Thursday, July 2, 2020 for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
 Chairman

Enclosure

Workforce Protections Subcommittee Hearing
“Examining the Federal Government’s Actions to Protect Workers from COVID-19”
 Thursday, May 28, 2020 10:15 a.m.

Representative Alma Adams (D-NC)

- CDC Guidelines eliminated the requirement that N-95 respirators be used by health care workers working in proximity to patients with actual or suspected COVID-19 infections, except when there are aerosol generating procedures (such as intubation). Hospitals contend that the main route of exposure from the novel coronavirus is droplet transmission and respirators are not required for health care workers in routine contact with confirmed or suspected COVID-19 infected patients.
 - With respect to health care facilities, such as hospitals, is there evidence that the pathogen which causes COVID-19 can be transmitted by aerosol particles (outside of aerosol generating procedures) in quantities capable of causing infection?
 - While CDC Guidelines call for the use of N-95 respirators for aerosol generating procedures, such as endotracheal intubation or bronchoscopy, are surgical masks sufficiently protective for health care workers who are caring for patients with actual or suspected COVID-19?
 - Given the potential for aerosol generation and the large percentage of asymptomatic infections, what are the best respirators for health care workers to be wearing when exposed to confirmed or suspected COVID-19 patients?
- In April, Providence St. John’s Medical Center in Santa Monica, CA, suspended nurses for refusing to enter a coronavirus unit without being provided with N95 respirators. The hospital stated that wearing surgical masks is consistent with a protocol that has been authorized by CDC and threatened to report them to the California Board of Registered Nursing for patient abandonment if they refused.
 - Do you consider the hospital’s actions consistent with CDC guidance?
- The Committee has received reports of hospitals refusing to provide nurses with new N95s after weeks or even months of use unless they are visibly soiled with blood.
 - Do you consider the hospital’s actions consistent with CDC guidance?
- If employers are giving “masks” to bus drivers, corrections officers, nursing home attendants, or warehouse employees with the intention of protecting the wearers from inhaling infectious particles (as opposed to just blocking their sneezes), are surgical or

cloth masks adequately protective?

- Many health care workers are dubious about reusing N-95 respirators. They do not feel safe. Is it the case that N-95 respirators can be successfully disinfected from the coronavirus and reused? What does the science tell us?
 - Do any of the current studies on respirator disinfection take into account the physical deterioration of respirators due to repeated use?
- There has been a severe mismatch between the supply and demand for PPE over the course of the COVID-19 pandemic. Your testimony stated that “domestic manufacturers, like 3M and Honeywell, have doubled or tripled their production capabilities. 3M is making 90 million N95s per month. Honeywell is making 20 million N95s per month.” However, these figures do not provide insight into the widely reported shortages that are persisting, and the requirement that health care workers discard well-defined infection control practices as a means to make supplies last longer.
 - Does the CDC agree that there is a shortage of N-95 masks and essential PPE for health care workers? Please quantify the shortfall.
 - What is the total estimated monthly supply (production and imports) and the monthly burn rate for N95 respirators in the US for the month of May 2020?
 - What is the estimated monthly supply and the burn rate for N-95 respirators for the remainder of this calendar year beginning June 1, 2020, assuming a typical influenza season and a second wave of COVID-19 in the fall and winter of 2020?
 - What is the estimated inventory of N-95 respirators and other essential PPE (gowns, gloves) in the national stockpile as of June 1, 2020?
 - On what date can health care workers in the US expect to have a supply of the necessary PPE without circumventing well established infection control practices?
- Dr. Howard, it has been reported that recommendations in an EPI-AID report conducted by CDC at a Smithfield processing plant in Sioux Falls, South Dakota were watered down between the first draft and the final version that was issued. Recommendations were reportedly reduced to mere “considerations” or actions were deemed “optional”.
 - Was NIOSH involved in the production of that EPI-AID report?
 - Was NIOSH involved in modifying the recommendations?
 - Did NIOSH concur with the modification of the recommendations?

- The final version released by CDC was labeled “Version 2.” Please provide the Committee with a copy of “Version 1”.
- What is the most effective way to keep the coronavirus out of congregate workplaces, such as prisons, nursing homes and meatpacking plants?
- Your testimony discussed NIOSH inspections of 34 meatpacking facilities in 12 states. Your testimony suggests that CDC based its recommendations on the hierarchy of controls, starting with elimination of the hazard or exposures. You state that checking employees’ temperatures for fever is a mechanism to prevent the spread of the disease. But studies show as many as 60% of individuals may be asymptomatic or pre-symptomatic. Consequently, absent regular testing for infection, individuals who are infected with the coronavirus can and will walk into the meatpacking plant completely undetected.
 - Would it be far more effective to keep the virus out of meatpacking plants by requiring regular testing of workers for COVID-19 before entering the plant?
 - How frequently should this testing be done? Weekly? Biweekly?
 - CDC/OSHA has not included any recommendations for regular testing in its guidance for meatpacking plants. Why is this?
 - Has NIOSH staff recommended a mandatory testing regimen to OSHA and CDC? If so, was it rejected?
- Congregate facilities such as correctional facilities are major hotspots for COVID-19. What is CDC/NIOSH’s strategy for protecting inmates and correctional facility workers?
- Does NIOSH have an estimate of the number of workers who have been infected with or died from COVID-19?
 - What kind of surveillance system is needed to better identify and count occupational transmissions of this infectious disease?
 - What specific authorities, directions or resources are needed from Congress to put this occupational disease surveillance system in place?
- On May 8th, the Centers for Medicare and Medicaid Service issued regulations requiring reporting of COVID-19 infections by all nursing homes and long-term care facilities that receive Medicare and Medicaid funding. Individual nursing homes are now required to electronically report information on COVID-19 infections and deaths among residents

and separately on staff members PPE supplies, staffing shortages, and testing and ventilator capacity. CMS has announced these facility reports will be publicly available

- In the interest of getting a more complete picture of health care worker infections and deaths, will CDC also require hospitals to report healthcare worker COVID-19 infections and deaths to the existing reporting requirements, just as now is in place for nursing homes?
 - What measures can CDC take to improve reporting on the state and local level of health care worker infections from COVID-19?
- California OSHA adopted an Airborne Transmissible Disease standard in 2009 covering health care facilities, correctional facilities and mortuaries. It has been applied to the COVID-19 pandemic.
 - Has NIOSH tracked the implementation of this CAL-OSHA standard?
 - Has this standard been effective in improving worker protections from transmissible infectious diseases? Has it been feasible for employers to implement?
 - Has NIOSH advised OSHA regarding its development of an Infectious Disease Standard? What advice has NIOSH provided?
 - Has NIOSH advised OSHA regarding the development of an Emergency Temporary Standard for COVID-19? If so, what advice has NIOSH provided?

Representative Bradley Byrne (R-AL)

- Dr. Howard, I appreciate the CDC's and NIOSH's diligent work to provide timely and industry-specific guidance to employers about how best to reduce hazards faced by workers and the public in the COVID-19 crisis. In my conversations with employers, however, I have heard that in some instances they have questions about the practical application of the guidance in specific situations. Has the CDC and NIOSH considered creating a process where the public could ask and the agency could answer questions about reducing hazards in specific situations? This would provide the CDC and NIOSH greater ability to gather data and potentially address specific hazards related to COVID-19. Other agencies, including the Department of Labor's Wage and Hour Division, have implemented similar programs to collect and answer questions and have hosted calls where the public can submit questions.
- Dr. Howard, the below are several questions I have heard from employers where additional guidance through a Q&A format would be helpful. To the extent possible, please provide answers to the following questions regarding the application of the CDC's

and NIOSH's guidance on social distancing and testing. I urge the agency to make answers to these questions available to the public in the form of guidance as soon as possible.

- a. While the six-foot distancing recommendation is widely known, there are many settings where maintaining that level of separation is not possible. As more companies come back, those types of settings will increase. What should employers do to protect their employees when keeping them six feet apart is not possible?
- b. For example, various workplaces are, by nature, very confined. These include restaurant kitchens, small retail boutiques, certain construction sites, and long-haul trucking and delivery services where the driver is accompanied. What does CDC and NIOSH recommend for these settings where six-foot separation is not possible?
- c. Whether customers are comfortable coming back to various businesses such as restaurants and stores may depend on whether they have confidence that publicly available restrooms have been sufficiently sanitized. What restroom cleaning protocols does CDC and NIOSH recommend?

Representative Greg Murphy (R-NC)

- Dr. Howard, while you are before the Subcommittee, I wanted to take this opportunity to ask about a related healthcare worker safety issue, which is so important during the COVID-19 pandemic. I am referring to the efforts of your agency to develop a protocol that hospitals may use to evaluate the appropriateness of so-called "Closed-System Transfer Devices" used to protect workers who compound or administer hazardous drugs like chemotherapies to patients. This is something in which I have an interest, having been fortunate enough to have served as the Chief of Staff at Vidant Medical Center in Greenville, North Carolina.
 - It is my understanding that your agency has been developing this protocol for a number of years, and you have been exploring various alternative proposals. As you know, it is important that you get this right based on the best available science. But it is also important that your work conclude as expeditiously as possible.
 - Could you give the Committee an estimate of when you will complete work on a protocol? Since this has taken longer than any of us would like, what procedures would you advise hospitals to follow in the interim before you finalize a protocol? Where do your data lead?



**COMMITTEE ON
EDUCATION AND LABOR**
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

June 18, 2020

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Ms. Loren Sweatt, MBA
Principal Deputy Assistant Secretary
Occupational Safety and Health Administration
200 Constitution Avenue, NW
Washington, D.C. 20210

Dear Ms. Sweatt,

I would like to thank you for testifying at the May 28th Workforce Protections Subcommittee hearing entitled *"Examining the Federal Government's Actions to Protect Workers from COVID-19."*

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Thursday, July 2, 2020 for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Workforce Protections Subcommittee Hearing
"Examining the Federal Government's Actions to Protect Workers from COVID-19"
 Thursday, May 28, 2020 10:15 a.m.

Chairman Robert C. "Bobby" Scott (D-VA)

- Has OSHA staff conducted any preliminary work on a draft Emergency Temporary Standard (ETS) for COVID-19? If so, what is the status of that preliminary work product?
- If an OSHA state plan requested a draft ETS for COVID-19 from OSHA, would OSHA provide a copy of its draft ETS for COVID-19?
- If an OSHA state plan requested technical assistance in drafting a state based ETS for COVID-19, would OSHA provide technical assistance in drafting an ETS for COVID-19?
- If an OSHA state plan issues an ETS that has additional safety requirements for COVID-19 beyond that set forth in the OSHA/CDC Guidance for Meat and Poultry Processing Workers and Employers, would OSHA seek to pre-empt that that state standard as inconsistent with the Guidance?
- The HEROES Act (H.R. 6800), which was passed by the House on May 15, 2020, includes a provision in Division L requiring OSHA to issue an Emergency Temporary Standard. That legislation would require employers to prepare an exposure control plan tailored to the particular workplace.
 - What is OSHA's position on this specific legislation? Does it support or oppose it? If opposed, please explain the specific reasons for OSHA's opposition?
 - Would you be prepared to work with the Committee to address OSHA's concerns?

Representative Alma Adams (D-NC)

- Do you believe that COVID-19 presents a "a grave danger" to workers?
 - If not, what is the DOL's threshold for determining whether COVID-19 presents a grave danger to workers?
- CDC reports that as of June 4, 2020, there are almost 80,000 health care workers infected with COVID-19 and over 400 who have died from COVID-19. Does this meet the threshold for COVID-19 to constitute a grave danger to health care workers?
- Last month, OSHA announced a new round of Susan Harwood Worker Training Grants, but these programs won't begin until October.

