CLEARING THE AIR: SCIENCE-BASED STRATEGIES TO PROTECT WORKERS FROM COVID-19 INFECTIONS

HEARING
BEFORE THE
SUBCOMMITTEE ON WORKFORCE PROTECTIONS
OF THE
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTEENTH CONGRESS
FIRST SESSION
HEARING HELD IN WASHINGTON, DC, MARCH 11, 2021
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CLEARING THE AIR: SCIENCE-BASED STRATEGIES TO PROTECT WORKERS FROM COVID–19 INFECTIONS

Thursday, March 11, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON WORKFORCE PROTECTIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:47 a.m., via Zoom, Hon. Alma S. Adams (Chairwoman of the subcommittee) presiding.

Present: Representatives Adams, Takano, Norcross, Jaypal, Omar, Stevens, Jones, Yarmuth, Scott, Foxx, Stefanik, Keller, Miller-Meeks, Good, Cawthorn, Steel.

Staff present: Tylease Alli, Chief Clerk; Jordan Barab, Senior Labor Policy Advisor; Ilana Brunner, General Counsel; Sheila Havenner, Director of Information Technology; Eli Hovland, Policy Associate; Ariel Jona, Policy Associate; Andre Lindsay, Policy Associate; Richard Miller, Director of Labor Policy; Max Moore, Staff Assistant; Mariah Mowbray, Clerk/Special Assistant to the Staff Director; Kayla Pennebecker, Staff Assistant; Veronique Pluviose, Staff Director; Theresa Thompson, Professional Staff; 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; Georgie Littlefair, Minority Legislative Assistant; John Martin, Minority Workforce Policy Counsel; Hannah Matesic, Minority Director of Operations; Audra McGeorge, Minority Communications Director; Carlton Norwood, Minority Press Secretary.

Ms. ADAMS. The Subcommittee on Workforce Protections will come to order. Welcome everyone. I note that a quorum is present. The subcommittee is meeting today to hear testimony on, “Clearing the Air: Science-Based Strategies to Protect Workers from COVID–19 Infections.”

I note for the subcommittee that Mr. Courtney of Connecticut is permitted to participate in today’s hearing with the understanding that his questions will come only after all Members of the subcommittee on both sides of the aisle were present, and have had an opportunity to question the witnesses.

This is an entirely remote hearing. All microphones will be kept muted as a general rule to avoid unnecessary background noise. Members and witnesses will be responsible for unmuteing them-
selves when they are recognized to speak, or when they wish to seek recognition.

I also ask that Members please identify themselves before they speak. Members should keep their cameras on while in the proceeding. Members shall be considered present in the proceeding when they are visible on camera, and they shall be considered not present when they are not visible on camera.

The only exception to this is if they are experiencing technical difficulty and inform Committee Staff of such difficulty. If any Member experiences technical difficulties during the hearing, you should stay connected on the platform, make sure you are muted, and use your phone to immediately call the Committee’s IT Director whose number was provided in advance. Should the Chair experience technical difficulty, or need to step away to vote on the floor, Mr. Scott of Virginia, as a Member of this subcommittee, or another Majority Member of the subcommittee if he’s not available is hereby authorized to assume the gavel in the Chair’s absence.

This is an entirely remote meeting. And as such the Committee's hearing room is officially closed. Members who choose to sit with their individual devices in the hearing room must wear headphones to avoid feedback, echoes and distortion resulting from more than one person on the software platform sitting in the same room.

Members are also expected to adhere to social distancing, and safe healthcare guidelines including the use of masks, hand sanitizer and wiping down their areas, both before and after their presence I the hearing room. In order to ensure that the Committee’s five-minute rule is adhered to, staff will be keeping track of time using the Committee’s field timer.

The field timer will appear on its own thumbnail picture and will be named 001 timer. There will be no one minute remaining warning. The field timer will sound its audio alarm when time is up. Members and witnesses are asked to wrap up promptly when their time has expired.

And while a roll call is not necessary to establish a quorum in official proceedings conducted remotely or with remote participation, the Committee has made it a practice whenever there is an official proceeding with remote participation for the clerk to call the roll to help make clear who is present at the start of the proceeding.

Members should say their name before announcing they are present. This helps the Clerk, and also helps those watching the platform and the livestream who may experience a few seconds delay.

At this time I ask the clerk to please call the roll.

The CLERK. Chairman Adams?
Ms. ADAMS. Present.

The CLERK. Mr. Takano?
Mr. TAKANO. Present.

The CLERK. Mr. Norcross?
Mr. NORCROSS. Present.

The CLERK. Ms. Jayapal?
Ms. JAYAPAL. Present.

The CLERK. Miss Omar?
Ms. OMAR. Present.
The CLERK. Ms. Stevens?
[No response.]
The CLERK. Mr. Jones?
Mr. JONES. Present.
The CLERK. Mr. Yarmuth?
Mr. YARMUTH. Present.
The CLERK. Mr. Scott?
[No response.]
The CLERK. Mr. Keller?
Mr. KELLER. Present.
The CLERK. Miss Stefanik sorry?
Ms. STEFANIK. Present.
The CLERK. Ms. Miller-Meeks?
[No response.]
The CLERK. Mr. Owens?
[No response.]
The CLERK. Mr. Good?
Mr. GOOD. Present.
The CLERK. Mr. Cawthorn?
Mr. CAWTHORN. Present.
The CLERK. Mrs. Steel?
[No response.]
The CLERK. Chairwoman Adams, that concludes the roll call.
Ms. ADAMS. Thank you, thank you for that.
Pursuant to Committee Rule 8(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 their questions.
I’ll recognize myself now for the purpose of making an opening Statement.

I want to welcome everyone to the first hearing of the Work Force Protection Subcommittee and the 117th Congress. Today we will discuss the imperative to protect worker’s health and safety. The COVID–19 pandemic has posed one of the most significant threats to worker’s health and safety in a century.

Across the country tens of thousands of workers have been infected by COVID–19 on the job, and many thousands have died. Meat packing workers, healthcare workers, transportation workers, correctional workers, and other frontline workers are all struggling with the severe physical and emotional trauma of the pandemic.

And while some of us have the luxury of working from home, these workers who are disproportionately low-income and people of color are risking their lives to keep our communities afloat. And one of our witnesses today, Pascaline Muhindura is a nurse at a hospital in Kansas City. Her coworker Celia Yap-Banago died of COVID–19 due to unsafe working conditions.

Miss Yap-Banago’s family is watching today’s hearing. I want to express our condolences for your loss and appreciation for the critical work for which Miss Yap-Banago gave her life. These tragic losses are even more heartbreaking considering that until recently the Occupational Safety and Health Administration, or OSHA, was missing in action, and opportunities to save lives were lost.

Under the Trump administration the Federal agency charged with protecting workers refused to issue new enforceable safety
standards leaving workers vulnerable to workplace infections. The agency made it harder to keep track of workplace illnesses and industries. The political appointees at OSHA failed to leverage the agency's resources to adequately inspect worksites, and allow multi-billion dollar corporations to get off with meager penalties, while ignoring worker deaths that were likely linked to COVID–19.

And during a hearing last year OSHA’s acting Assistant Secretary even refused to acknowledge that COVID–19 possesses or poses a grave danger for workers. OSHA’s inspectors and staff have worked hard to keep workplaces safe given the resources they have. But the Trump administration’s political leadership abandoned OSHA’s mission, and left workers with little to no help from their government.

As a recent report from the Department of Labor’s Inspector General found, worker complaints have skyrocketed during the pandemic, but OSHA inspections have fallen dramatically over the past year. The report also calls on OSHA to consider issuing an emergency temporary standard.

A recent Wall Street Journal investigation revealed a litany of major workplace COVID outbreaks, OSHA complaints, and insufficient responses from Federal OSHA or State OSHA plans. The main argument for inaction Federal OSHA had no COVID-related standards. The Journal identified more than 1,000 worker deaths from COVID–19 that were likely linked to workplace transmission of the virus, but had never been investigated by OSHA.

Employers had failed to report many of these fatalities to OSHA. So today our witnesses would help us assess how the Biden administration can recover from these failures and keep workers safe and healthy moving forward. First OSHA must swiftly issue a strong emergency temporary standard, or ETS to protect workers against COVID–19 infections.

For more than a year Chairman Scott and I urged the previous administration to issue an ETS, but OSHA refused. Thankfully, the Biden administration has moved quickly to restore OSHA’s purpose by directly OSHA to consider issuing an ETS. And I’m hopeful that we will see this ETS soon, but we must do far more to protect workers.

And as our witnesses will share, we must better protect workers from the airborne transmission of COVID–19. We know the virus spreads not just through large droplets that quickly dissipate, but through microscopic particles that can travel long distances and for long periods.

This has major implications for protecting workers who are frequently in close contact with others. Yet the Centers for Disease Control and Prevention has not updated its workplace guidance to reflect this clear scientific evidence, which is essential to shape a strong OSHA standard.

We also need a plan to get vaccines to all of the essential workers who have risked their lives to keep our economy going. Americans across the country are thankfully starting to get vaccinated, but we still have no national strategy to ensure that in addition to emergency responders and healthcare workers, grocery store clerks, meat processing workers, teachers, transportation workers, corrections officers and others are not left behind.
We must also take clear steps to track workplace COVID–19 infections. Shockingly, the Federal Government has no system for monitoring the number of workers who have gotten sick, or where they are employed. The previous administrative effectively gutted requirements for employers to report COVID–19 related worker hospitalizations.