- In the meantime, is it true that OSHA is prohibiting current grantees from conducting COVID-19 training, or changing the terms of their work plans to include COVID-19 training?
- As you know, following the H1N1 pandemic, OSHA began work in earnest on an Infectious Disease Standard. Although OSHA's Bloodborne Pathogens Standard has been very effective in protecting workers from bloodborne pathogens, it does not address infectious diseases transmitted by other routes (e.g., contact, droplet and airborne). Work on the Infectious Disease Standard was relegated to the long-term agenda in 2017. Please address the following:
 - What remained to be done to issue an official proposal for this Infectious Disease Standard?
 - When do you expect to issue a proposed standard for notice and comment?
 - What specific actions have been taken with respect to the completion of the OSHA Infectious Disease Standard since it was relegated to the long-term agenda? Please list these actions.
 - Who specifically decided to remove the Infectious Disease Standard from the active regulatory agenda? Was this decision made by the Secretary of Labor? Was this decision made by the White House?
 - In addition to COVID-19, workers are also exposed to tuberculosis, influenza, MRSA and other transmissible pathogens (not covered under the bloodborne pathogen standard). What are the benefits to worker safety from finalizing a comprehensive Infectious Disease Standard particularly for health care workers, first responders, and other populations at elevated risk? How do these benefits compare with just relying on existing standards and the General Duty Clause?
 - If the permanent Infectious Disease Standard had been issued prior to the COVID-19 pandemic, would it have provided OSHA with additional tools to protect health care and social assistance workers during the COVID-19 pandemic?
 - Does OSHA intend to resume work on a permanent Infectious Disease Standard this calendar year?
 - What is OSHA's next planned action for a permanent infectious disease standard?
- There has been a widespread and growing number of COVID-19 infections of workers in the meatpacking industry.

- How many complaints has OSHA received regarding conditions in meatpacking and poultry plants?
- How many physical, onsite inspections has OSHA conducted in the meatpacking and poultry industry?
- How many of these inspections has OSHA closed?
- How many citations have been issued following these meatpacking and poultry plant inspections?
- After President Trump issued the April 28, 2020 Executive Order Delegating Authority Under the DPA with Respect to Food Supply Chain Resources During the National Emergency Caused by the Outbreak of COVID-19, you and Solicitor of Labor Kate O'Scannlain issued a statement stating that "OSHA will take into account good faith attempts to follow the Joint Meat Processing Guidance."
 - Who directed you and the Solicitor to issue this Memorandum?
 - Please define "good faith attempts" and provide any instructions to CSHO's describing how to determine whether an employer has made a "good faith attempt" to comply with CDC guidance.
 - Please explain how OSHA defines "feasible" in this context and provide any instructions to CSHO's describing how to determine whether an employer's claim that it was infeasible to comply with CDC guidance is legitimate.
 - How many times has OSHA declined to issue a citation, despite an identified violation of an OSHA standard or the General Duty Clause, because the employer documented a "good faith" attempt to comply with the OSHA/CDC Guidelines? Please provide examples.
 - How many times has OSHA declined to issue a citation, despite an identified violation of an OSHA standard or the General Duty Clause, because the employer documented infeasibility to comply with the OSHA/CDC Guidelines? Please provide examples.
 - Keeping workers infected with COVID-19 out of meatpacking plants is necessary. However, the OSHA/CDC Guidelines say that "Screening meat and poultry processing workers for COVID-19 symptoms (such as temperature checks) is an optional strategy that employers may use." How does an employer show "good faith", since testing is optional?
- Since studies show that many of those who are infected with COVID-19 are asymptomatic, or pre-symptomatic, please explain why screening for fevers prior to employee entry to a meatpacking plant is sufficient to keep the infection out of work

settings?

- Would mandatory testing of employees for COVID-19 on a regular basis prior to entry to a meatpacking plant be more effective than screening for fevers? If so, why has the OSHA/CDC Guidelines not been updated to require this?
- Except for state and local regulations that are of “general applicability”, OSHA’s regulations generally pre-empt the field of worker safety protections in those states where federal OSHA has jurisdiction.
 - Is it DOL’s view that non-binding OSHA Guidance or non-binding OSHA/CDC Guidance pre-empts enforcement actions by state health agencies, if the state health agencies require meat processors to take more protective measures than those in the Joint CDC/OSHA Guidance for Meatpacking Industry?
 - Are regulations and enforcement actions by state health agencies, which are seeking to control infections in congregate workplace settings as a necessary means of controlling community spread, subject to federal pre-emption by OSHA?
- How are you ensuring that OSHA inspectors can perform inspections without putting themselves at risk of infection?
- OSHA officials have stated previously that the Bloodborne Pathogens Standard can be effectively used to keep workplaces safe from COVID-19. Can you explain how this standard is relatable to a virus that is spread through airborne droplets?

Representative Pramila Javapal (D-WA)

- How many on-site inspections has OSHA conducted related to COVID-19?
 - How many remote investigations or inquiries related to COVID-19 has OSHA conducted using remote “Phone-Fax” or Rapid Response Investigation (RRI) procedures?
 - How many of those remote investigations or inquiries were the result of complaints?
 - How many of these remote investigations or inquiries resulted in inadequate responses from the employer?
 - In how many of those remote investigations or inquiries, conducted as a result of complaints, did OSHA contact the complainant to determine if the employer’s assurances were accurate, as described in Chapter 9, Section I(I) of the Field Operations Manual?

- How many Hazard Alert Letters has OSHA issued recommending the implementation of protective measures that address SARS-CoV-2 hazards? Please provide a total, sorted by 4-digit NAICS code.
- How many COVID-19 related fatality reports has OSHA received? Please provide this information sorted by 4-digit NAICS code.
- How many of the fatality reports that OSHA has received were investigated?
- How many of those investigated were conducted by on-site inspections?
- Please provide a list of facilities that have submitted fatality reports to OSHA for deaths due to COVID-19 infections.
- How many of OSHA's fatality investigations for COVID-19 resulted in citations related to the fatality?
- Please describe any actions OSHA is taking to ensure that all COVID-19 work-related fatalities are reported to OSHA.

Representative Bradley Byrne (R-AL)

- Ms. Sweatt, OSHA's recent guidance on recording COVID-19 cases asked employers to ascertain whether an individual came down with COVID-19 as a result of exposure at work. The guidance requires employers to interview employees about other possible sources of exposure. I am concerned about workers' privacy. Does OSHA have suggestions on how to handle privacy concerns?
- Ms. Sweatt, I am also worried about the reliability of this data given that our understanding about transmission, recovering, and asymptomatic infections is constantly evolving and that employers are not equipped to do the type of contact tracing needed to identify sources. Inaccurate data could later be used to make erroneous conclusions or misused to mischaracterize the situation at a workplace or in a community. While I know it's very important for public health agencies to track cases, has OSHA considered alternatives to having employers make cursory and possibly unreliable work-related determinations?

QFRs for May 28, 2020 Committee on Education and Labor
Workforce Protections Subcommittee Hearing—
Examining the Federal Government's Actions to Protect Workers from COVID-19

Representative Alma Adams (D-NC)

CDC Guidelines eliminated the requirement that N-95 respirators be used by health care workers working in proximity to patients with actual or suspected COVID-19 infections, except when there are aerosol generating procedures (such as intubation). Hospitals contend that the main route of exposure from the novel coronavirus is droplet transmission and respirators are not required for health care workers in routine contact with confirmed or suspected COVID-19 infected patients.

- **QUERY 1:** With respect to health care facilities, such as hospitals, is there evidence that the pathogen which causes COVID-19 can be transmitted by aerosol particles (outside of aerosol generating procedures) in quantities capable of causing infection?

RESPONSE:

Currently, CDC Guidelines recommend that healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions (outlined here: <https://www.cdc.gov/hicpac/recommendations/core-practices.html>) and use a National Institute for Occupational Safety and Health (NIOSH)-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. Further information on infection prevention control and prevention recommendations for healthcare personnel during the COVID-19 pandemic is provided here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>.

At present, CDC's understanding is that the virus that causes COVID-19 [spreads mainly from person-to-person](#) in the following ways:

- Between people who are in close contact with one another (within about 6 feet).
 - Through respiratory droplets produced when an infected person coughs, sneezes or talks.
 - These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
 - Some recent studies have suggested that COVID-19 may be spread by people who are not showing symptoms.
- **QUERY 2:** Given the potential for aerosol generation and the large percentage of asymptomatic infections, what are the best respirators for health care workers to be wearing when exposed to confirmed or suspected COVID-19 patients?

RESPONSE: CDC recommends that healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions (outlined here: <https://www.cdc.gov/hicpac/recommendations/core-practices.html>) and use a National Institute for Occupational Safety and Health (NIOSH)-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. N95 respirators include standard and surgical N95 respirators. In the United States, all N95 respirators used in occupational settings are approved by NIOSH and used in accordance with Occupational Safety and Health Administration (OSHA) standards.

It is also acceptable to use NIOSH-approved alternatives to N95 respirators where feasible. These alternatives include other classes of filtering facepiece respirators, elastomeric half-mask and full facepiece air purifying respirators, and powered air purifying respirators (PAPRs). All of these alternatives will provide equivalent or higher protection than N95 respirators when properly worn. NIOSH maintains a searchable, online version of the certified equipment list identifying all NIOSH-approved respirators. Please see <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> for additional information.

However, personal protective equipment (PPE) shortages pose a tremendous challenge to the U.S. healthcare system. CDC has provided optimization strategies that offer options for use when PPE supplies are running critically low or cannot be obtained (available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>).

In April, Providence St. John's Medical Center in Santa Monica, CA, suspended nurses for refusing to enter a coronavirus unit without being provided with N95 respirators. The hospital stated that wearing surgical masks is consistent with a protocol that has been authorized by CDC and threatened to report them to the California Board of Registered Nursing for patient abandonment if they refused.

- **QUERY 3: Do you consider the hospital's actions consistent with CDC guidance?**

RESPONSE:

CDC's infection control guidance (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>) and guidance for use of PPE (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>) continue to stress providing the utmost protection for healthcare personnel (HCP). HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions (<https://www.cdc.gov/hicpac/recommendations/core-practices.html>) and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.

However, PPE shortages pose a tremendous challenge to the U.S. healthcare system. CDC has provided additional guidance on optimizing the supply of PPE (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>), which offers options for use when PPE supplies are running critically low or cannot be obtained. These include strategies to help stretch PPE supplies when shortages are anticipated and additional strategies for use during severe PPE shortages to help stretch available supplies for the most critical needs. CDC's National Institute for Occupational Safety and Health (NIOSH) is also developing an early warning system for detecting PPE supply chain disruptions.

CDC has published crisis capacity strategies for healthcare workers during known shortages. Using facemasks when respirators are recommended is only suggested as an option during crisis capacity conditions. Decisions to implement crisis strategies are based upon these assumptions:

1. Facilities understand their current N95 respirator inventory and supply chain
 2. Facilities understand their N95 respirator utilization rate
(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>)
 3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
 4. Facilities have already implemented contingency capacity measures
(https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirators-strategy%2Fconventional-capacity-strategies.html)
 5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care
- **Query 4: The Committee has received reports of hospitals refusing to provide nurses with new N95s after weeks or even months of use unless they are visibly soiled with blood. Do you consider the hospital's actions consistent with CDC guidance?**

RESPONSE: PPE shortages pose a tremendous challenge to the U.S. healthcare system. CDC has provided additional guidance on optimizing the supply of PPE that offers options for use when PPE supplies are running critically low or cannot be obtained (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>). These options include strategies to help stretch PPE supplies when shortages are anticipated and additional strategies for use during severe PPE shortages to help stretch available supplies for the most critical needs.

Whether and how a facility decides to implement specific crisis strategies is at the discretion of its administrators and should be based on present and projected risk mitigation needs and local, regional, and national availability of N95s.

To reduce the chances of decreased protection caused by a loss of respirator functionality, respiratory program managers should consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model(s) used in that facility.

If no manufacturer guidance is available, preliminary data suggests limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin. The concern with filtering facepiece respirator reuse is that multiple donnings could stress components which over time could impair the fit. The recommendation for 5 donnings is based on results from a 2012 study by Bergman, et al. that found that 5 consecutive donnings can be performed before respirator fit drops below an acceptable level. Each time a respirator is donned is considered a "use."

While disposable filtering facepiece respirators (FFRs), like N95s, are not approved for routine decontamination as conventional standards of care, FFR decontamination may be needed during times of shortage to ensure continued availability. Based on the limited research available, as of April 2020,

ultraviolet germicidal irradiation, vaporous hydrogen peroxide, and moist heat have shown the most promise as potential methods to decontaminate FFRs. CDC summarizes research about decontamination of FFRs before reuse here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>.

- **Query 5: If employers are giving “masks” to bus drivers, corrections officers, nursing home attendants, or warehouse employees with the intention of protecting the wearers from inhaling infectious particles (as opposed to just blocking their sneezes), are surgical or cloth masks adequately protective?**

RESPONSE: Different settings require different levels of protection for workers, depending on the level of interaction with the public; ability to maintain a 6 feet distance from others; and the setting (i.e., retail, restaurant, or warehouse) in which they work. Generally speaking, individuals need to follow healthy hygiene practices, stay at home when sick, practice physical distancing to lower the risk of disease spread, and use a cloth face covering (with some exceptions as outlined here: <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-faq.html>) in

community settings when physical distancing cannot be maintained. These universal precautions are appropriate regardless of the extent of mitigation needed.

CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain, especially in areas of significant community transmission. Cloth face coverings may prevent people who don't know they have the virus from transmitting it to others. These face coverings are not surgical masks or respirators and are not appropriate substitutes for them in workplaces where masks or respirators are recommended or required. In the current COVID-19 pandemic, use of respiratory protection such as surgical masks or N95 respirators are being prioritized for healthcare workers and other medical first responders, as recommended by current CDC guidance. Additional personal protective equipment may be needed based on setting and product.

- **QUERY 6: Many health care workers are dubious about reusing N-95 respirators. They do not feel safe. Is it the case that N-95 respirators can be successfully disinfected from the coronavirus and reused? What does the science tell us?**

RESPONSE: Current CDC recommendations on disinfection of filtering facepiece respirators (FFR) such as N95s are based on the best available evidence. While disposable N95s are not approved for routine decontamination as conventional standards of care, FFR decontamination and reuse may be needed during times of shortage to ensure continued availability. Based on the limited research available, as of April 2020, ultraviolet germicidal irradiation, vaporous hydrogen peroxide, and moist heat have shown the most promise as potential methods to decontaminate FFRs. CDC's decontamination guidance summarizes research about decontamination of FFRs before reuse (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>). Whether and how a facility decides to implement specific crisis strategies is at the discretion of its administrators and should be based on present and projected risk mitigation needs and local, regional, and national availability of N95s.

Before using any decontamination method, it should be evaluated for its ability to retain: 1) filtration performance, 2) fit characteristics achieved prior to decontamination, and 3) safety of the FFR for the wearer (e.g., by inactivating SARS-CoV-2).

Respirator re-use and disinfection should be discontinued as soon as possible once a supply of new N95s can be obtained.

- **QUERY 7: Do any of the current studies on respirator disinfection take into account the physical deterioration of respirators due to repeated use?**

RESPONSE: The existing evidence on respirator disinfection takes into account the physical deterioration of respirators due to repeated use. CDC NIOSH's National Personal Protective Technology Laboratory (NPPTL) and other researchers have investigated the impact of various decontamination methods on filtration efficiency, facepiece fit of FFRs, and the ability to reduce viable virus or bacteria on the FFRs. Information about specific methods of decontamination can be found on our website at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>.

There has been a severe mismatch between the supply and demand for PPE over the course of the COVID-19 pandemic. Your testimony stated that “domestic manufacturers, like 3M and Honeywell, have doubled or tripled their production capabilities. 3M is making 90 million N95s per month. Honeywell is making 20 million N95s per month.” However, these figures do not provide insight into the widely reported shortages that are persisting, and the requirement that health care workers discard well-defined infection control practices as a means to make supplies last longer.

- **QUERY 8: Does the CDC agree that there is a shortage of N-95 masks and essential PPE for health care workers? Please quantify the shortfall.**

RESPONSE: Personal Protective Equipment (PPE) shortages are currently posing a tremendous challenge to the U.S. healthcare system because of the COVID-19 pandemic. Healthcare facilities are having difficulty accessing the needed PPE and are having to identify alternate ways to provide patient care. CDC's NIOSH released a PPE Tracker App (<https://www.cdc.gov/niosh/ppe/ppeapp.html>) to assist facilities in estimating their PPE supplies. Facilities can use the NIOSH PPE Tracker App to calculate their average PPE consumption rate or “burn rate,” and the app provides an estimate of how many days a PPE supply will last given current inventory levels.

Hospital data, including data related to supplies, can be accessed through HHS Protect, a platform for sharing healthcare information, that allows the U.S. government to harness data for the COVID-19 response

CDC's National Healthcare Safety Network (NHSN) collects COVID-19 data from long-term care facilities, including nursing homes. NHSN provided the first national lens into the burden of disease in nursing homes and its impact on staffing and supplies, including PPE. In addition, CDC has shared PPE

shortage data with FEMA and testing supply data with the White House Coronavirus Task Force to assist in their response efforts.

- **QUERY 9: What is the total estimated monthly supply (production and imports) and the monthly burn rate for N95 respirators in the US for the month of May 2020?**

RESPONSE: CDC defers to the HHS Joint Coordination Center (JCC) for this information.

- **QUERY 10: What is the estimated monthly supply and the burn rate for N-95 respirators for the remainder of this calendar year beginning June 1, 2020, assuming a typical influenza season and a second wave of COVID-19 in the fall and winter of 2020?**

RESPONSE: CDC defers to the HHS Joint Coordination Center (JCC) for this information

- **QUERY 11: What is the estimated inventory of N-95 respirators and other essential PPE (gowns, gloves) in the national stockpile as of June 1, 2020?**

RESPONSE: CDC defers to HHS ASPR for this information.

- **QUERY 12: On what date can health care workers in the US expect to have a supply of the necessary PPE without circumventing well established infection control practices?**

RESPONSE: CDC defers to the HHS Joint Coordination Center (JCC) for this information.

Dr. Howard, it has been reported that recommendations in an EPI-AID report conducted by CDC at a Smithfield processing plant in Sioux Falls, South Dakota were watered down between the first draft and the final version that was issued. Recommendations were reportedly reduced to mere “considerations” or actions were deemed “optional”.

- **QUERY 13: Was NIOSH involved in the production of that EPI-AID report?**

RESPONSE: NIOSH was part of a CDC team that visited the Smithfield processing plant in Sioux Falls, SD on April 16 and 17. CDC began working on the memo draft immediately after the site visit concluded on April 17. A pre-clearance draft of the site visit memo was sent to the South Dakota Department of Health on April 20 via email with a copy to Smithfield executives and a member of the Union that works with Smithfield. This is consistent with CDC’s process of partnering with state health departments in this kind of Epi-Aid. The site visit memo was cleared internally by two task forces within the CDC response.

- **QUERY 14: Was NIOSH involved in modifying the recommendations?**

RESPONSE: CDC issued a first version of the site visit memo on April 21. CDC subsequently updated the memo with language to clarify that CDC recommendations are non-binding and recalled the original site visit memo. The second version was sent to the requesters of the Epi-Aid on April 22. While the substance of CDC's recommendations did not change between the first and second version, a sentence was added at the beginning to clarify that this was not a regulatory document and throughout there were some wording changes (couched in "if phrases") to reinforce the non-regulatory nature of the report. These changes clarified that while CDC made recommendations according to the Epi-Aid findings, CDC does not have enforcement authority.

For the purposes of Epi-Aids, CDC is not a regulatory agency; CDC issues non-binding guidance and recommendations. The recommendations in the joint CDC/OSHA meat processing guidance (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>) are designed to help guide employers as they address return to work issues. The feasibility or non-feasibility of these recommendations was important to emphasize, as CDC does not intend its guidance to be used as non-discretionary standards by states and other regulatory bodies.

Because the science is still evolving related to COVID-19, the effectiveness and feasibility of controls is not fully known, especially in terms of the exposure science and intervention effectiveness as related to COVID-19. This is in contrast to making recommendations in other public health situations. For example, in addressing an occupational chemical exposure, levels of exposure and the effectiveness of control measures are typically well known, which allows us to make much more precise recommendations.

- **QUERY 15: Did NIOSH concur with the modification of the recommendations?**

RESPONSE: The CDC field team that deployed to the Smithfield plant was led by a NIOSH expert, and NIOSH experts were involved with the drafting and clarifying changes made to the report.

- **QUERY 16: The final version released by CDC was labeled "Version 2." Please provide the Committee with a copy of "Version 1".**

RESPONSE: Please see the included copy of Version 1.

- **QUERY 17: What is the most effective way to keep the coronavirus out of congregate workplaces, such as prisons, nursing homes and meatpacking plants?**

RESPONSE: CDC has developed guidance to support a variety of facilities and workplaces to reduce the risk of spread of COVID-19. The latest guidance on Communities, Schools, Workplaces, and Events is

posted here: <https://www.cdc.gov/coronavirus/2019-ncov/community/index.html> Tailored recommendations for select facilities can be found here:

1. Businesses: <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.html>
2. Correctional facilities: <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>
3. Nursing homes: <https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/index.html>
4. Meat and poultry processing plants: <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>
 - [Eight key strategies highlighted in this one pager - https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/FS-MeatProcessing-EMPLOYERS.pdf.](https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/FS-MeatProcessing-EMPLOYERS.pdf)

Guidance for other workplace settings can be found at <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/index.html>

Your testimony discussed NIOSH inspections of 34 meatpacking facilities in 12 states. Your testimony suggests that CDC based its recommendations on the hierarchy of controls, starting with elimination of the hazard or exposures. You state that checking employees' temperatures for fever is a mechanism to prevent the spread of the disease. But studies show as many as 60% of individuals may be asymptomatic or pre-symptomatic. Consequently, absent regular testing for infection, individuals who are infected with the coronavirus can and will walk into the meatpacking plant completely undetected.

QUERY 18: Would it be far more effective to keep the virus out of meatpacking plants by requiring regular testing of workers for COVID-19 before entering the plant?

RESPONSE: Outbreaks of illness among workers in food-producing facilities and surrounding communities have raised unique questions that identified the need for testing for COVID-19 to supplement existing guidance. On June 13, CDC posted a testing strategy to supplement existing guidance which provides options for testing of workers exposed to a COVID-19 case. This testing document (<https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>) may be utilized when public health organizations and employers determine testing is needed to help support existing disease control measures. Such strategies can aid in identifying infectious individuals with the goal of reducing transmission of SARS-CoV-2 in the workplace. These strategies augment and do not replace existing guidance.

CDC recommends that a testing strategy should only be implemented if results will lead to specific actions. If a testing strategy is implemented, when a confirmed case of COVID-19 is identified, interviewing and testing potentially exposed co-workers should occur as soon as possible to reduce the

risk of further workplace transmission. Testing should be implemented in consultation with the state, territorial, or local health departments or through occupational health providers. More information can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>.

Testing is one element of infection control to prevent the spread of COVID-19 in facilities. CDC recommends that workplaces such as meatpacking plants take a variety of actions to prevent infection. Along with screening and monitoring workers' health, CDC recommends that businesses consider implementing the following:

1. Engineering controls such as modifying the alignment of workstations, using physical barriers, and ensuring adequate ventilation;
2. Administrative controls to promote social distancing such as staggered schedules, visual cues such as signs, and requiring the use of cloth face coverings;
3. Education and training staff about reducing the spread of COVID-19 in languages spoken and understood by employees;
4. Establishing protocols to increase the frequency and sanitization in work and common spaces; and
5. Screening and monitoring workers.