And so we cannot hope to learn from the lessons of this pandemic without the data to understand how to protect workers in the future. Any discussion about protecting healthcare workers must also address the disproportionately high rates of violence that healthcare and social service workers face on the job.

Today we will discuss legislation introduced by Representative Courtney that requires OSHA to promptly issue a workplace violence prevention standard to protect healthcare and social service workers. Finally, in order for OSHA to identify and address the most dangerous workplaces, it must be able to collect accurate injury and illness data.

Today our witnesses will also discuss legislation introduced by Representative Takano that would allow OSHA to more effectively enforce its injury and illness recordkeeping requirements. National emergencies, such as this pandemic, are the exact reason why OSHA was first established, yet for far, far, too long OSHA’s leadership was asleep at the wheel costing the lives of workers. Now we have the opportunity to restore OSHA’s mission and protect workers health and safety at a time when they need it most.

Today’s hearing is an important first step toward that goal. I’d now like to recognize the distinguished Ranking Member for the purpose of making an opening Statement.

[The statement of Chairwoman Adams follows:

STATEMENT OF HON. ALMA S. ADAMS, CHAIRWOMAN, SUBCOMMITTEE ON WORKFORCE PROTECTIONS

I want to welcome everyone to the first hearing of the Workforce Protections Subcommittee in the 117th Congress. Today, we will discuss the imperative to protect workers’ health and safety.

The COVID–19 pandemic has posed one of the most significant threats to workers’ health and safety in a century.

Across the country, tens of thousands of workers have been infected by COVID–19 on the job and many thousands have died. Meatpacking workers, health care workers, transportation workers, correctional workers, and other frontline workers are all struggling with the severe physical and emotional trauma of the pandemic.

While some of us have the luxury of working from home, these workers-who are disproportionately low-income and people of color-are risking their lives to keep our communities afloat.

One of our witnesses today, Pascaline Muhindura, is a nurse at a hospital in Kansas City. Her coworker, Celia Yap-Banago, died of COVID–19 due to unsafe working conditions. Ms. Yap-Banago’s family is watching today’s hearing. I want to express our condolences for your loss and appreciation for the critical work for which Ms. Yap-Banago gave her life.

These tragic losses are even more heartbreaking considering that, until recently, the Occupational Safety and Health Administration, or OSHA, was missing in action.

Under the Trump Administration, the Federal agency charged with protecting workers refused to issue new enforceable safety standards, leaving workers vulnerable to workplace infections. The agency made it harder to keep track of workplace illnesses and injuries.

The political appointees at OSHA failed to leverage the agency’s resources to adequately inspect worksites, and allowed multi-billion-dollar corporations to get off with meager penalties while ignoring worker deaths that were likely linked to COVID–19.

}
And, during a hearing last year, OSHA’s Acting Assistant Secretary even refused to acknowledge that COVID–19 poses a “grave danger” for workers.

Now, OSHA’s inspectors and staff have worked hard to keep workplaces safe given the resources they have. But the Trump Administration’s political leadership abandoned OSHA’s mission and left workers with little to no help from their government.

As a recent report from OSHA’s Inspector General found, worker complaints have skyrocketed during the pandemic, but OSHA inspections have fallen dramatically over the past year. The report also called on OSHA to consider issuing an Emergency Temporary Standard.

A recent Wall St. Journal investigation revealed a litany of major workplace COVID outbreaks, OSHA complaints, and insufficient responses from Federal OSHA or State OSHA plans. The main argument for inaction: Federal OSHA had no COVID-related standards. The Journal identified more than 1,000 worker deaths from COVID–19 that were likely linked to workplace transmission of the virus but had never been investigated by OSHA. Employers had failed to report many of these fatalities to OSHA.

Today, our expert witnesses will help us assess how the Biden Administration can recover from these failures and keep workers safe and healthy moving forward.

First, OSHA must swiftly issue a strong Emergency Temporary Standard, or ETS, to protect workers against COVID–19 infections. For more than a year, Chairman Scott and I urged the previous Administration to issue an ETS, but OSHA refused. Thankfully, the Biden Administration has moved quickly to restore OSHA’s purpose by directing OSHA to consider issuing an ETS. I am hopeful we will see this ETS soon, but we must do far more to fully protect workers.

As our witnesses will share, we must better protect workers from the airborne transmission of COVID–19. We now know the virus spreads not just through large droplets that quickly dissipate, but through microscopic particles that can travel long distances and for long periods. This has major implications for protecting workers who are frequently in close contact with others. Yet, the Centers for Disease Control and Prevention has not updated its workplace guidance to reflect this clear scientific evidence, which is also needed to shape a strong OSHA standard.

We also need a plan to get vaccines to all the essential workers who have risked their lives to keep our economy going. Americans across the country are thankfully starting to get vaccinated. But we still have no national strategy to ensure that—in addition to emergency responders and health care workers—grocery store clerks, meat processing workers, teachers, transportation workers, corrections officers and others are not left behind.

We must also take clear steps to keep track of workplace infections. Shockingly, the Federal Government has no system for monitoring the number of workers who have gotten sick or where they are employed. The previous administration even effectively gutted requirements for employers to report COVID–19-related worker hospitalizations. We cannot hope to learn from the lessons of this pandemic without the data to understand how to protect workers in the future.

Any discussion about protecting health care workers must also address the disproportionately high rates of violence that health care and social services workers face on the job. Today, we will discuss legislation introduced by Representative Courtney that requires OSHA to quickly issue a workplace violence prevention standard to protect health care and social service workers.

Finally, in order for OSHA to identify and address the most dangerous workplaces, it must be able to collect accurate injury and illness data. Today, our witnesses will also discuss legislation, introduced by Representative Takano, that would allow OSHA to effectively enforce its injury and illness recordkeeping requirements.

National emergencies, such as this pandemic, are the exact reason why OSHA was first established. Yet, for far too long, OSHA’s leadership was asleep at the wheel, costing the lives of workers. Now, we have the opportunity to restore OSHA’s mission and protect workers’ health and safety at a time when they need it most. Today’s hearing is an important first step toward that goal.

I now yield to the Ranking Member, Mr. Keller, for his opening Statement.

Mr. Keller. Thank you Madam Chair. I’m disappointed that today’s hearing is being held in a completely virtual format. As I can show you in today’s Washington Post, the people working in the House chamber show up every day and do their jobs, and I think we should be here in our committee’s hearing room.
I'm currently in committee hearing room and it can comfortably accommodate the 16 Members of this subcommittee. This hearing should be in person, and we can participate and do this work safely. After all, the subject to today's hearing is science-based strategies to protect workers, and Members of the subcommittee should have the opportunity to set a positive example by conducting this hearing in person while adhering to the most current workplace safety guidelines.

Over the last year the pandemic has created unprecedented challenges for all Americans, especially workers and job creators. The top priority for employers throughout this crisis has been, and will continue to be preventing the spread of COVID–19 in the workplace to ensure the health and safety of workers and customers. Thankfully, a year to the date after the World Health Organization declared COVID–19 a pandemic, America now is equipped with much greater and thorough scientific knowledge of the virus and innovative employers have developed effective procedures and policies to keep workplaces as safe as possible.

Over the past year business centers have worked around the clock to operate safely under the evolving State and local mandates, CDC and OSHA guidelines, and industry-recognized best practices to protect their workers. The vast majority of businesses, regardless of size and location have invested significant resources to implement comprehensive and effective safety precautions specific to their workplaces.

And now thanks to the successful efforts of Operation Warp Speed, essential workers have been prioritized for vaccination, and President Biden has stated that the U.S. should have enough vaccine doses for every eligible adult in the United States by the end of May.

We are not out of the woods yet, but America is on the path to recovery, both in terms of health of our citizens and our economy. Under the Trump administration the Federal Government collaborated with businesses across the country, updating them as new information arose on the newest guidelines and procedures to keep workers and customers safe.

This dialog allowed businesses the flexibility to create health and safety plans that fit their specific workplace, creating an efficient path forward for businesses. My Democrat colleagues have said almost from day one of this pandemic that it is necessary for OSHA to issue an emergency temporary standard, or ETS. A rigid, one-size-fits-all regulation specific to COVID–19 that would apply to every workplace throughout the country.

Not one ETS has been issued since 1983 because of legal challenges and lack of due process for affected stakeholders. In 2021 an ETS would do far more harm than good to workers, employers and the American economy by denying businesses the opportunity to respond quickly to new scientific findings and industry-specific needs.

Not all workplaces are the same, yet democrats are eager to impose rigid and inflexible mandates on businesses. This inflexible lagging method to keep workers safe will only hinder our economy recovery, and make it more difficult for employers to ensure safety in their respective workplaces.
If OSHA had enacted an ETS a year ago as committee democrats demanded it, it would be woefully inadequate in protecting workers today. Issuing an ETS is not a science-based approach, and is instead another example of overbearing government policy that will do nothing but constrict employers from safely running their businesses.

Four States across the country have adopted State-wide emergency temporary COVID–19 regulations. In California we're already seeing its negative effects. Since issued in November, the regulations have conflicted at various points with CDC guidance for workplaces, causing massive confusion for employees and their employers.

Additionally, the California emergency rule places many new significant burdens on employers and job creators related to workplace testing, paid leave, and required reporting to public health authorities. This is no way to help an already suffering economy. More mandates from Washington, including an OSHA ETS would not only add burdens and regulations on employers that stifle creatively and ultimately hold them back.

Instead, the Federal Government should be focusing on ensuring adequate vaccine supply and distribution to vaccinate all workers and providing timely public health guidance to our employers as this Nation works toward economic prosperity. I'd like to thank all of our witnesses for joining us today and I look forward to hearing your testimony. Thank you and I yield back.

[The statement of Ranking Member Keller follows:]

STATEMENT OF HON. FRED KELLER, RANKING MEMBER, SUBCOMMITTEE ON WORKFORCE PROTECTIONS

Thank you, Madam Chair. I am disappointed that today's hearing is being held in a completely virtual format. The Committee's hearing room that I am currently sitting in can comfortably accommodate the 16 Members of the subcommittee. This hearing should be in a hybrid format, so Members who want to participate in person can do so safely.

After all, the subject of today's hearing is "Science-Based Strategies to Protect Workers" and Members of this subcommittee should have the opportunity to set a positive example by conducting this hearing in person while adhering to the most current workplace safety guidelines.

Over the last year, the pandemic has created unprecedented challenges for all Americans, especially workers and job creators. The top priority for employers throughout this crisis has been, and will continue to be, preventing the spread of COVID–19 in the workplace to ensure the health and safety of workers and customers.

Thankfully, a year to the date after the World Health Organization declared COVID–19 a pandemic, America is now equipped with much greater and thorough scientific knowledge of the virus, and innovative employers have developed effective procedures and policies to keep workplaces as safe as possible.

Over the past year, business owners have worked around the clock to operate safely under evolving State and local mandates, CDC and OSHA guidelines, and industry-recognized best practices to protect their workers. The vast majority of businesses, regardless of size and location, have invested significant resources to implement comprehensive and effective safety precautions specific to their workplaces.

And now, thanks to the successful efforts of Operation Warp Speed, essential workers have been prioritized for vaccination, and President Biden has Stated that the U.S. should have enough vaccine doses for every eligible adult in the United States by the end of May.

We are not out of the woods yet, but America is on the path to recovery, both in terms of the health of our citizens and our economy.

Under the Trump administration, the Federal Government collaborated with businesses across the country, updating them as new information arose on the newest guidelines and procedures to keep workers and customers safe. This dialog allowed
businesses the flexibility to create health and safety plans that fit their specific workplace, creating an efficient path forward for businesses.

But my Democrat colleagues have said almost from day one of the pandemic that it is necessary for OSHA to issue an Emergency Temporary Standard, or ETS—a rigid, one-size-fits-all regulation specific to COVID–19 that would apply to every workplace throughout the country.

Not one ETS has been issued since 1983 because of legal challenges and a lack of due process for affected stakeholders. In 2021, an ETS will do far more harm than good for workers, employers, and the American economy by denying businesses the opportunity to respond quickly to new scientific findings and industry-specific needs. Not all workplaces are the same, yet Democrats are eager to impose rigid and inflexible mandates on businesses. This inflexible, lagging method to keep workers ‘safe’ will only hinder our economic recovery and make it more difficult for employers to ensure safety in their respective workplaces.

If OSHA enacted an ETS a year ago, as Committee Democrats demanded, it would be woefully inadequate in protecting workers today. Issuing an ETS is not a science-based approach and is instead yet another example of overbearing government policy that will do nothing but constrict employers from safely running their businesses.

Four States across the country have adopted State-wide emergency temporary COVID–19 regulations. In California, we’re already seeing its negative effects. Since issued in November, the regulations have conflicted at various points with CDC guidance for workplaces, causing massive confusion for employers. Additionally, the California emergency rule places many new and significant burdens on employers related to workplace testing, paid leave, and required reporting to public health authorities. This is no way to help an already suffering economy.

More mandates from Washington, including an OSHA ETS, will only add burdensome regulations on employers that stifle creativity and, ultimately, hold them back. Instead, the Federal Government should be focused on ensuring adequate vaccine supply and distribution to vaccinate essential workers and providing timely public health guidance to our employers as this Nation works toward economic prosperity.

I’d like to thank all our witnesses for joining us today and I look forward to hearing your testimony.

Ms. ADAMS. Thank you to the Ranking Member. Without objection all of the 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. March 25, 2021.

I’d now like to introduce our witnesses. Our first witness will be Dr. Linsey Marr. Dr. Marr is the Charles P. Lunsford Professor of Civil and Environmental Engineering at Virginia Tech. She’s one of a small number of researchers in the world who study viruses in the air. She holds a BS in engineering science from Harvard and a Ph.D. in civil and environmental engineering from US Berkeley, and she completed her post-doctoral training at MIT.

Our next witness will be Miss Pascaline Muhindura. Miss Muhindura is a registered nurse in Kansas City, Missouri. She works in a critical care unit. And since March 2020 she’s been caring for COVID patients. She’s a member of the National Nurses United and serves as a nurse representative and a member of the Professional Practice Committee for her union.

Following Ms. Muhindura will be Mr. Manesh Rath. Mr. Rath is a partner with Keller and Heckman in Washington, DC. He represents employers in a wide range of matters related to occupational safety and health, law, litigation, wage and hour and class action litigation and association law.

Our final witness will be Dr. David Michaels. Dr. Michaels is an epidemiologist and Professor of Environmental and Occupational Health at George Washington University. He served as Assistant Secretary of Labor for the Occupational Safety and Health Admin-
istration from 2009 to 2017, and he was a member of the Biden Harris transition COVID–19 Advisory Board.

To our witnesses we appreciate you for participating today. We look forward to your testimony, and let me remind you that we've read your written Statements, and they will appear in full in the hearing record, pursuant to Committee Rule 8(d) and the committee practice, each of you is asked to limit your oral presentation to a five-minute summary of your written Statement.

I also want to remind the witnesses that pursuant to Title 18 of U.S. Code Section 1001 it is illegally to knowingly and willfully falsify any Statement, representation, writing, documents, or material fact presented to Congress or otherwise concealed, or cover up a material fact. So before you begin your testimony please remember to unmute your microphone. During your testimony staff will be keeping track of time, and a timer will sound when time is up.

Please be attentive to the time. Wrap up when your time is over and re-mute your microphone. If you experience technical difficulties during your testimony or later, in the hearing you should stay connected on the platform and make sure you are muted. Use your phone to immediately call the committee’s IT director whose number was provided in advance.

So we will let the witnesses make their presentations before we move to Member questions. When answering a question please remember to unmute your microphone. I want to recognize first Dr. Linsey Marr.

Dr. Marr.

STATEMENT OF DR. LINSEY MARR, PH.D., PROFESSOR OF CIVIL AND ENVIRONMENTAL ENGINEERING, VIRGINIA POLYTECHNICAL INSTITUTE AND STATE UNIVERSITY, BLACKSBURG, VA

Dr. Marr. Thank you. Chairwoman Adams, Ranking Member Keller, and Members of the subcommittee my name is Linsey Marr, and I am a Professor of Civil and Environmental Engineering at Virginia Tech. I have studied airborne transmission of viruses for the past 12 years, and have published more than 30 scientific papers on the topic.

I co-authored the recent letter to the Biden administration and the CDC calling for immediate action to address inhalation exposure of SARS–CoV–2 to prevent COVID–19 infections and deaths. Today I will address four major points. One, how COVID–19 is transmitted mainly by breathing in aerosol particles carrying the virus.

Two, how best to protect workers and the public through the use of appropriate face coverings and other controls. Three, what updates are needed to CDC’s guidance. And four, what needs to be done to protect workers and the public from becoming infected.

There are three possible ways for the virus to be transmitted. You can touch an object that has been contaminated with the virus and transfer it to your eyes, nose, or mouth, or you could be hit by large respiratory droplets that fly out of a sick person’s mouth and land directly in your eyes, nose or mouth. Or finally, you can breathe in small aerosol particles from the air that float around for an extended period of time like cigarette smoke.
There is now overwhelming evidence that inhalation of tiny virus-containing aerosols is the main route of transmission for COVID–19. When people breathe, talk, sing, laugh, cough or sneeze, they release far more aerosols than large droplets as shown in this diagram.

These aerosols shown in red are most concentrated close to the sick person, and they don't fall quickly to the ground like the large droplets which are shown in blue. The aerosols remain floating in the air and follow air currents for more than six feet like cigarette smoke, filling a room and building up over time if the space does not have good ventilation, as also shown in the diagram.

When people are talking in close proximity, it is much more likely that they will breathe in each other's respiratory aerosols than shower each other with large droplets of spittle. Workers require special consideration because they may spend 8 to 12 hours in a poorly ventilated environment where they cannot avoid sharing the air with other people, much longer than a customer who briefly passes through the space.

If ventilation if inadequate, or workers do not wear a good mask or respirator, they could breathe in enough viruses from the air to become sick with COVID–19. The most effective way to protect workers is to control the source of infection. Unfortunately, workers may be exposed to members of the public who are unmasked, especially in restaurants and some businesses.

The next priority is to use engineering controls such as ventilation, to dilute the virus in the air. Respirators and masks are considered the final line of defense. Because SARS–CoV–2 is transmitted mainly by aerosols, the appropriate PPE for workers at elevated risk is a high-performance mask or a respirator.

Unfortunately, most CDC guidance has not yet been updated or strengthened to address and limit inhalation exposure to aerosols. To use a technical term, it is as clear as mud. Their webpages downplay aerosols and airborne transmission, a position that is exactly opposite the best scientific evidence.

Their guidance continues to put workers and the public at serious risk of infection, and undermines the effectiveness of an OSHA standard. I coauthored a letter calling for CDC to update and strengthen its guidelines to fully address transmission via inhalation of aerosols at both close distances and farther away.