This guidance can be found at <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>. Additional guidance from the Occupational Safety and Health Administration (OSHA) can also be found at <https://www.osha.gov/Publications/OSHA3990.pdf>.

• **QUERY 19: How frequently should this testing be done? Weekly? Biweekly?**

RESPONSE: CDC recommends that meatpacking and other high-density, critical infrastructure work settings consider implementing a testing strategy as one tool available to aid in reducing transmission of illness in the workplace after a COVID-19 case is identified at the workplace. This testing strategy provides a risk-based approach to evaluating exposed co-workers and prioritizing testing for workers most likely to be exposed, and therefore most likely to become infected. The testing strategy also discusses options for testing more broadly in the event public health organizations or employers decide this is the best option for workforce health.

The current testing strategy for workers exposed to a case of COVID-19 is based on the available literature and data regarding timing of testing in relation to when an exposed person might become infectious and transmit disease to others. If the testing strategy is implemented, an initial or baseline test should be done as soon as possible after exposure. Testing at different points in time, also referred to as serial testing, may be more likely to detect acute infection among workers with repeat exposures than testing done at a single point in time. For critical infrastructure workplaces that do not implement the 14-day quarantine of exposed workers, two different serial testing approaches are outlined in the strategy. The testing strategy does not replace other protections to protect worker

health. These strategies incorporate repeat (serial) testing of potentially exposed workers, because testing right after the exposure is identified (baseline testing) may not identify everyone who will become infected. A testing interval of 3 days is suggested in order to quickly identify and isolate exposed workers who develop infection. This information is further described on CDC's website: <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>.

The testing strategies described above are designed to be implemented after a COVID-19 case is identified in a worker, as part of CDC's considerations under *Recommended testing for asymptomatic individuals with known or suspected exposure to SARS-CoV-2 to control transmission* (https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fclinical-criteria.html#asymptomatic_exposure). CDC also provides recommendations for testing asymptomatic individuals who do not have known or suspected SARS-CoV-2 exposure to support early identification in special settings, such as those that can experience rapid spread of SARS-CoV-2 (available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fclinical-criteria.html#asymptomatic_without_exposure). This may include high density critical infrastructure work settings where COVID-19 cases have not yet (or not recently) been identified. Facilities are encouraged to work with local, territorial, and state health departments to help inform decision-making about broad-based testing. Before testing large numbers of asymptomatic individuals without known or suspected exposure, the facility should have a plan in place for how it will modify operations based on test results.

- **QUERY 20: CDC/OSHA has not included any recommendations for regular testing in its guidance for meatpacking plants. Why is this?**

RESPONSE: Localities face different circumstances with regard to the COVID-19 pandemic. On June 13, CDC developed and posted information separate from the CDC/OSHA guidance for meatpacking plants to provide testing strategy options for exposed co-workers in high-density, critical infrastructure work settings (such as meatpacking plants). Such strategies can aid in identifying infectious individuals with the goal of reducing transmission of SARS-CoV-2 in the workplace. These strategies augment existing guidance and are available here: <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>.

Testing is one element of infection control to prevent the spread of COVID-19 in facilities. CDC recommends that workplaces such as meatpacking plants take a variety of actions to prevent infection. Along with screening and monitoring workers' health, CDC recommends that businesses consider implementing the following:

1. Engineering controls such as modifying the alignment of workstations, using physical barriers, and ensuring adequate ventilation;
2. Administrative controls to promote social distancing such as staggered schedules, visual cues such as signs, and requiring the use of cloth face coverings;

3. Education and training about reducing the spread of COVID-19;
4. Establishing protocols to increase the frequency and sanitization in work and common spaces; and
5. Screening and monitoring workers.

For facilities that wish to implement a testing strategy, CDC has provided a suggested strategy that can be found at <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>.

- **QUERY 21: Has NIOSH staff recommended a mandatory testing regimen to OSHA and CDC? If so, was it rejected?**

RESPONSE: NIOSH has not recommended a mandatory testing regimen to OSHA and CDC. NIOSH has been an active participant in development of CDC information about optional testing strategies in [high-density critical infrastructure workplaces](#) and [non-healthcare workplaces](#).

- **QUERY 22: Congregate facilities such as correctional facilities are major hotspots for COVID-19. What is CDC/NIOSH's strategy for protecting inmates and correctional facility workers?**

RESPONSE: Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

CDC issued interim guidance for correctional and detention facilities (<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>), which is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness** (<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#operational-preparedness>). This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention** (<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#prevention>). This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening of

new intakes, visitors, and staff, continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).

- **Management** (<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#management>). This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

On June 17, CDC updated the FAQs for Correctional and Detention Facilities

(<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/faq.html>).

Facilities can contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying actions or concerns not specifically covered in the CDC guidance.

- **QUERY 23: Does NIOSH have an estimate of the number of workers who have been infected with or died from COVID-19?**

RESPONSE: Throughout the pandemic, NIOSH has been working with other parts of CDC to recommend that information be collected about the jobs of all workers with COVID-19, but collecting such information has been challenging, as described in a recent NIOSH Science Blog post (<https://blogs.cdc.gov/niosh-science-blog/2020/06/11/covid-surveillance/>). CDC recommends that healthcare providers report cases of COVID-19 to their local or state health department immediately. CDC provides guidance and standard case report forms to collect and submit data as part of case reporting and notifications sent to CDC. These data are included in the National Notifiable Diseases Surveillance System (NNDSS). The case report forms are kept brief to minimize the burden on health department staff conducting case investigations.

Before May 5, the only data collected on work in the CDC case report form was whether the patient was a healthcare worker. As of June 26, 2020, 85,577 cases, including 472 deaths, reported to CDC were identified among healthcare workers. This number is now updated daily on CDC's website (<https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>).

The revised CDC COVID-19 case report form released May 5 added questions about categories of healthcare personnel and about workplace exposures in critical infrastructure. States were asked to start using this new form by May 15. Data about cases among workers collected using the new form are currently being analyzed.

A standardized message mapping guide for COVID-19 is currently under development and will support collection of one or multiple occupations and industries for each case, so that standardized data elements and responses can be collected and submitted to CDC through NNDSS. As NIOSH waits for

these changes to yield data, we are trying to learn more about the burden of COVID-19 among various occupations and industries through other data collected by CDC, state and local health departments, and other organizations.

CDC also tracks the number of outbreaks in high-risk settings such as food processing facilities via situational awareness methods. By investigating outbreaks, CDC has learned about, and reported on, cases among other groups of U.S. workers. For example:

- As of April 27, 4,913 cases, including 20 deaths, among meat and poultry processing workers had been reported to CDC from 19 states (https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e3.htm?s_cid=mm6918e3_w).
- As of April 15, 33 cases were identified among homeless shelter staff in 4 cities (https://www.cdc.gov/mmwr/volumes/69/wr/mm6917e1.htm?s_cid=mm6917e1_w).
- As of April 21, 2,778 cases, including 15 deaths, were identified among correctional and detention facility staff (https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm?s_cid=mm6919e1_e&deliveryName=USCDC_921-DM27552).
- **QUERY 24: What kind of surveillance system is needed to better identify and count occupational transmissions of this infectious disease?**

RESPONSE: CDC maintains the National Notifiable Disease Surveillance System (NNDSS) which is designed to capture occurrence of over 120 designated infectious diseases and chronic conditions. In Spring 2020, Council of State and Territorial Epidemiologists, in coordination with CDC programs, designated COVID-19 a notifiable condition. However, case notification to CDC is based on voluntary submission of case data by each jurisdiction. This system works well and may identify work-related cases of COVID-19 if the case data reported to CDC/NIOSH include specific information on an individual's job and type of business they work in.

In this situation, for case reporting of acute infectious diseases, such as COVID-19, CDC recommends asking all employed people about their current occupation (type of job) and industry (employer's type of business). Ideally, these two pieces of information should be recorded as free text that can be coded to standard occupation and industry classification systems, so that consistency can be maintained across data collection efforts. Guidance for collecting these data can be found on the NIOSH topic page [Collecting and Using Industry and Occupation Data](https://www.cdc.gov/niosh/topics/coding/collect.html) (<https://www.cdc.gov/niosh/topics/coding/collect.html>) and in the Council of State and Territorial Epidemiologists (CSTE) Occupational Health Subcommittee's Recommended Interim Guidance for Collecting Employment Information about COVID-19 (https://cdn.ymaws.com/www.cste.org/resource/resmgr/publications/Guidance_collecting_io_covid.pdf).

A standardized message mapping guide (MMG) for COVID-19 that is currently being implemented by the first states supports collection of one or multiple occupations and industries for each case. This will

standardize the data elements and responses and allow it to be collected and submitted to CDC through the National Notifiable Diseases Surveillance System (NNDSS). However, there are limitations in using case surveillance systems as the means for capturing occupational information, which is often missing from initial COVID-19 case reports. Additional means, such as contact tracing interviews with those who test positive will identify potential disease transmission opportunities, including workplaces. The CSTE Occupational Health Subcommittee is developing guidance to help identify COVID-19 cases that may be work-related, for surveillance purposes.

- **QUERY 25: What specific authorities, directions or resources are needed from Congress to put this occupational disease surveillance system in place?**

RESPONSE: CDC has broad authority through the Public Health Service Act to collect disease surveillance data. Similarly, NIOSH has authority through the OSH Act to collect occupational surveillance data; therefore, additional authority is not needed at this time.

On May 8th, the Centers for Medicare and Medicaid Service issued regulations requiring reporting of COVID-19 infections by all nursing homes and long-term care facilities that receive Medicare and Medicaid funding. Individual nursing homes are now required to electronically report information on COVID-19 infections and deaths among residents and separately on staff members PPE supplies, staffing shortages, and testing and ventilator capacity. CMS has announced these facility reports will be publicly available.

- **QUERY 26: In the interest of getting a more complete picture of health care worker infections and deaths, will CDC also require hospitals to report healthcare worker COVID- 19 infections and deaths to the existing reporting requirements, just as now is in place for nursing homes?**

RESPONSE: On April 10, 2020, Secretary Azar sent a letter to all hospital administrators requesting that they submit crucial hospital capacity data to the federal government for the purposes of the emergency response. In this letter, Secretary Azar described several methods through which hospitals could report these essential data, and CDC's National Healthcare Safety Network (NHSN) is one of these methods. NHSN is the system that CMS requires for the nursing home reporting mentioned above. At this time, the hospital reporting in NHSN collects information about the availability and shortages of key resources, including hospital beds, intensive care unit beds, ventilators, personal protective equipment (PPE), and healthcare personnel. Related to healthcare personnel, NHSN collects data related to current and anticipated shortages, but does not collect information related to healthcare personnel infections in hospitals at this time.

The Human Infection with 2019 Novel Coronavirus Case Report Form (<https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf>) includes a field called Healthcare Worker Information. CDC encourages providers to fill in this portion of the form in order to determine which COVID-19 case patients were healthcare workers.

Healthcare Worker Information

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

If yes, what is their occupation (type of job)?

☐ Physician	☐ Respiratory therapist	☐ Other, specify: _____	☐ Hospital	☐ Rehabilitation facility	☐ Other, specify: _____
☐ Nurse	☐ Environmental services	☐ Unknown	☐ Long-term care facility	☐ Nursing home/assisted living facility	☐ Unknown

If yes, what is their job setting?

- **QUERY 27: What measures can CDC take to improve reporting on the state and local level of health care worker infections from COVID-19?**

RESPONSE: CDC continues to assess means by which to improve reporting on healthcare personnel (HCP) COVID-19 infections at the state and local levels.

A current activity that can improve this type of reporting is the CMS requirement that long-term care facilities use CDC's NHSN long-term care COVID-19 module to report COVID-19 cases. Within this NHSN module, long-term care facilities can also report cases of healthcare worker infections from COVID-19.