We also urge OSHA to issue an emergency standard on COVID–19 that requires implementation of control measures including ventilation and respiratory protection against aerosols for all healthcare workers and other workers at high risk, including those in meat packing, corrections and public transit.

It is clear from the evidence and our experience over the last year that only strong CDC guidance and OSHA standards that are based on the best available science will enable us to safely reopen workplaces and schools while ending this pandemic and better preparing us for the next one. Thank you.

[The prepared Statement of Dr. Marr follows:]
Testimony of

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Subcommittee on Workforce Protections

Committee on Education and Labor

United States House of Representatives

March 11, 2021
Protection Against Transmission of COVID-19

Chairwoman Adams, Ranking Member Keller, Chairman Scott, Ranking Member Foxx, and Members of the Subcommittee. My name is Linsey Marr, and I am a professor of civil and environmental engineering at Virginia Tech. I have studied airborne transmission of viruses for the past 12 years, and have published more than 30 scientific papers on the topic, among more than 100 papers total on topics related to air pollution and health. I co-authored the recent letter to the Biden Administration and the CDC calling for immediate action to address inhalation exposure of SARS-CoV-2 to prevent COVID-19 infections and deaths.

Today, I will address three major points: (1) how COVID-19 is transmitted mainly by breathing in aerosol particles carrying the virus, (2) how best to protect workers and the public through the use of appropriate face coverings and other controls, and (3) what updates are needed to CDC’s guidance. I will conclude by stating what needs to be done to protect workers and the public from becoming infected.

1. How is COVID-19 transmitted?

In theory, there are three possible ways for the virus to be transmitted:

1) You could touch a sick person or an object that has been contaminated with the virus and transfer it to your eyes, nose, or mouth.

2) You could be hit by large, respiratory droplets that fly like mini cannonballs out of a sick person’s mouth and land directly in your eyes, nose, or mouth. These droplets may contain virus.
3) You could breathe in small aerosol particles from the air. These are much smaller than large respiratory droplets, so small that we cannot see them. They float around in the air like cigarette smoke. These aerosols may contain virus.

At the beginning of the pandemic, most of the emphasis was on wiping down your groceries to avoid transmission by touching contaminated surfaces. However, all evidence suggests that transmission from contaminated surfaces is rare. It is possible, but there are zero documented cases involving this type of transmission. Although laboratory studies have shown that this coronavirus can survive for many hours on different types of surface materials, the experiments used unrealistically large amounts of virus in unrealistically large droplets.

For over a century, physicians and many scientists have believed that colds and the flu are spread mainly by large droplets released during coughing. The droplets could land on your eyes, nose, or mouth, and they are large enough that, if they don’t hit anybody, they fall to the ground within 3 to 6 feet of the sick person. Many cases of COVID-19 have been traced to “close contacts,” and this was incorrectly interpreted to mean that large droplets were responsible for transmitting the disease.

However, this assumption ignores the fact that when people breathe, talk, sing, laugh, cough, or sneeze, they release far more aerosols than large droplets, as shown in Figure 1. When we speak, we release hundreds of aerosols for every one large droplet. These aerosols are most concentrated close to the sick person, and they don’t fall quickly to the ground. Instead of falling like cannonballs, they remain floating in the air and follow air currents like cigarette smoke.
Thus, when you are close to someone, you are in the most concentrated part of their exhaled air, as shown in Figure 1. When people are talking in close proximity, it is much more likely that they will breathe in each other’s respiratory aerosols than shower each other with large droplets of spittle. Because aerosols can float in the air for long periods of time, they can easily travel more than 6 feet, filling a room and building up over time if the space does not have good ventilation, as also shown in Figure 1.

**Figure 1.** Exposure to large droplets (blue) and aerosols (red) at close proximity and farther away. When we speak, we release hundreds of aerosols for every one large droplet, as shown in the respiratory plume shaded in yellow. At close proximity, you are exposed more by breathing in aerosols than by having droplets land on your eyes, nostrils, or mouth. Aerosols can travel well beyond 6 feet. They can easily spread throughout a room and can accumulate in the air if the room is poorly ventilated. People far away from the infected person can breathe in the aerosols.
There is overwhelming evidence that inhalation of virus-containing aerosols is the main route of transmission for COVID-19.

1) **Superspreading events.** Examples include the choir practice at which 53 out of 61 attendees became sick and two died,¹ and the gym classes where 55 out of 81 people became sick, even though they were at least 6 feet apart.² Inhalation of aerosols in shared air is the best explanation for superspreading events, as clearly not everyone has spent 15 minutes close to the infected person.

2) **Asymptomatic/pre-symptomatic transmission.**³ If people can transmit the virus without coughing, then the virus must be transmitted by just talking and breathing, which produce aerosols but few large droplets compared to coughing.⁴

3) **Indoor transmission.** There is much less transmission outdoors than indoors. Aerosols are rapidly diluted in outdoor air, so it is much less likely that someone will breathe in enough viruses outdoors to become sick. In a study that traced over 7000 cases of disease, there was only one instance of transmission that occurred outdoors.⁵

4) **Scientific studies.** Infectious coronavirus has been found in aerosol samples collected in hospitals.⁶ The virus can survive for many hours in aerosols.⁷ A careful study of droplets and aerosols traveling through the air demonstrated that the greatest exposure at close

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² https://www.cdc.gov/mmwr/volumes/70/wr/mm7005e2.htm
³ https://www.nature.com/articles/d41586-020-01141-3
⁶ https://www.jidonline.com/article/S0196-6534(20)30726-6/fulltext
⁷ https://www.medrxiv.org/content/10.1101/2020.07.13.20041672v2
contact comes from breathing in the aerosols, not by having large droplets land on you.\(^8\)

Transmission in animals has been shown to occur by breathing in aerosols.\(^9\)

2. How to prevent transmission

If you spend a long time around other people indoors and do not wear a “good” mask (which I
describe below), you could breathe in enough virus-containing aerosols to become sick with
COVID-19. The simplest way to prevent transmission is to limit exposure to the virus. One way
of accomplishing this is by avoiding crowded indoor spaces and limiting the amount of time
spent indoors with those who are not part of the same household. When contact with others
cannot be avoided, as is the case for essential workers, it is critical to reduce exposure to virus in
the air by ensuring good ventilation—this reduces the amount of virus in the air—and wearing
high-performance masks or respirators.

2a. What this means for workers

The total amount of virus that someone breathes in depends on both the concentration of the
virus in the air and the amount of time spent breathing that air. Thus, someone who spends 8-12
hours in a poorly ventilated workplace where they share the air with other people is at much
greater risk for transmission than a customer who passes through the space for a short period of
time.

2b. Cloth masks vs. respirators

\(^8\) https://www.sciencedirect.com/science/article/pii/S0360132372030183
\(^9\) https://www.nature.com/articles/s41586-020-2342-5
I will now discuss different types of face coverings and how they work. Face coverings work in both directions. They reduce the amount of virus that an infected person spreads into the air. We call this “source control.” Face coverings can also reduce the amount of virus that the wearer breathes in from the air around them. Some types of face coverings are much more effective than others against aerosols. The performance of a face covering depends on the filtration efficiency of the material and the fit.

Cloth masks are better at source control than at protecting the wearer from breathing in viruses from the air around them, as shown by studies in my laboratory and others. Cloth masks are only partly effective against aerosols and have wildly varying efficiencies. A good cloth mask might have a filtration efficiency of 50%, but there are some that have an efficiency of only 10%. The actual protection afforded to the wearer may be further degraded if the mask does not fit well. Most cloth masks are not sufficient to protect, for example, a worker in a grocery store who spends 8-12 hours surrounded by unmasked shoppers.

Surgical masks fit loosely and are not designed to protect the wearer from inhaling aerosols. They are designed to protect the patient from large droplets released by a healthcare worker. The material they are made out of—meltblown, non-woven polypropylene—can filter out aerosols very efficiently, but surgical masks do not fit well. Large gaps around the sides allow aerosols to easily circumvent the mask, like having a dam with holes in it. Surgical masks are good at filtration efficiency but bad at fit.

In contrast to masks, respirators are designed to be tight fitting and to filter out aerosols with very high efficiency. They are required by OSHA to protect workers from respiratory hazards. An N95 is one type of respirator that filters out at least 95% of aerosols, and OSHA requires the wearer to undergo a fit test to ensure the N95 does not leak. N95s offer much greater protection compared to cloth and surgical masks. Likewise, elastomeric respirators, which look like gas masks, are designed to seal to the face, and they have replaceable filters that are at least 95% efficient. Another option is a powered air purifying respirator (PAPR), which consists of a hood that is supplied with air that has passed through a high-efficiency filter that removes all aerosols.

2c. Protecting workers

Because workers may spend 8-12 hours in a poorly ventilated workplace with frequent contact with co-workers, patients, and members of the public who may be unmasked, workers require special considerations. According to the hierarchy of controls, the first priority is to control the source. Unfortunately, workers may be exposed to members of the public who are unmasked, especially in restaurants and localities where masks are not required.

The next priority is to use engineering controls, such as ventilation, to reduce the amount of virus in the air. Fresh air dilutes the virus, so it cannot build up to dangerous levels. Opening windows and doors is an easy way to improve ventilation. Workplaces should ensure that HVAC systems are running with as much outdoor air, rather than recirculated air, as possible. Improved filtration also helps remove viruses from the air. Filters in HVAC systems should be upgraded if possible.
Portable air filters are an alternative way to reduce virus concentrations in the air. Upgrades to HVAC systems can be costly and take time to implement.