California OSHA adopted an Airborne Transmissible Disease standard in 2009 covering health care facilities, correctional facilities and mortuaries. It has been applied to the COVID-19 pandemic.

- **QUERY 28: Has NIOSH tracked the implementation of this CAL-OSHA standard?**

RESPONSE: NIOSH was not involved in the development of the CAL-OSHA Airborne Transmissible Disease standard and has not tracked its implementation.

- **QUERY 29: Has this standard been effective in improving worker protections from transmissible infectious diseases? Has it been feasible for employers to implement?**

RESPONSE: NIOSH has not tracked the implementation of this CAL-OSHA standard and cannot comment on its effectiveness or feasibility.

- **QUERY 30: Has NIOSH advised OSHA regarding its development of an Infectious Disease Standard? What advice has NIOSH provided?**

RESPONSE: In August 2010, NIOSH provided formal comments to a federal OSHA Request for Information on Infectious Diseases, OSHA Docket No. OSHA-2010-0003 (<https://www.osha.gov/dsg/id/OSHA-2010-0003-0001.pdf>). OSHA requested information on occupational exposure to infectious agents in settings where healthcare is provided (e.g., hospitals, outpatient clinics, clinics in schools and correctional facilities), and healthcare-related settings (e.g., laboratories that handle potentially infectious biological materials, medical examiner offices and mortuaries). OSHA stated they would use the information "to determine what action, if any, the Agency may take to further limit the spread of occupationally-acquired infectious diseases in these types of settings."

- **QUERY 31:** Has NIOSH advised OSHA regarding the development of an Emergency Temporary Standard for COVID-19? If so, what advice has NIOSH provided?

RESPONSE: NIOSH has not advised OSHA regarding the development of an Emergency Temporary Standard for COVID-19.

Representative Bradley Byrne (R-AL)

Dr. Howard, I appreciate the CDC's and NIOSH's diligent work to provide timely and industry-specific guidance to employers about how best to reduce hazards faced by workers and the public in the COVID-19 crisis. In my conversations with employers, however, I have heard that in some instances they have questions about the practical application of the guidance in specific situations.

- **QUERY 32:** Has the CDC and NIOSH considered creating a process where the public could ask, and the agency could answer questions about reducing hazards in specific situations? This would provide the CDC and NIOSH greater ability to gather data and potentially address specific hazards related to COVID-19. Other agencies, including the Department of Labor's Wage and Hour Division, have implemented similar programs to collect and answer questions and have hosted calls where the public can submit questions.

RESPONSE: CDC-INFO is CDC's national contact center (<https://www.cdc.gov/cdc-info/index.html>). CDC-INFO offers live agents by phone and email to provide the latest, reliable, and science-based health information on COVID-19 and 750 other topics. It currently operates 24 hours a day, 7 days a week. Specific questions that cannot be answered by CDC-INFO operators using standard responses are passed along to subject matter experts for a response. From January 20 to June 20, 30,902 inquiries related to occupational safety and health made up about 10% of the total coming into CDC-INFO. Of these, 28,286 were answered by operators using NIOSH-prepared responses and 2,616 inquiries were elevated to NIOSH's experts in industrial hygiene, engineering, PPE, epidemiology, and communications for a response.

Additionally, NIOSH responds to public questions on personal protective equipment (PPE) through PPEConcerns@cdc.gov. This mailbox was established before the COVID-19 pandemic, and from January 1 to June 20, NIOSH has responded to 4,367 inquiries about COVID-19 through PPE Concerns, 15 times the usual number. The information gathered through both CDC-INFO and PPE Concerns informs CDC guidance. For example, the General Business FAQ (<https://www.cdc.gov/coronavirus/2019-ncov/community/general-business-faq.html>) was developed and has been periodically updated in response to inquiries.

NIOSH has also engaged with many stakeholder groups through calls and webinars. NIOSH has collaborated with 72 partner organizations to participate in 24 calls with an average of 122 participants and 29 webinars with an average of 420 participants. Nearly every one of these calls and webinars includes the opportunity to ask questions during the event or to send them in advance. For example,

NIOSH is a routine participant in the weekly CDC Private Sector Partner call, which is open to the public and then recorded and posted online.

Dr. Howard, the below are several questions I have heard from employers where additional guidance through a Q&A format would be helpful. To the extent possible, please provide answers to the following questions regarding the application of the CDC's and NIOSH's guidance on social distancing and testing. I urge the agency to make answers to these questions available to the public in the form of guidance as soon as possible.

- **QUERY 33:** While the six-foot distancing recommendation is widely known, there are many settings where maintaining that level of separation is not possible. As more companies come back, those types of settings will increase. What should employers do to protect their employees when keeping them six feet apart is not possible? For example, various workplaces are, by nature, very confined. These include restaurant kitchens, small retail boutiques, certain construction sites, and long-haul trucking and delivery services where the driver is accompanied. What does CDC and NIOSH recommend for these settings where six-foot separation is not possible?

RESPONSE: CDC has developed a variety of guidance materials for businesses, including those with settings in which employees are unable to maintain a distance of 6 feet apart. CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain, **especially** in areas of significant community-based transmission. Wearing a cloth face covering, however, does not replace the need to practice social distancing.

All employers need to consider how best to decrease the spread of COVID-19 and lower the impact in their workplaces. This could include activities to:

- prevent and reduce transmission among employees,
- maintain healthy business operations, and
- maintain a healthy work environment.

Businesses can take the following measures to decrease the spread of COVID-19.

- **Engineering Controls:** Assess job hazards for feasibility of engineering controls such as configuring partitions as a barrier shield; moving electronic payment readers away from cashiers; and using verbal announcements, signage, and visual cues to promote social distancing.
- **Administrative controls:**
 - Management and communications such as monitoring state and local public health communications about COVID-19; encouraging sick workers to report symptoms, stay home, and follow CDC guidance; and promoting social distancing; and cloth face coverings.

- Clean and disinfect frequently touched surfaces and provide employees with disinfectant supplies such as wipes and sprays.
- Provide employees with training on policies to reduce the spread of COVID-19 and general hygiene.
- PPE: Conduct a workplace hazard assessment to determine what PPE is needed for workers based on specific job duties.

More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html>. OSHA has also provided information on returning to work, which is available here: <https://www.osha.gov/Publications/OSHA4045.pdf>.

- **QUERY 33: Whether customers are comfortable coming back to various businesses such as restaurants and stores may depend on whether they have confidence that publicly available restrooms have been sufficiently sanitized. What restroom cleaning protocols does CDC and NIOSH recommend?**

RESPONSE: CDC has developed guidance for disinfecting facilities, including restrooms. This guidance can be found at <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>. Some recommendations from these guidelines are as follows:

1. Clean surfaces using soap and water, then use disinfectant.
2. Practice routine cleaning of frequently touched surfaces, and more frequent cleaning and disinfection may be required based on level of use. Toilets, faucets, and sinks are defined as high touch surfaces.
3. Recommend use of EPA-registered household disinfectant. Follow the instructions on the label to ensure safe and effective use of the product.

Representative Greg Murphy (R-NC)

Dr. Howard, while you are before the Subcommittee, I wanted to take this opportunity to ask about a related healthcare worker safety issue, which is so important during the COVID-19 pandemic. I am referring to the efforts of your agency to develop a protocol that hospitals may use to evaluate the appropriateness of so-called “Closed-System Transfer Devices” used to protect workers who compound or administer hazardous drugs like chemotherapies to patients. This is something in which I have an interest, having been fortunate enough to have served as the Chief of Staff at Vidant Medical Center in Greenville, North Carolina.

It is my understanding that your agency has been developing this protocol for a number of years, and you have been exploring various alternative proposals. As you know, it is important that you get this right based on the best available science. But it is also important that your work conclude as expeditiously as possible.

- **QUERY 34: Could you give the Committee an estimate of when you will complete work on a protocol? Since this has taken longer than any of us would like, what procedures would you advise hospitals to follow in the interim before you finalize a protocol? Where do your data lead?**

RESPONSE: NIOSH anticipates that the research and initial writing portion of the protocol will be completed within 3 months after the researchers are able to safely return to the laboratory. At that point, the updated draft would be released into the public domain to initiate the appropriate review and clearance process. The scientists and engineers working on this project have not been able to access their laboratories since March 15, 2020, due to the COVID-19 pandemic.

Until there is a universal test protocol for all Closed-System Transfer Devices (CSTD) technologies, healthcare facilities could use the following approach to select a safe and appropriate CSTD:

1. **For barrier-type CSTD:** The hospital could ask the manufacturers for evidence of third-party testing of the CSTD. The third-party could use the *draft* NIOSH Protocol: A Vapor Containment Performance Protocol for Closed System Transfer Devices Used During Pharmacy Compounding and Administration of Hazardous Drugs (<https://www.cdc.gov/niosh/docket/review/docket288/pdfs/a-vapor-containment-performance-protocol-for-closed-system-transfer-devices.pdf>). NIOSH data gathered during the development of the draft protocol and testing conducted since the 2016 review showed that the draft protocol was effective for evaluating barrier-type CSTDs. Additional questions to ask the CSTD manufacturers include: a) whether the CSTD has received FDA's ONB product code clearance and b) if there are any drugs for which their CSTD is not compatible. ONB is a product code specific for CSTDs.
2. **For air-cleaning type of CSTD:** The hospital could ask the CSTD manufacturer for evidence of third-party testing. The hospital should request information on how the device was tested to validate containment efficacy. Additional questions might include: a) which drugs or surrogates was the CSTD tested against; b) was the CSTD tested against the drugs alone or also against a wide range of drugs plus their diluent additives; c) has the CSTD received FDA's ONB product code clearance; and d) if there are any drugs for which their CSTD is not compatible.

Responses of Loren Sweatt, Principal Deputy Assistant Secretary, Occupational Health and Safety Administration, U.S. Department of Labor, to Questions for the Record stemming from May 28, 2020, hearing of the Subcommittee on Workforce Protections, Committee on Education and Labor, U.S. House of Representatives

QUESTIONS SUBMITTED BY REPRESENTATIVE ROBERT C. SCOTT

Mr. Scott: Has OSHA staff conducted any preliminary work on a draft Emergency Temporary Standard (ETS) for COVID-19? If so, what is the status of that preliminary work product?

Ms. Sweatt: The Occupational Safety and Health Administration (OSHA) may issue an Emergency Temporary Standard (ETS) only if it is “necessary to protect employees from” an identified grave danger. An ETS is necessary only where it would substantially reduce the grave danger during the six months it serves as the standard (before the statute requires a permanent rule) and that such reduction in danger could not be obtained by enforcement of existing standards, requirements administered by other health authorities, or by widespread voluntary compliance. OSHA has determined this steep threshold is not met with regard to COVID-19, at least not at this time. OSHA’s existing standards, such as its respiratory protection, personal protective equipment, and sanitization standards, as well as the Occupational Safety and Health Act’s General Duty Clause, already address COVID-19. Issuing an ETS would be counterproductive to OSHA’s COVID-19-related efforts. OSHA’s time and resources are better spent issuing industry-specific guidance that adds substance and permits flexibility as more is learned about this virus. Given more is learned about COVID-19 every day, carving rules in stone through an ETS (and later a permanent rule) may undermine worker protection by permanently mandating precautions that later prove to be inefficacious. Last month, the United States Court of Appeals for the District of Columbia Circuit concluded that “OSHA reasonably determined that an ETS is not necessary at this time.” *In re: Am. Fed’n of Labor & Cong. of Indus. Organizations*, Petitioner, No. 20-1158, 2020 WL 3125324, at *1 (D.C. Cir. June 11, 2020).

Mr. Scott: If an OSHA state plan requested a draft ETS for COVID-19 from OSHA, would OSHA provide a copy of its draft ETS for COVID-19?

Ms. Sweatt: OSHA may issue an ETS only if it is “necessary to protect employees from” an identified grave danger. An ETS is necessary only where it would substantially reduce the grave danger during the six months it serves as the standard (before the statute requires a permanent rule) and that such reduction in danger could not be obtained by enforcement of existing standards, requirements administered by other health authorities, or by widespread voluntary compliance. OSHA has determined this steep threshold is not met with regard to COVID-19, at least not at this time. OSHA’s existing standards, such as its respiratory protection, personal protective equipment, and sanitization standards, as well as the Occupational Safety and Health Act’s General Duty Clause, already address COVID-19. Issuing an ETS would be counterproductive to OSHA’s COVID-19-related efforts. OSHA’s time and resources are better spent issuing industry-specific guidance that adds substance and permits flexibility as more is learned about this virus. Given that more is learned about COVID-19 every day, carving rules in

stone through an ETS (and later a permanent rule) may undermine worker protection by permanently mandating precautions that later prove to be inefficacious. Last month, the United States Court of Appeals for the District of Columbia Circuit concluded that “OSHA reasonably determined that an ETS is not necessary at this time.” *In re: Am. Fed’n of Labor & Cong. of Indus. Organizations*, Petitioner, No. 20-1158, 2020 WL 3125324, at *1 (D.C. Cir. June 11, 2020).

Mr. Scott: If an OSHA state plan requested technical assistance in drafting a state based ETS for COVID-19, would OSHA provide technical assistance in drafting an ETS for COVID-19?

Ms. Sweatt: OSHA may issue an Emergency Temporary Standard (ETS) only if it is “necessary to protect employees from” an identified grave danger. An ETS is necessary only where it would substantially reduce the grave danger during the six months it serves as the standard (before the statute requires a permanent rule) and that such reduction in danger could not be obtained by enforcement of existing standards, requirements administered by other health authorities, or by widespread voluntary compliance. OSHA has determined this steep threshold is not met with regard to COVID-19, at least not at this time. OSHA’s existing standards, such as its respiratory protection, personal protective equipment, and sanitization standards, as well as the Occupational Safety and Health Act’s General Duty Clause, already address COVID-19. Issuing an ETS would be counterproductive to OSHA’s COVID-19-related efforts. OSHA’s time and resources are better spent issuing industry-specific guidance that adds substance and permits flexibility as more is learned about this virus. Given that more is learned about COVID-19 every day, carving rules in stone through an ETS (and later a permanent rule) may undermine worker protection by permanently mandating precautions that later prove to be inefficacious. Last month, the United States Court of Appeals for the District of Columbia Circuit concluded that “OSHA reasonably determined that an ETS is not necessary at this time.” *In re: Am. Fed’n of Labor & Cong. of Indus. Organizations*, Petitioner, No. 20-1158, 2020 WL 3125324, at *1 (D.C. Cir. June 11, 2020).

Mr. Scott: If an OSHA state plan issues an ETS that has additional safety requirements for COVID-19 beyond that set forth in the OSHA/CDC Guidance for Meat and Poultry Processing Workers and Employers, would OSHA seek to pre-empt that that state standard as inconsistent with the Guidance?

Ms. Sweatt: OSHA covers most private sector employers and workers in all 50 states, the District of Columbia, and the other United States (U.S.) jurisdictions – either directly through OSHA or through an OSHA-approved State Plan. Twenty-two states or territories have OSHA-approved State Plans that cover both private and state and local government workers, and an additional five states and one U.S. territory (Virgin Islands) have OSHA-approved State Plans that cover state and local government workers only. These State Plans are required to have standards, and programs enforcing those standards, that are at least as effective as Federal OSHA’s, but may have additional or more stringent requirements.

Mr. Scott: The HEROES Act (H.R. 6800), which was passed by the House on May 15, 2020, includes a provision in Division L requiring OSHA to issue an Emergency

Temporary Standard, That legislation would require employers to prepare an exposure control plan tailored to the particular workplace.

What is OSHA's position on this specific legislation? Does it support or oppose it? If opposed, please explain the specific reasons for OSHA's opposition?

Ms. Sweatt: As stated in the May 14, 2020, Statement of Administration Policy, the Administration opposes H.R. 6800, the Health Economic Recovery Omnibus Emergency Solutions (HEROES) Act.

OSHA may issue an ETS only if it is "necessary to protect employees from" an identified grave danger. 29 U.S.C. § 655(c)(1). An ETS is necessary only where it would substantially reduce the grave danger during the six months it serves as the standard (before the statute requires a permanent rule) and that such reduction in danger could not be obtained by enforcement of existing standards, requirements administered by other health authorities, or by widespread voluntary compliance. *See, e.g., Asbestos Info. Ass'n/N. Am. v. OSHA*, 727 F.2d 415, 426 (5th Cir. 1984); *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1156 (D.C. Cir. 1983). OSHA has determined this steep threshold is not met with regard to COVID-19, at least not at this time. OSHA's existing standards, such as its respiratory protection, personal protective equipment, and sanitization standards, as well as the Occupational Safety and Health Act's General Duty Clause, already address COVID-19. Issuing an ETS would be counterproductive to OSHA's COVID-19-related efforts. OSHA's time and resources are better spent issuing industry-specific guidance that adds real substance and permits flexibility as more is learned about this virus. Given that more is learned about COVID-19 every day, carving rules in stone through an ETS (and later a permanent rule) may undermine worker protection by permanently mandating precautions that later prove to be inefficacious. Last month, the United States Court of Appeals for the District of Columbia Circuit concluded that "OSHA reasonably determined that an ETS is not necessary at this time." *In re: Am. Fed'n of Labor & Cong. of Indus. Organizations*, Petitioner, No. 20-1158, 2020 WL 3125324, at *1 (D.C. Cir. June 11, 2020).

Mr. Scott: Would you be prepared to work with the Committee to address OSHA's concerns?

Ms. Sweatt: The Department of Labor and OSHA always stand ready to provide technical assistance.

QUESTIONS SUBMITTED BY REPRESENTATIVE ALMA ADAMS

Ms. Adams: Do you believe that COVID-19 presents "a grave danger" to workers?

Ms. Sweatt: The Occupational Safety and Health Administration (OSHA) recognizes the risk COVID-19 presents to society at large. Ensuring worker safety and health during the COVID-19 pandemic has been, and remains, OSHA's top priority as the nation works together to reduce the disease's spread.

Ms. Adams: If not, what is the DOL's threshold for determining whether COVID-19

presents a grave danger to workers?

Ms. Sweatt: Making that determination is fact specific. As OSHA explained in recent litigation, a “grave danger” is a degree of risk higher than the “significant risk” required to promulgate a permanent safety and health standard under Section 6(b) of the Occupational Safety and Health Act (OSH Act). *Compare Indus. Union Dep’t, AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 639 (1980) (permanent standard), *with Dry Color Mfrs. Ass’n v. Dep’t of Labor*, 486 F.2d 98, 104-05 (3d Cir. 1973) (ETS).

Ms. Adams: CDC reports that as of June 4, 2020, there are almost 80,000 health care workers infected with COVID-19 and over 400 who have died from COVID-19.

Does this meet the threshold for COVID-19 to constitute a grave danger to health care workers?

Ms. Sweatt: OSHA is concerned with the reported prevalence of exposure to the SARS-CoV-2 virus in healthcare facilities. OSHA takes the virus’s potential risk to these workers very seriously and has determined that the best approach for protecting them during this crisis is to enforce the existing OSH Act requirements that address infectious disease hazards, while also issuing detailed, industry-specific guidance that can be quickly amended and adjusted. To this end, OSHA has issued specific guidance tailored to the needs of those workers. These dedicated resources are available at: <https://www.osha.gov/SLTC/covid-19/healthcare-workers.html>.

Ms. Adams: Last month, OSHA announced a new round of Susan Harwood Worker Training Grants, but these programs won’t begin until October.

In the meantime, is it true that OSHA is prohibiting current grantees from conducting COVID-19 training, or changing the terms of their work plans to include COVID-19 training?

Ms. Sweatt: No, OSHA has not prohibited current grantees from conducting COVID-19 training or changing the plans. In fact, the opposite is true. OSHA allowed current, eligible grantees to conduct COVID-19 related training. Current Harwood grantees, whose existing grant authorized them to conduct training on an occupational safety and health topic associated with protecting workers from infectious agents, were permitted to cover COVID-19 in their training materials and training programs. This was allowed in accordance with the terms of their awards. As these grantees already demonstrated they had the necessary subject matter expertise and ability to conduct this training, and significant changes to their training materials were not required, they were considered qualified to conduct COVID-19 related training. This included grantees approved to cover the topics of personal protective equipment and healthcare workers. In addition, these grantees have been given an exception to expand their training audience by modifying their work plans.

Ms. Adams: As you know, following the H1N1 pandemic, OSHA began work in earnest on an Infectious Disease Standard. Although OSHA’s Bloodborne Pathogens Standard has been very effective in protecting workers from bloodborne pathogens, it does not address

infectious diseases transmitted by other routes (e.g., contact, droplet and airborne). Work on the Infectious Disease Standard was relegated to the long-term agenda in 2017. Please address the following:

What remained to be done to issue an official proposal for this Infectious Disease Standard?

When do you expect to issue a proposed standard for notice and comment?

What specific actions have been taken with respect to the completion of the OSHA Infectious Disease Standard since it was relegated to the long-term agenda? Please list these actions.

Who specifically decided to remove the Infectious Disease Standard from the active regulatory agenda? Was this decision made by the Secretary of Labor? Was this decision made by the White House?

In addition to COVID-19, workers are also exposed to tuberculosis, influenza, MRSA and other transmissible pathogens (not covered under the bloodborne pathogen standard). What are the benefits to worker safety from finalizing a comprehensive Infectious Disease Standard particularly for health care workers, first responders, and other populations at elevated risk? How do these benefits compare with just relying on existing standards and the General Duty Clause?

If the permanent Infectious Disease Standard had been issued prior to the COVID-19 pandemic, would it have provided OSHA with additional tools to protect health care and social assistance workers during the COVID-19 pandemic?

Does OSHA intend to resume work on a permanent Infectious Disease Standard this calendar year?

What is OSHA's next planned action for a permanent infectious disease standard?

Ms. Sweatt: OSHA issued a Request for Information on May 6, 2010 (RIN: 1218-AC46). Following analysis of the public comments, OSHA held two stakeholder meetings in July 2011. The agency completed the Small Business Regulatory Enforcement Fairness Act (SBREFA) panel process on December 22, 2014. The SBREFA panel report contains pertinent information about the regulatory effort and can be found at <https://www.regulations.gov/document?D=OSHA-2010-0003-0250>. The next step in the regulatory process is to issue a notice of proposed rulemaking (NPRM). This remains a long term action on the regulatory agenda and a date for the issuance of an NPRM has yet to be determined.

Ms. Adams: There has been a widespread and growing number of COVID-19 infections of workers in the meatpacking industry.

How many complaints has OSHA received regarding conditions in meatpacking and poultry plants?

Ms. Sweatt: As of July 29, 2020, OSHA has received 91 valid complaints (i.e., complaints alleging a safety or health violation over which OSHA has jurisdiction) related to COVID-19 from establishments in the Animal Slaughtering and Processing industries (NAICS 31161).

Ms. Adams: How many physical, onsite inspections has OSHA conducted in the meatpacking and poultry industry?

Ms. Sweatt: As of July 29, 2020, OSHA has opened 67 inspections related to COVID-19 in the Animal Slaughtering and Processing industries (NAICS 31161). OSHA's data system does not currently track the distinction between on-site and remote inspections.

Ms. Adams: How many of these inspections has OSHA closed?

Ms. Sweatt: One of the 67 inspections has been closed as of July 29, 2020.

Ms. Adams: How many citations have been issued following these meatpacking and poultry plant inspections?

Ms. Sweatt: No citations in the Animal Slaughtering and Processing industries have been issued as of July 29, 2020.