Personal protective equipment (PPE) is considered the final line of defense. Because SARS-CoV-2 is transmitted mainly by aerosols, the appropriate PPE for workers at elevated risk is a high-performance mask (e.g., filtration efficiency of at least 80% according to the new ASTM standard) or a respirator (e.g., N95, elastomeric respirator, or PAPR), depending on the level of risk. This intervention can be implemented quickly, and supplies are readily available.

3. Problems with CDC’s guidance

Unfortunately, most CDC guidance and recommendations have not yet been updated or strengthened to address and limit inhalation exposure to aerosols. The failure to address inhalation exposure to SARS-CoV-2 continues to put workers and the public at serious risk of infection and undermines the effectiveness of an OSHA standard.

CDC’s stance on how the virus spreads is as clear as mud. CDC’s FAQ on “How does the virus spread?”³⁴, emphasizes close contact and says nothing about inhaling the virus. The Scientific Brief entitled “SARS-CoV-2 and Potential for Airborne transmission”³⁵ obfuscates by incorrectly equating all transmission at close proximity with exposure to droplets. This is wrong because transmission in close contact is dominated by inhalation of aerosols. The webpage

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downplays aerosols and airborne transmission, a position that is exactly opposite the best scientific evidence.

Why doesn’t CDC just say that COVID-19 is spread mainly by breathing in the virus from the air? First, there has been a limited understanding of aerosols in the medical community. When different transmission routes were first identified in the early 1900s, there was no way to detect the invisible aerosols, so researchers focused their efforts on pathogens carried in large, visible droplets. Therefore, there has been a longstanding bias against transmission of viruses through the air, leading to a higher burden of proof required before this route of transmission is accepted for a particular disease. Transmission by large droplets is automatically assumed, even though there is no direct evidence that this actually occurs for any disease.

Second, there has been reluctance to describe the coronavirus as “airborne” because the word has a specific meaning in hospitals. If a disease is labeled “airborne,” then hospitals must use negative-pressure rooms for patients, in addition to N95s; and these precautions are resource-intensive. Initially, it was not clear whether healthcare workers were becoming infected, but studies have now shown that they are at increased risk compared to the general public.13

Third, early in the pandemic, concerns about limited supplies of N95s influenced recommendations. Government officials seemed reluctant to identify hazards and make

recommendations that could not be achieved due to shortages of supplies. However, to my knowledge, there is no longer a shortage.

4. What needs to be done

CDC must update and strengthen its guidelines to fully address transmission via inhalation of aerosols at both close distances and farther away. Most CDC guidance and recommendations continue to emphasize distancing and surface cleaning, which are important, but less important than using high-performance masks and sufficient ventilation to clean the air. CDC is moving in the right direction, for example with its web pages “Improve How Your Mask Protects You”\(^\text{14}\) and “Ventilation in Buildings,”\(^\text{15}\) but clear and explicit explanation of why these actions help protect against inhalation of aerosols is needed so that people understand why certain interventions work better than others. Improved guidance is sorely needed so that people can better protect themselves against infection, especially workers who may be exposed to elevated levels of virus in the air for long periods of time.

In a letter to the Biden Administration and CDC that I co-authored with 12 other leading medical and scientific experts, many of whom were members of President Biden’s Transition COVID-19 Advisory Board, we call for CDC and OSHA to issue recommendations and requirements that address transmission of COVID-19 by inhalation of aerosols. Specifically, we urge OSHA to issue an emergency standard on COVID-19 that requires implementation of control measures, including effective respiratory protection for all healthcare workers and other workers at high

risk, including those in meatpacking, corrections, and public transit. Similar letters have been sent by other experts to governments and public health agencies in Australia, Canada, Colombia, Spain, and the UK.

Calling the virus “airborne” is the clearest way to convey how it is transmitted. Airborne, meaning “borne by air,” is directly analogous to the terms waterborne, foodborne, bloodborne, and vector-borne for describing how pathogens are transmitted. For now, the word “airborne” can continue to retain its special meaning in hospitals, just like the word “chart” means something different in hospitals than among the general public.

While CDC has been reluctant to call the virus “airborne,” in my experience, the general public appreciates learning how the virus really spreads. This knowledge empowers them to make the best decisions to protect themselves and others. My colleagues and I have received numerous messages from the public, thanking us for delivering the clear and simple message that airborne transmission of COVID-19 is most likely the main way it spreads. This message has saved lives.

Summary

There is overwhelming evidence that inhalation of virus-containing aerosols is the main way that COVID-19 spreads. It is critical for the CDC to state this clearly and to provide appropriate guidance and recommendations. It is equally critical for OSHA to base its standards on this evidence. Improved guidance is sorely needed so that people can better protect themselves against infection, especially workers who may be exposed to elevated levels of virus in the air for long periods of time. We know how to protect people from aerosols: using high-performance masks and respirators and cleaning the air by ensuring good ventilation and/or filtration. Strong CDC guidance and OSHA standards that are based on the best available science will enable us to safely reopen workplaces and schools, while ending this pandemic and better preparing us for the next one.

Ms. Adams. Thank you very much Dr. Marr.
We'll now hear from Miss Pascaline Muhindura. You’re recognized ma’am.

STATEMENT OF MS. PASCALINE MUHINDURA, REGISTERED NURSE, COVID PROGRESSIVE CARE UNIT, RESEARCH MEDICAL CENTER, KANSAS CITY, MO, ON BEHALF OF NATIONAL NURSES UNITED

Ms. Muhindura. Good morning. And thank you Chairwoman Adams, Ranking Member Keller, and Members of the subcommittee for giving me the opportunity to testify today. I’m a critical care nurse at Research Medical Center, an HCA healthcare facility in Kansas City, Missouri. And I’m a proud union member of National Nurses United.

I will make three main points today. First, my employer has failed to protect us. Second, the CDC and OSHA have failed to protect us. And third, the CDC and OSHA must take immediate steps to ensure that nurses and other workers get the protections we need.

For more than a year I have been caring for patients in a COVID unit in my hospital. Every single nurse and healthcare worker in my unit has contracted COVID because we were not given the protections we need. My colleague Celia lost her life. As Dr. Marr outlined SARS–CoV–2 is transmitted through the inhalation of aerosol particles.

That means that nurses and other frontline workers must be given respiratory protection. At minimum, we need N95 respirators which are only safe for a single use. Power aired purifying respirators and elastomeric respirators are more protective, and are safely reusable.

In January 2020, nurses urge our employer to prepare for COVID. They didn’t. When the pandemic started in March none of the COVID nurses had been fit tested for N95’s. Management had not implemented our recommendation from January. On March 21 management collected all of the PPE in the hospital, locked it up, and began rationing N95’s.

The next day a patient was transferred from the emergency department to the cardiac telemetry unit. The nurses on the unit recognized the patient had signs of COVID and the asked management for N95’s. Management refused. The patient later tested positive, and as a result of her exposure to this patient, my colleague Celia Yap-Banago contracted COVID and lost her life.

Despite Celia’s death, the hospital continues to ration N95’s. Management is still forcing us to unsafely reuse the same N95 for an entire shift, and is recommending that we use surgical masks with COVID patients. To be clear, nurses on my unit are still caring for COVID patients without adequate protection.

This isn’t just happening in my hospital. In NNU’s February 2021 survey of nurses across the country, more than 81 percent report that they still have to reuse at least one type of single use PPE. As union nurses, my colleagues and I have been fighting these dangerous policies every step of the way. As registered nurses we know that as long as our safety is compromised, our patients are also at risk.
In all of our conversations with management they have told us the same thing. They’re following CDC guidelines. The CDC guidelines are not based on science. To this day the CDC does not recognize aerosol transmission of COVID. The guidelines allow healthcare employers to give nurses surgical masks, instead of respirators, and to reuse N95’s.

Management withholds PPE and they used CDC guidelines as their justification for putting our lives at risk. My union filed a complaint with OSHA last spring about the circumstances that led to Celia’s death. OSHA found clear evidence Celia and other nurses have been exposed to COVID because of our employer’s failure to provide PPE.

But OSHA could not cite my employer because the CDC guidelines are weak, and because OSHA doesn’t have a standard on infectious disease. As union nurses, with our practice rooted in science, we have clear recommendations for what we need to be able to care for our patients safely.

First, we need the CDC to update its COVID guidelines to be based on scientific evidence, especially regarding aerosol transmission. The CDC needs to revoke the crisis standard on optimization of PPE which are based on supply consideration, not science. Second, we need a thorough OSHA standard that requires our employers to protect our health and safety at work. If these recommendations had been implemented 1 year ago, my colleague Celia, along with thousands of other healthcare workers would be alive today.

We need immediate action so that nurses and our patients get the protections we need.

[The prepared Statement of Ms. Muhindura follows.]
PREPARED STATEMENT OF PASCALINE MUHINDURA

Testimony of Pascaline Muhindura, RN
On Behalf of National Nurses United
Before the
Subcommittee on Workforce Protections
Committee on Education and Labor
March 11, 2021

Hearing on “Clearing the Air: Science-Based Strategies to Protect Workers from Covid-19 Infection”

Good morning and thank you, Chairwoman Adams and Ranking Member Keller, and members of the subcommittee for giving me the opportunity to testify here today. I have been a registered nurse (RN) for six years, and I am a proud union member of National Nurses Organizing Committee, an affiliate of National Nurses United (NNU). NNU is the largest union of RNs in the United States, representing over 170,000 members who work as direct care health professionals in every state in the nation.