Ms. Adams: After President Trump issued the April 28, 2020 Executive Order Delegating Authority Under the DPA with Respect to Food Supply Chain Resources During the National Emergency Caused by the Outbreak of COVID-19, you and Solicitor of Labor Kate O'Scannlain issued a statement stating that "OSHA will take into account good faith attempts to follow the Joint Meat Processing Guidance."

Who directed you and the Solicitor to issue this Memorandum?

Ms. Sweatt: Solicitor O'Scannlain and I issued our April 28, 2020 Statement of Enforcement Policy regarding meat and poultry processing facilities in response to President Trump's Executive Order on Delegating Authority Under the Defense Production Act with Respect to Food Supply Chain Resources During the National Emergency Caused by the Outbreak of COVID-19. The statement, which addresses guidance and enforcement actions regarding worker safety at meat, pork, and poultry processing facilities, provides clarity for businesses whose continued operation will be critical to America's food supply.

Ms. Adams: Please define "good faith attempts" and provide any instructions to CSHOs describing how to determine whether an employer has made a "good faith attempt" to comply with CDC guidance.

Ms. Sweatt: On April 16, 2020, OSHA issued interim guidance to advise compliance safety and health officers (CSHOs) to evaluate an employer's good faith efforts to comply with safety

and health standards during the coronavirus pandemic. The guidance, which is available at <https://www.osha.gov/memos/2020-04-16/discretion-enforcement-when-considering-employers-good-faith-efforts-during>, recognizes that some employers may face difficulties complying with OSHA standards due to the ongoing health emergency, explains how CSHOs should assess whether an employer has made good faith efforts to comply, and directs OSHA Area Offices to take such efforts into strong consideration in determining whether to cite a violation. This enforcement discretion only applies for the duration of the COVID-19 pandemic.

Ms. Adams: Please explain how OSHA defines “feasible” in this context and provide any instructions to CSHOs describing how to determine whether an employer’s claim that it was infeasible to comply with CDC guidance is legitimate.

Ms. Sweatt: The joint coronavirus-related interim guidance by OSHA and the Centers for Disease Control and Prevention (CDC) for meatpacking and meat processing workers and employers includes recommended actions employers can take to reduce the risk of exposure to SARS-CoV-2, the virus that causes COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>). Some of the information in the guidance is in the form of CDC recommendations that are not directly enforceable by OSHA, but may inform the agency’s enforcement of other applicable requirements. There are several OSHA standards that apply to protecting workers from occupational exposure to SARS-CoV-2. For example, the Agency’s existing personal protective equipment standards, including those in 29 CFR 1910 Subpart I, require the use of gloves, eye, and face protection, and respiratory protection, when necessary to protect workers. OSHA’s Bloodborne Pathogens standard applies to occupational exposure to human blood and other potentially infectious materials; and the provisions of the standard may help control some sources of the virus that causes COVID-19. In addition, the General Duty Clause authorizes enforcement action in cases involving “recognized hazards that are causing or are likely to cause death or serious physical harm”—which could include exposure to the SARS-CoV-2 virus.

To claim infeasibility in the context of OSHA standards, the employer would have to provide documentation of its efforts to comply and why compliance with an OSHA standard is infeasible (i.e., why compliance cannot be achieved). To establish an infeasibility defense, the employer would have to demonstrate compliance with the requirement is technologically or economically infeasible and that no feasible alternative means of protection exists. An employer is not entitled to this defense if it would have been possible to partially comply with the standard.

Ms. Adams: How many times has OSHA declined to issue a citation, despite an identified violation of an OSHA standard or the General Duty Clause, because the employer documented a “good faith” attempt to comply with the OSHA/CDC Guidelines? Please provide examples.

Ms. Sweatt: As discussed above, on April 16, 2020, OSHA issued enforcement guidance entitled Discretion in Enforcement when Considering an Employer’s Good Faith Efforts During the Coronavirus Disease 2019 (COVID-19) Pandemic. Under the memorandum, compliance officers use a specific code for documenting inspections in which the deferral of abatement was

accepted by OSHA. The coding will allow OSHA to identify those establishments in the future and conduct follow-up inspections to ensure that abatement was accomplished by the employer.

As of July 29, 2020, four complaints have been coded indicating that abatement deferral was accepted. All four of those were conducted as non-formal complaint investigations. Because the employers were able to demonstrate they were making good faith efforts toward hazard abatement, OSHA was able to remove workers from hazardous situations without expanding to a formal inspection. Follow up inspections will be conducted to ensure abatement was completed.

Also, three inspections have been identified in which a violation was noted but not cited. The inspections are marked with a code that indicates the deferral of abatement was accepted by OSHA. For further information, Chapter 3, Section VIII.E. of the Field Operations Manual discusses the concern of feasibility and the process OSHA follows for considering such arguments. <https://www.osha.gov/enforcement/directives/cpl-02-00-164/chapter-3>

Ms. Adams: How many times has OSHA declined to issue a citation, despite an identified violation of an OSHA standard or the General Duty Clause, because the employer documented infeasibility to comply with the OSHA/CDC Guidelines? Please provide examples.

Ms. Sweatt: At this time, in addition to the four complaints noted above in which workers were removed from hazardous situations, no inspections have been identified in which a violation was noted but not cited due to a claim of infeasibility. For further information, Chapter 3, Section VIII.E. of the Field Operations Manual discusses the concern of feasibility and the process OSHA follows for considering such arguments. <https://www.osha.gov/enforcement/directives/cpl-02-00-164/chapter-3>

Ms. Adams: Keeping workers infected with COVID-19 out of meatpacking plants is necessary. However, the OSHA/CDC Guidelines say that “Screening meat and poultry processing workers for COVID-19 symptoms (such as temperature checks) is an optional strategy that employers may use.” How does an employer show “good faith”, since testing is optional?

Ms. Sweatt: Neither the OSH Act nor OSHA standards prohibit employer screening for COVID-19, if applied in a transparent manner applicable to all employees (i.e., non-retaliatory). Because people infected with SARS-CoV-2 can spread the virus even if they do not have signs or symptoms of infection, temperature screening may have limited utility on its own. OSHA has provided FAQs that address screening and testing for COVID-19 in its Guidance on Returning to Work (<https://www.osha.gov/Publications/OSHA4045.pdf>).

Ms. Adams: Since studies show that many of those who are infected with COVID-19 are asymptomatic, or pre-symptomatic, please explain why screening for fevers prior to employee entry to a meatpacking plant is sufficient to keep the infection out of work settings?

Ms. Sweatt: Several cross-sectional investigations found that between 40 percent and 60

percent of individuals with SARS-CoV-2 were asymptomatic or presymptomatic at the time of testing. Experts believe asymptomatic individuals can transmit the virus. However, the relative importance of asymptomatic versus symptomatic transmission is currently unknown. For these reasons, employers should take other actions, in addition to pre-entry fever and symptom screening, to protect workers.

The OSHA and CDC joint guidance for meat packing and poultry processing workers and employers lays out a number of recommended actions employers can take to reduce the risk of exposure to the coronavirus, including creating and implementing a COVID-19 assessment and control plan; educating and training workers and supervisors about how they can reduce the spread of COVID-19; cleaning and disinfecting tools and work and common spaces; and selecting, providing, and ensuring the proper use of personal protective equipment.

Ms. Adams: Would mandatory testing of employees for COVID-19 on a regular basis prior to entry to a meatpacking plant be more effective than screening for fevers? If so, why has the OSHA/CDC Guidelines not been updated to require this?

Ms. Sweatt: Although a strategy of periodic pre-entry SARS-CoV-2 testing of workers may eventually be feasible for a wide range of employers, the strategy currently suffers from at least six limitations: imperfect validity of the diagnostic test results, test interpretation, testing frequency, testing logistics, testing process, and privacy and reporting issues.

Neither the OSH Act nor OSHA standards prohibits employer screening for COVID-19, if applied in a transparent manner applicable to all employees (i.e., non-retaliatory). Employers may consider implementing strategies to reduce risks to the safety and health of workers and workplaces from COVID-19 that include conducting daily in-person or virtual health checks (e.g., symptom and/or temperature screening, questionnaires, self-checks and self-questionnaires). Any such screening should consider ways to maintain confidentiality, as required by the Americans with Disabilities Act.

Because people infected with SARS-CoV-2 can spread the virus even if they do not have signs or symptoms of infection, temperature screening may play a part in a comprehensive program to monitor worker health during the pandemic, but may have limited utility on its own. In many workplaces, temperature screening efforts are likely to be most beneficial when conducted at home by individual workers, with employers' temperature screening plans relying on workers' self-monitoring and staying home if they have a fever or other signs or symptoms of illness, rather than employers directly measuring temperatures after workers arrive at the work site. Employers may consider implementing such programs in conjunction with sick leave policies that encourage sick workers, including those whose self-monitoring efforts reveal a fever or other signs or symptoms of illness, to stay at home.

Regardless of whether or how employers ultimately decide to implement temperature checks or other health screening measures, they should act cautiously on results. Employers should not presume that individuals who do not have a fever or report experiencing other symptoms of COVID-19 do not have SARS-CoV-2, the virus that causes COVID-19. Employers should continue to implement the basic hygiene, social distancing, workplace controls and flexibilities, and employee training described in this guidance in ways that reflect the risk of community

spread of COVID-19, including from asymptomatic and pre-symptomatic individuals, in the geographical area where the workplace is located.

Ms. Adams: Except for state and local regulations that are of “general applicability”, OSHA’s regulations generally pre-empt the field of worker safety protections in those states where federal OSHA has jurisdiction.

Is it DOL’s view that non-binding OSHA Guidance or non-binding OSHA/CDC Guidance pre-empts enforcement actions by state health agencies, if the state health agencies require meat processors to take more protective measures than those in the Joint CDC/OSHA Guidance for Meatpacking Industry?

Ms. Sweatt: Guidance issued by OSHA does not preempt enforcement actions brought by state or local health agencies.

Ms. Adams: Are regulations and enforcement actions by state health agencies, which are seeking to control infections in congregate workplace settings as a necessary means of controlling community spread, subject to federal pre-emption by OSHA?

Ms. Sweatt: Under Section 18 of the OSH Act, states that wish to develop and enforce their own occupational safety and health standards may do so by submitting a “State [P]lan for the development of such standards and their enforcement” to federal OSHA. Once federal OSHA grants a State Plan final approval, federal OSHA relinquishes its authority to cover occupational safety and health matters that are covered by the State Plan. State Plans may adopt and enforce standards in a manner that differs from—and that may be more stringent than—federal OSHA’s standards, and its enforcement of such standards. However, State Plans must be at least as effective in protecting workers and in preventing work-related injuries, illnesses and deaths.

Section 18(a) of the OSH Act also states, “Nothing in this Act shall prevent any State agency or court from asserting jurisdiction under State law over any occupational safety or health issue with respect to which no [federal] standard is in effect . . .” Interpreting Section 18 of the OSH Act, the U.S. Supreme Court in *Gade v. National Solid Wastes Management Association* held that OSHA standards governing specific occupational safety and health issues will preempt the entire field of workplace safety and health law with respect to these issues, unless a state has an OSHA-approved State Plan. This field preemption would apply even if a state’s law does not directly conflict with federal OSHA regulations, and even if it serves a dual purpose (e.g., protecting workers as well as the public). However, non-conflicting state laws of general applicability that regulate the conduct of workers and non-workers alike (e.g., traffic safety and fire safety requirements), would generally not be preempted.

Ms. Adams: How are you ensuring that OSHA inspectors can perform inspections without putting themselves at risk of infection?

Ms. Sweatt: OSHA has taken steps to protect the agency’s CSHOs, commonly referred to as OSHA inspectors, by implementing a safety and health management system throughout the agency. The agency’s plan is laid out in the enforcement memo entitled Updated Interim

Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19). *See* <https://www.osha.gov/memos/2020-05-19/updated-interim-enforcement-response-plan-coronavirus-disease-2019-covid-19>. In this document, OSHA provides specific guidance on identifying risk levels of workplace settings for purposes of prioritizing enforcement activities. In addition, this updated plan describes in detail inspection planning, CSHO training, inspection procedures, CSHO protection, safety practices during on-site inspections, and use of CDC recommendations. To complement the updated plans, OSHA further provided CSHOs with guidance on face coverings, voluntary use of filtering facepiece respirators (FFRs), a conversation guide, and other regional guidance documents to assist OSHA CSHOs in safely executing their important work.

All OSHA CSHOs have the flexibility to hold pre- and post-inspection meetings outdoors or in well-ventilated spaces, and utilize social distancing as much as possible. OSHA has also provided guidance on cleaning and sanitizing Government Owned Vehicles and other devices or tools that may be commonly touched. In addition, OSHA has ensured that CSHOs know they can discuss their personal health risk, or that of their family members, with their supervisors, if they are concerned about their well-being at any time.

Ms. Adams: OSHA officials have stated previously that the Bloodborne Pathogens Standard can be effectively used to keep workplaces safe from COVID-19.

Can you explain how this standard is relatable to a virus that is spread through airborne droplets?

Ms. Sweatt: OSHA's Bloodborne Pathogens standard applies to occupational exposure to human blood and other potentially infectious materials that typically do not include respiratory secretions that may contain SARS-CoV-2 (unless visible blood is present). The provisions of the standard offer a framework that may help control some sources of the virus, including exposures to body fluids (e.g., respiratory secretions) not covered by the standard. In addition, some workers covered by the standard are also exposed to COVID-19; by complying with the standard to protect themselves against bloodborne pathogens, they can also receive protection against transmission of COVID-19. A comparison of the universal precautions of OSHA's Bloodborne Pathogens standard to the standard precautions and the transmission-based precautions used by healthcare practitioners for infection control is available at https://www.osha.gov/SLTC/bloodbornepathogens/worker_protections.html.

QUESTIONS SUBMITTED BY REPRESENTATIVE PRAMILA JAYAPAL

Ms. Jayapal: How many on-site inspections has OSHA conducted related to COVID-19?

Ms. Sweatt: As of July 29, 2020, the Occupational Safety and Health Administration (OSHA) has opened 768 inspections related to COVID-19. OSHA's enforcement data does not distinguish between inspections conducted remotely and those conducted on-site.

Ms. Jayapal: How many remote investigations or inquiries related to COVID-19 has OSHA conducted using remote "Phone-Fax" or Rapid Response Investigation (RRI) procedures?

Ms. Sweatt: As of July 29, 2020, OSHA has initiated a total of 8,128 phone/fax or rapid response investigations related to COVID-19.

Ms. Jayapal: How many of those remote investigations or inquiries were the result of complaints?

Ms. Sweatt: As of July 29, 2020, 7,323 of the total 8,128 phone/fax or rapid response investigations related to COVID-19 were the result of complaints.

Ms. Jayapal: How many of these remote investigations or inquiries resulted in inadequate responses from the employer?

Ms. Sweatt: As of July 29, 2020, 311 of the total 8,128 phone/fax or rapid response investigations related to COVID-19 indicated an inadequate response from the employer.

Ms. Jayapal: In how many of those remote investigations or inquiries, conducted as a result of complaints, did OSHA contact the complainant to determine if the employer's assurances were accurate, as described in Chapter 9, Section I(I) of the Field Operations Manual?

Ms. Sweatt: OSHA does not track this specific information, as the Field Operations Manual you mention requires CSHOs to contact the complainant as part of their ordinary job responsibilities. However, OSHA identified 60 complaints of the 7,323 phone/fax investigations noted above in which the complainant disputed the employer's response after OSHA indicated a satisfactory response from the employer.

Ms. Jayapal: How many Hazard Alert Letters has OSHA issued recommending the implementation of protective measures that address SARS-CoV-2 hazards? Please provide a total, sorted by 4-digit NAICS code.

Ms. Sweatt: As of July 29, 2020, OSHA has issued nine Hazard Alert Letters (HALs) (including two HALs not yet received by employer):

- One HAL was issued for an inspection in NAICS 4451 (Grocery Stores);
- One HAL was issued for an inspection in NAICS 4539 (Other Miscellaneous Store Retailers);
- One HAL was issued for an inspection in NAICS 5629 (Remediation and Other Waste Management Services);
- One HAL was issued for an inspection in NAICS 6211 (Offices of Physicians);
- One HAL was issued for an inspection in NAICS 6221 (General Medical and Surgical Hospitals);
- Three HALs were issued for inspections in NAICS 6231 (Nursing Care Facilities (Skilled Nursing Facilities)); and
- One HAL was issued for an inspection in NAICS 9281 (National Security and International Affairs).

Ms. Jayapal: How many COVID-19 related fatality reports has OSHA received? Please provide this information sorted by 4-digit NAICS code.

Ms. Sweatt: As of July 29, 2020, OSHA has received 530 reports of fatalities related to COVID-19. The attached table includes a breakdown by 4-digit NAICS code.

Ms. Jayapal: How many of the fatality reports that OSHA has received were investigated?

Ms. Sweatt: As of July 29, 2020, OSHA has opened inspections in response to 487 of the fatality reports.

Ms. Jayapal: How many of those investigated were conducted by on-site inspections?

Ms. Sweatt: OSHA's enforcement data does not distinguish between inspections conducted remotely and those conducted on-site.

Ms. Jayapal: How many of OSHA's fatality investigations for COVID-19 resulted in citations related to the fatality?

Ms. Sweatt: As of July 29, 2020, OSHA has 455 open fatality/catastrophe inspections related to COVID-19. OSHA must issue a citation and proposed penalty within six months of a violation's occurrence. Thus, the agency has no more than six months to complete its investigations and issue any citations. To date, no citations have been issued for fatality/catastrophe inspections.

Ms. Jayapal: Please describe any actions OSHA is taking to ensure that all COVID-19 work-related fatalities are reported to OSHA.

Ms. Sweatt: OSHA regulations require that employers report: 1) work-related in-patient hospitalization, amputation or loss of an eye within 24 hours, and 2) all work-related fatalities within eight hours. Pursuant to those regulations, COVID-19 employee work-related illnesses that result in an in-patient hospitalization or death must be reported to OSHA within 24 hours, and work-related COVID-19 fatalities must be reported to OSHA within eight hours.

Attachment

COVID-19 Related Fatality Reports Received by Federal OSHA as of July 29, 2020

Site NAICS (4-Digit)	NAICS Title	COVID- 19 Related Fatality Reports
1123	Poultry and Egg Production	1

2361	Residential Building Construction	1
2362	Nonresidential Building Construction	1
3112	Grain and Oilseed Milling	2
3113	Sugar and Confectionery Product Manufacturing	5
3114	Fruit and Vegetable Preserving and Specialty Food Manufacturing	4
3116	Animal Slaughtering and Processing	42
3118	Bakeries and Tortilla Manufacturing	2
3119	Other Food Manufacturing	4
3212	Veneer, Plywood, and Engineered Wood Product Manufacturing	1
3231	Printing and Related Support Activities	5
3254	Pharmaceutical and Medicine Manufacturing	1
3256	Soap, Cleaning Compound, and Toilet Preparation Manufacturing	2
3261	Plastics Product Manufacturing	2
3311	Iron and Steel Mills and Ferroalloy Manufacturing	1
3315	Foundries	2
3321	Forging and Stamping	1
3328	Coating, Engraving, Heat Treating, and Allied Activities	2
3329	Other Fabricated Metal Product Manufacturing	1
3331	Agriculture, Construction, and Mining Machinery Manufacturing	1
3334	Ventilation, Heating, Air-Conditioning, and Commercial Refrigeration Equipment Manufacturing	1
3344	Semiconductor and Other Electronic Component Manufacturing	1
3363	Motor Vehicle Parts Manufacturing	1
3371	Household and Institutional Furniture and Kitchen Cabinet Manufacturing	3
4234	Professional and Commercial Equipment and Supplies Merchant Wholesalers	1
4238	Machinery, Equipment, and Supplies Merchant Wholesalers	1
4239	Miscellaneous Durable Goods Merchant Wholesalers	1
4244	Grocery and Related Product Merchant Wholesalers	3
4451	Grocery Stores	4
4452	Specialty Food Stores	1
4453	Beer, Wine, and Liquor Stores	1
4471	Gasoline Stations	1
4529	Other General Merchandise Stores	3
4539	Other Miscellaneous Store Retailers	1
4852	Interurban and Rural Bus Transportation	1
4911	Postal Service	1
4931	Warehousing and Storage	3
5611	Office Administrative Services	1
5612	Facilities Support Services	5
5613	Employment Services	4
5616	Investigation and Security Services	2
5617	Services to Buildings and Dwellings	4
6111	Elementary and Secondary Schools	3
6211	Offices of Physicians	16

6213	Offices of Other Health Practitioners	3
6214	Outpatient Care Centers	14
6216	Home Health Care Services	5
6219	Other Ambulatory Health Care Services	12
6221	General Medical and Surgical Hospitals	164
6222	Psychiatric and Substance Abuse Hospitals	3
6223	Specialty (except Psychiatric and Substance Abuse) Hospitals	15
6231	Nursing Care Facilities (Skilled Nursing Facilities)	124
6232	Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities	7
6233	Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly	14
6241	Individual and Family Services	3
6243	Vocational Rehabilitation Services	4
7223	Special Food Services	2
Total		530

QUESTIONS SUBMITTED BY REPRESENTATIVE BRADLEY BYRNE

Mr. Byrne: Ms. Sweatt, OSHA’s recent guidance on recording COVID-19 cases asked employers to ascertain whether an individual came down with COVID-19 as a result of exposure at work. The guidance requires employers to interview employees about other possible sources of exposure. I am concerned about workers’ privacy.

Does OSHA have suggestions on how to handle privacy concerns?

Ms. Sweatt: The Occupational Safety and Health Administration’s (OSHA) recordkeeping regulation includes requirements on how employers must handle privacy concern cases. *See* 29 CFR 1904.29(b)(6)-(b)(10). In these situations, when the employers record an injury or illness, they do not enter the employee’s name on the OSHA 300 log. Instead, an employer enters “privacy concern case” in the space normally used for the employee’s name. This protects the privacy of the employee when other employees, or their representatives, are provided access to the log. Section 1904.29(b)(7) specifically defines what is considered a privacy concern case. Section 1904.29(b)(7)(vi) provides that, if the employee independently and voluntarily requests that his or her name not be entered on the log, the employer must treat that illness as a “privacy concern case.” OSHA’s May 19, 2020, guidance on recording aims to protect “employee privacy concerns.” <https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>.

Mr. Byrne: Ms. Sweatt, I am also worried about the reliability of this data given that our understanding about transmission, recovering, and asymptotic infections is constantly evolving and that employers are not equipped to do the type of contact tracing needed to identify sources. Inaccurate data could later be used to make erroneous conclusions or misused to mischaracterize the situation at a workplace or in a community.

While I know it's very important for public health agencies to track cases, has OSHA considered alternatives to having employers make cursory and possibly unreliable work-related determinations?

Ms. Sweatt: OSHA acknowledges the challenges employers face in determining the work-relatedness of COVID-19 cases. Recording or reporting a work-related injury, illness, or fatality does not mean that the employer or employee was at fault, that an OSHA rule has been violated, nor that the employee is eligible for workers' compensation or other benefits. However, there is no provision in 29 CFR 1904 for excluding an injury or illness from the recording and reporting requirements simply because determining work-relatedness is difficult.

Nevertheless, to provide certainty to employers and workers during this challenging time, OSHA has issued guidance to its Compliance Safety and Health Officers for enforcing the requirements of 29 CFR Part 1904 with respect to the recording of cases of COVID-19. The most recent guidance is available at: <https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>.

[Whereupon, at 1:34 p.m., the subcommittee was adjourned.]