I have worked as a critical care nurse at Research Medical Center, an HCA Healthcare facility, in Kansas City, Missouri for four years. When the pandemic began one year ago, my unit became a Covid-19 unit, and I have been caring for Covid patients ever since.

In my testimony today, I will share the details of my experiences as a Covid-19 nurse over the course of the pandemic and make three main points. First, my employer has failed to provide the N95 respirators and other workplace protections that my colleagues and I needed to do our jobs safely, which has led to many Covid-19 infections and ultimately the death of one of my coworkers. Second, the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) have failed to protect nurses and other frontline workers from Covid-19. The guidance issued by the CDC about Covid-19 transmission and worker protections has not been based on science and has directly led to infections and deaths of workers. Due to the CDC’s faulty guidance and the lack of an OSHA standard on infectious diseases, OSHA has been unable to effectively cite employers for Covid-related hazards. Third, it is critical that the CDC immediately recognize aerosol transmission of Covid-19 in their guidelines, and that OSHA issue an emergency temporary standard to protect workers from Covid-19 which recognizes aerosol transmission and the need for respiratory protection.

All Nurses and Health Care Workers On My Unit Contracted Covid-19 Because Our Employer Failed to Protect Us

Over the course of the past year, every single nurse and health care worker in my unit has contracted Covid-19. One of my colleagues died from Covid-19. As of March 5, 2021, at least 3,379 health care workers, including 345 RNs, have died from Covid-19 nationally.1 Our

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families have been put at risk of getting Covid-19 and many of our family members have gotten infected because of our jobs. All this illness and death was preventable – if only our employers and government had taken the necessary steps to protect us.

Our employers and government have failed to protect nurses, other health care workers, and our patients, despite the clear scientific evidence on aerosol transmission of SARS-CoV-2 and the measures necessary to prevent transmission (see Attachment 1). A vast body of scientific research has shown that this virus is transmitted through the inhalation of aerosol particles that are produced through breathing, talking, coughing, and sneezing, and which can remain viable in air for long periods of time and which can travel long distances. A growing number of outbreak investigations have found that aerosol transmission is the only possible explanation for the outbreak. Despite the evidence on aerosol transmission, many health care employers still do not provide the respiratory protection and other workplace controls that we need to be able to care for our patients safely.

The surgical masks that many employers, including mine, have given nurses to wear while caring for Covid-positive patients do not provide respiratory protection from infectious aerosols. An N95 filtering facepiece respirator is the minimum respiratory protection needed to reduce exposure to an aerosol transmitted disease. There are more protective respirators, specifically Powered Air-Purifying Respirators (PAPRs) and elastomeric respirators, which are safely reusable and offer a higher degree of protection. Unfortunately, in my hospital we are still fighting for N95s to be used for single use only, as intended by the manufacturer, and there is only limited stock of more protective respirators.

The reality is that our employers should have started with this highest level of protection from the beginning of the pandemic. Our Professional Practice Committee (PPC, a union committee to address health and safety and nursing practice in the hospital, of which I am an active committee member) submitted recommendations about preparations for a Covid-19 response to the Chief Nursing Officer (CNO) of the hospital on January 24, 2020. Despite those recommendations, when the Covid-19 pandemic first started in March, there was no preparation from hospital management to respond to the emerging outbreak, and we quickly saw that our employer had no strategy to contain the spread of the virus in our facility. There are evidence-based strategies for protecting health care workers from novel infectious disease outbreaks, and our hospital did not use them. Our union immediately called on our health care employers and all public health agencies to follow the precautionary principle, which states that we cannot wait until we know for certain that something is harmful before action is taken to protect people’s health. We can always take layers off as we go but we can never add them back later.

It is because of the precautionary principle that nurses knew, more than a year ago, that we should have been given optimal respiratory protection to protect us from airborne transmission of Covid-19. But the hospital was not prepared with the personal protective equipment (PPE) stock that should be on hand in the event of an infectious disease outbreak, and none of the nurses on

my unit had been fit-tested for N95 filtering facepiece respirators (N95s). Fit-testing of N95s is necessary to ensure protection—and required by OSHA’s Respiratory Protection Standard\(^2\)—and without it, nurses could not be assured that their N95 would protect them.

**Our Employer Rationed and Withheld the N95 Respirators We Needed to Do Our Jobs Safely**

For the first three weeks of March 2020, PPE including N95s remained available for nurses to use on our unit, although we had not been fit-tested for the N95s. During those first three weeks as the virus was slowly spreading in our community, our PPC compiled a list of health and safety concerns that we delivered to the CNO of the hospital. At the end of the third week of March, the PPC met with the CNO’s designee and the Critical Care Units Director to discuss our concerns. We raised many issues, including access to PPE, and the need for nurses to receive fit-testing for N95s. In that meeting, management informed us that doctors were already being fit-tested for N95s, but that they could not offer any guidance on fit-testing for nurses at that time. Given the relative chances of exposure, it was absurd that hospital management was fit-testing doctors but refusing to fit-test nurses. They told us that they were following CDC guidelines. We objected to this plan and pointed out that the CDC guidelines at the time allowed for bandanas to be used for protection against Covid-19 – which was a truly dangerous suggestion. In response, management laughed at us.

The day after that meeting, hospital management removed all the PPE from our units and placed it into a storage facility on one floor in the hospital. We were told that we needed to go to that particular hospital floor in order to check out any PPE that we needed and that PPE would be rationed. When we questioned why N95s and other PPE were being rationed, we were informed that the hospital had adequate supply of N95s and other PPE and management was choosing to ration these supplies because they were concerned about the possibility of a supply shortage in the future. Management consistently reaffirmed the strength of HCA’s supply chain, while continuing to ration supplies.

The next day, a patient was sent from the Emergency Department to the Cardiac Telemetry Unit, which was not supposed to receive any Covid-positive or potential Covid-19 patients. The RNs on the unit recognized the patient had signs and symptoms of Covid-19 even though the hospital had not classified the patient as a potential Covid-19 case. The RNs did not have access to PPE and cared for the patient without PPE. The patient later tested positive and was transferred to my unit. As a result of this exposure and our employer’s failure to provide adequate PPE, one of my colleagues, Celia Yap-Banago, contracted Covid-19 and lost her life.

The situation in those first months was dire. We continued to have little access to the N95 respirators and other PPE we needed. Not only were we forced to ration N95s and care for Covid-19 patients without respiratory protection, but we were also forced to reuse gowns.

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\(^2\) 29 CFR §1910.134
notified about exposures to suspected or confirmed Covid-19 patients and we were expected to continue reporting to work when we had been exposed.

The situation was chaotic and extraordinarily stressful. Our Covid-19 units were constantly experiencing deaths of patients and our hospital was often overrun. We were terrified every day that we would be exposed, and risk exposing our families at home, to Covid-19 because we did not have the PPE we needed.

I am lucky to work in a hospital where the nurses are represented by a union. It was through our union that nurses were able to successfully fight hard to force the hospital to get us some of the PPE we needed and to begin fit-testing nurses for N95s. When we received N95s, we originally had to use the same respirator for multiple shifts. The hospital tried to implement programs where they would use unproven procedures to “decontaminate” our N95s, procedures that not only had not been proven to work but that potentially damaged the N95s and also put nurses at risk of chemical exposures. With the union, we have continually fought back against the reuse, decontamination, and extended use of N95s with some significant success.

The science on the safe use of N95s is crystal clear: N95s are single use only respirators, and they should only be used one time, with one patient. Every time an N95 is reused, or used for an extended period, the risk of exposure increases. As you reuse an N95, the material of the mask degrades, the elastic becomes loose, and you cannot be guaranteed a proper fit.

One Year into the Pandemic, Employers Continue the Unsafe Rationing of N95 Respirators

Today, one year later, our employer is still not providing the protections we need. Even though N95s are now available on our unit, we are still fighting for them to be used properly. Our employer has plenty of supply but is still choosing to ration N95s. Right now, we are only allowed to use one N95 per shift. This means that we are using the same N95 with multiple patients, for a full 12-hour shift. After about four hours of wearing the N95, I can feel the mask degrading and the elastic getting loose, and I know the efficacy of the respirator is decreasing. Because we only have one respirator for the entire shift, nurses don’t want to take the respirator off because our chances of exposure to the virus increase each time we take the respirator on and off. The respirator gets full of sweat and mucus and can be coated with the virus on the outside. Reusing a respirator or using it for an extended time is like using a dirty tissue to blow your nose. It is not sanitary and it is not the standard of care we should have.

The current policy on PPE use when taking care of Covid-positive patients is dangerous and irresponsible. We are still being told that we are not allowed to wear N95 respirators when taking care of certain Covid-positive patients. Management is requiring the use of level-three surgical masks for Covid-positive patients who are either on room air (which means that they are not using oxygen or a ventilator), or who are on a lower level of oxygen. We are only allowed to use N95s for aerosol-generating procedures or if the patient is on high-flow oxygen. This is contrary
to the scientific evidence showing that Covid-19 is transmitted via infectious aerosols emitted when Covid-positive individuals breathe, talk, cough, and sneeze.\(^3\)

To be clear, in my hospital, nurses in Covid-19 units are still being forced to care for confirmed Covid-positive patients without any respiratory protection. This is despite the fact that there is existing supply of respirators in our hospital, and it is despite the fact that HCA, the corporation that owns my hospital, made more than $3.7 Billion in profits in 2020.\(^4\)

At the end of the day, not recognizing the aerosol/airborne transmission of Covid-19 and refusing to give us the respiratory protection we need has resulted in workers getting sick, and for some, it has resulted in death. This was the case for my colleague Celia.

I got Covid-19 the week of Thanksgiving. One week before I tested positive for Covid-19, I responded to a code blue for a Covid-19 patient. I was wearing the same N95 that I had been wearing throughout my entire shift and was doing chest compressions on the patient. It was a highly stressful situation, and I was sweating a lot. I knew that my N95 had already been degraded over the course of my shift, and I was very nervous about potential exposure. One week later, on the Sunday before Thanksgiving, I came into work and was feeling unwell and was coughing. There is a screening system before you enter the building, but the screeners let me walk through even though I told them I was coughing. I worked on the unit for about five hours before I was sent to the Emergency Department to get tested and found out I had Covid-19. In those five hours, I could have exposed many patients and coworkers.

The next two weeks were a harrowing experience for me. While my symptoms weren’t critical, I was sick and suffering from a cough and shortness of breath. I share custody of my kids with their father, and at the time I tested positive, my kids were at his house. Because of my positive test, they had to stay with their father and I wasn’t able to see them for two weeks, until I had fully recovered. I suffered from immense anxiety during this time and was unable to see any member of my family during Thanksgiving. I also was unable to spend my daughter’s birthday with her. To make matters worse, my three-year-old daughter was experiencing respiratory symptoms during this period. While she tested negative for Covid-19, I felt very concerned that she may have been exposed to the virus from me. In the following weeks after I tested positive, many staff on my unit also contracted the virus.

Many of my nurse colleagues throughout the country have had similar experiences to those that we have experienced in Kansas City. In NNU’s February 2021 survey of over 9,200 nurses, more than 81 percent report that they still have to reuse at least one type of single-use PPE (see

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Attachment 4 for full results). And about 24 percent of hospital RNs report that their employer has recently limited the use of N95 respirators.

In addition to a lack of PPE, hospital employers across the country are still failing to provide the basic infection control measures that are needed to prevent transmission of Covid-19 within their facilities. About 54 percent of RNs report having ever been tested for Covid-19, despite testing being the only way to identify asymptomatic and pre-symptomatic cases. Many employers are also failing to conduct thorough contact tracing and failing to promptly notify RNs about exposures. Only 32 percent of RNs report that their employer informs them of exposures in a timely manner (see Attachment 4).

**Covid-19 has Exacerbated Existing Health and Safety Concerns in Health Care, Especially Workplace Violence**

While the pandemic has created its own life-threatening health and safety hazards, it has also exacerbated existing health and safety concerns in the hospital. For example, nurses have been dealing with high levels of workplace violence for many years. Throughout the pandemic, the frequency of violent incidents in the workplace has increased. NNU’s most recent survey also found that workplace violence has been increasing during the pandemic—about 22% of hospital RNs reported a slight or substantial increase in workplace violence during the pandemic (see Attachment 4).

Workplace violence is something that all nurses experience on the job. In my unit, we have had severe violent incidents take place in the last few years. One of the nurses who worked in my unit was punched in the face by a patient in front of four other nurses. Nothing was done by management, and there was no follow up on the situation. A few weeks after the incident, she was reassigned to care for the same patient with no additional safety measures or supports, despite having been previously assaulted by the patient. My colleague felt fear and anxiety returning to work after this incident. Often, when nurses report workplace violence incident, management tells us that this violence is “just a part of the job.”

In my first year as a nurse, I was taking care of a patient who was very agitated. At one point, the patient became angry and grabbed my stethoscope, which I was wearing around my neck. The patient began strangling me with the stethoscope. Luckily, a coworker was in the patient room with me at the time and was able to help me get free and leave the room. Since that time, I am careful to avoid wearing my stethoscope around my neck with any patients that may be violent.

The increase we have seen in workplace violence incidents throughout the pandemic is symptomatic of the many ways that employers have failed to protect the health and safety of nurses and other health care workers. These working conditions have deeply impacted the mental health of nurses and our families.
Pascaline Muhindura, Testimony on behalf of National Nurses United
House Committee on Education and Labor, Subcommittee on Workforce Protections
Hearing on "Clearing the Air: Science-Based Strategies to Protect Workers from Covid-19 Infection"
March 11, 2021

Pandemic Stress and Health and Safety Hazards Have Led to High Turnover

Nurses are exhausted. The turnover in my unit is rapid and is due to the stress of the pandemic and not having the protections we need. The people we started with last March are no longer working in my unit anymore. There are only two full-time RNs on dayshift who were working in my unit at the start of the pandemic that I know are still working there; everyone else is a travel nurse or is floating from a different unit. Over the course of 2020, 249 RNs left the bedside at Research Medical Center. This is roughly one-third of our entire registered nursing staff. The turnover has been shocking, but not surprising. The hospital has failed to adequately replace nurses; we currently have 115 fewer RNs in the hospital then we did before the pandemic. Many of my coworkers have left to work in other units that do not have Covid-19 patients.

People keep leaving because of the way we have been treated and the emotional toll of this job during the pandemic. With Covid-19, patients are some of the sickest we have ever seen and there is an environment of constant death in the hospital and in the Covid-19 units especially. Nurses are trained to deal with illness and death, and our job before the pandemic was often very stressful. But we need the staffing, the equipment, and the protections necessary to do our jobs well. On top of learning about a novel pathogen and trying to take care of our acutely ill patients, we have had to fight for the basic protections we need so that we can stay healthy and alive in order to provide patient care. This reality has made the pandemic unbearable for many nurses.

CDC, OSHA, and the Federal Government Have Failed to Protect Nurses and Health Care Workers from Covid-19

Something that has compounded the impact of the pandemic and having to fight for basic protections is that the CDC and other federal agencies have also abandoned us. Throughout the pandemic, the federal government, especially the CDC, has issued weak guidance that is not based on science or the precautionary principle. The CDC’s guidance for health care employers does not recognize aerosol/airborne transmission of Covid-19. The crisis strategies for PPE— which the CDC calls “optimization strategies”— gives employers a menu of options to avoid protecting their workers.\(^2\) The CDC guidance still allows employers to give nurses surgical masks when they care for Covid-19 patients or to require nurses to reuse N95s, putting us and our patients at risk of infection. CDC’s guidance on exposures to health care staff tells employers they do not need to do contact tracing if they do not want to put resources towards that while there is transmission within the community.\(^3\) This guidance treats respirators and facemasks as equivalent levels of protection, even though there is an abundance of research showing they are

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not. Management uses this CDC guidance as the rationale for these policies that have made my colleagues and myself sick and that led to Celia’s death.

To be clear, my employer and other hospital employers across the country are using the CDC guidelines to justify withholding the PPE that we desperately need, despite having ample supply of PPE.

When my union filed a complaint with OSHA last spring, OSHA did not and could not issue a citation to my employer because of the CDC guidelines and the lack of an OSHA standard on infectious diseases (see Attachment 2). Our complaint addressed a multitude of hazards that our employer had not prevented, including the circumstances that led to the death of Celia Yap-Banago. OSHA investigated our complaint but did not cite our employer despite finding clear evidence that Celia and other nurses had been exposed to Covid-19 because of our employer’s failure to provide PPE.

The CDC’s reckless guidance and failure to recognize aerosol transmission of this virus has deeply contributed to the stress and exhaustion that nurses have experienced over the past year. CDC’s crisis standards, which are not based on science, have been used as cover by hospital employers across the country for not providing optimal PPE or instituting proper infection control protocols, thus endangering nurses, other health care workers and our patients. As a result, nurses have been forced to work despite substandard protections so many times that it has become hard for some nurses to imagine what having optimal protections would be like. Before this pandemic, nurses could get fired for re-using an N95. Now, reality has shifted so far that having one N95 for a 12-hour shift is a win, despite the risk of exposure.

Throughout the pandemic, many of my colleagues and I have spoken out about these dangerous working conditions, the weak CDC guidance, and the lack of an OSHA emergency temporary standard on infectious diseases, and we have demanded the optimal PPE and other measures that we need to do our jobs. As RNs, we see this advocacy as part of our practice; we are patient advocates—that means doing what we can to make sure our patients get the safe, quality care they need. But speaking out like this can carry its own risks. For me, speaking out has put a target on my back at my workplace. Before Covid-19, I was a clinical instructor for nursing students and a preceptor for new employees. My performance reviews were always stellar. But since I began speaking out publicly and raising concerns about the dangerous working conditions during the pandemic, my performance reviews have dropped even though I am working the same way. The protection of the union has meant that I have not seen more severe retaliation. But this is not true for nurses in other hospitals who do not have the protection of the union.

Recommendations to the CDC and OSHA to Make Strong, Science-Based Decisions to Protect Workers and Combat Covid-19

As unionized direct care RNs, with our practice rooted in science, we have clear recommendations for what we need to be able to care for our patients safely. First, we need the
Pascaline Muhindura, Testimony on behalf of National Nurses United
House Committee on Education and Labor, Subcommittee on Workforce Protections
Hearing on “Clearing the Air: Science-Based Strategies to Protect Workers from Covid-19 Infection”
March 11, 2021

CDC to update its Covid-19 guidelines to be based on scientific evidence, especially regarding aerosol transmission of the virus. The CDC must rewrite a significant portion of the guidance for health care and other industries to make stronger recommendations regarding respiratory protection, ventilation, and other control measures to reduce and prevent aerosol transmission of Covid-19. Additionally, the CDC needs to revoke the crisis standards on “optimization” of PPE, which are guidelines based on supply considerations not science.

Second, we need a federal OSHA standard that fully recognizes aerosol transmission of Covid-19 and establishes strong requirements for our employers to implement the infection control plans needed to protect our health and safety at work. These infection control plans must include providing optimal respiratory protection, ventilation, patient screening and isolation, testing, paid precautionary leave, and more (as outlined in the Nurses’ Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic, see Attachment 6).

It is devastating to know with certainty that if these recommendations had been implemented immediately one year ago, my colleague Celia, along with thousands of other nurses, health care workers, and frontline workers would be alive today. I urge every member of this committee to take steps to ensure that the protections we need are implemented as soon as possible. This pandemic is not over, and employers across the country are still knowingly subjecting their workers to exposure to Covid-19. We need your urgent support to ensure that the CDC guidelines are updated and that OSHA issues a strong and enforceable standard to protect workers during this pandemic and any future infectious disease outbreaks.
Attachments:


4. Results from National Nurses United’s Surveys of Registered Nurses on Covid-19 in Their Workplaces.


DROPLET VS. AIRBORNE: HOW IS SARS-COV-2 TRANSMITTED?

The U.S. Centers for Disease Control and Prevention (CDC) states that the primary mode of transmission for COVID-19 is droplet transmission and that "airborne transmission from person-to-person over long distances is unlikely."

**Droplet vs. Airborne: Some History**

The CDC's categorical distinction between droplet (large) and airborne (small) transmission was established in the 1930s and has not been substantially updated since. This paradigm requires a focus on the behavior of isolated droplets and a simplified distinction between large and small droplets and their corresponding evaporation rates. Together, these give the false sense that droplets behave in only one of two ways and create a division between two types of transmission and their ranges, either close or far.

**Droplet vs. Airborne: Updating the Science**

Recent research confirms that when a person breathes, talks, coughs, or sneezes, they produce a multistage turbulent gas cloud (or plume) of warm air containing respiratory droplets ranging in size from microscopic to visible (called "aerosols"). This plume and its aerosols are transported by ambient air. Aerosols remain suspended or fall in relation to a variety of factors including their size, evaporation rates, air current, temperature, and humidity. Larger aerosols can remain suspended in the air for several minutes before settling on the ground or on a surface, while smaller particles can be kept aloft by the dynamics of the plume, allowing them to linger in the air and travel up to 27 feet through the room and ventilation systems.

For example, think about perfume spray which can be smelled from a distance for quite some time as the particles disperse throughout the room.

Definitions:

**DROPLET TRANSMISSION**

Large respiratory droplets are propelled onto the face and mucous membranes of those nearby the infected person (within six feet).

**AIRBORNE TRANSMISSION**

Transmission of small respiratory droplets or droplet nuclei that can travel through and/or remain suspended in the air for a period of time leading to airborne transmission.

**AEROSOL TRANSMISSION**

An updated understanding of the complex ways that respiratory particles are created, how they move, and where they go.

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#ProtectNurses. All Our Lives Depend On It.

www.NationalNursesUnited.org  NationalNurses  @NationalNurses
Is SARS-CoV-2 aerosol transmissible?
While models of transmission have yet to be fully established for the novel SARS-CoV-2 virus, emerging studies support aerosol transmission.

- Two recent studies have found that SARS-CoV-2 can survive and remain infectious in aerosols for over 16 hours.
- Recent research also shows that SARS-CoV-2 can survive on surfaces for an extended period of time.
- Evidence of environmental contamination also show that SARS-CoV-2 can travel long distances from patients. For example, genetic material from SARS-CoV-2 was detected on a number of surfaces in the Diamond Princess cruise cabins of both symptomatic and asymptomatic infected passengers 17 days after they vacated.
- A recent study of SARS-CoV-2 aerosolization from the University of Nebraska also found widespread environmental contamination. They found significant contamination on air handling grates as well as positive air samples in the hallways and on window ledges which were greater than six feet away from patients.

These data support aerosol transmissibility of COVID-19 and challenges the CDC’s assertion that transmission over long distances is unlikely.

What does this mean for nurses and other health care workers?
The emerging evidence that aerosol transmission of COVID-19 is likely underlines the importance of protecting nurses and other health care workers—including both respiratory protection and contact precautions. Nurses and other health care workers should have the highest level of personal protective equipment (PPE) when caring for patients with suspected or confirmed COVID-19. The highest level of PPE for COVID-19 includes a powered air-purifying respirator (PAPR) and coveralls impermeable to viral penetration that incorporate head and shoe covering, and gloves.

References:

#ProtectNurses. All Our Lives Depend On It.

www.NationalNursesUnited.org — @NationalNurses — @NationalNurses
Julie Perry  
222 W Gregory Blvd Ste 241  
Kansas City, MO 64114

RE: OSHA Complaint No. 1583505

Dear Ms. Perry:

In response to your complaint concerning safety and/or health hazards at Research Medical Center, the Occupational Safety and Health Administration (OSHA) conducted an inspection. That inspection was completed on 07/13/2020. The results of our investigation of your complaint items are as follows:

Complaint item(s) and Responses:

ITEM 1: March 20th. Union stewards met with Stephanie Droppelman and Director Kim Dunnels (CNO designee). Reviewed multiple concerns and one was a request they fit test all RN’s for N95’s. Nurses were not being fit-tested for N95’s. They said they had no intentions and were only doing this for doctors.

RESPONSE: A meeting was held with the nurses. Following the meeting nurses were given fit tests beginning on March 20, 2020 and on subsequent days. OSHA has a memorandum dated March 14, 2020, Temporary Enforcement Guidance- Health Care Respiratory Protection Annual Fit-testing for N95 Filtering Face pieces during the COVID-19 Outbreak. If a good faith effort to comply with 29 CFR 1910.134 is being made then a citation is not issued.

ITEM 2: On March 21st, the Personal Protective Equipment warehouse was created on the first floor, in 1N. PPE had been removed from areas such as 3N, Medical Care and was only available on the first floor. Nurses were emailed on March 30 about having a PPE warehouse.

RESPONSE: Information was given to OSHA that medical staff were informed about the PPE warehouse during the week of March 20-27th huddles, the pre-shift staff meetings held on the floors. The PPE warehouse was being utilized to keep an inventory of PPE availability in the hospital. No citations regarding this complaint item.

ITEM 3: On March 22/23: A nurse on the 4th Floor, 4 N/C, Cardiac Telemetry Unit, received a Covid infected patient on the night shift of 3/22/20 from the ED. She voiced her concerns to the charge RN that the patient had signs and symptoms of COVID-19. There was no PPE to use on their unit. Celia Yap-Banago also had to care for the same patient without ppe until the patient was transferred to a Covid-19 cohort unit.

RESPONSE: A patient was transferred to the 4 N/C Cardiac Telemetry Unit that had pneumonia.
The patient had been screened in the emergency room using the CDC questions at the time: which were based on having a temperature, had the person travelled out of the country, was the patient experiencing Shortness of Breath. The night shift nurse recognized that the patient had signs and symptoms of COVID-19. The night shift nurse and day shift nurse did not wear PPE. Their unit 4 North was not supposed to have PUI (Patient Under Investigation) or COVID-19 patients. The PPE warehouse information was talked about in the pre-shift huddle meetings the week of March 20th-27th. The Charge Nurse was supposed to pick up PPE for employees at the time. The Charge Nurse on Day Shift took over once she was told that the patient could possibly have COVID-19. The patient could not be relocated until a doctor had ordered a COVID-19 test. The patient was then transferred to a PUI Patient Under Investigation unit. The charge nurse wore a level 3 mask, goggles, gown, and gloves. Citations were not issued in regard to this complaint item.

ITEM 4: March 24th; the Research Psychiatric Center, RPC, RN’s do not have PPE in their center. It is housed in another building in RMS. The RN’s do not have readily available access to PPE.

RESPONSE: Nurses and or charge nurses could get the PPE for use from the PPE warehouse even though it was housed in the Research Medical Center building. There was a Hazard Alert Letter issued in regard to fit testing at the Research Psychiatric Center.

ITEM 5: March 24th; RN’s on 4 N/C are lacking the use of N95 masks and instead are using level 3 surgical masks. There have been complaints on how they were to cluster the covid or potential covids together and RN’s would be assigned to only covids or non covids. If they had the covids/potential covids, they got 1 mask and 1 gown for the shift. The shifts are 12 hours.

RESPONSE: On March 24th, the hospital was conserving PPE as no one knew if there would be a PPE shortage. Level 3 masks were being used by staff caring directly for potential PUI (Patients Under Investigation). The N95’s were required during intubating and aerosolizing procedures for employees in PUI and COVID-19 units. There was no citation in regard to this item.

ITEM 6: March 28 or March 29th. A nurse in the float pool was floated to 4W, PCU. The nurse was assigned to potential covid patients. This is a covid cohort unit, one came back positive on this shift. The nurse’s N95 broke. The nurse tried to get a PAPR and was denied use. Nurse was told to use a surgical 3 and goggles.

RESPONSE: This incident was not able to be verified. The OSHA Compliance Safety and Health Officer was unable to interview those involved in this incident. No citations regarding this item.

ITEM 7: March 24th and March 30th, a nurse on 4W, PCU, was caring for potential covids. The doctors kept telling the nurse to be careful, they knew they had covid. The unit manager, Jillian Curley, RN was asked for an N95. The nurse was told if I give you one, I have to give one to everyone. By Friday, the test showed they were positive covids. March 30th, the director took the PAPR away when the nurse had 2 covid aerosolized patients.

RESPONSE: The employee was issued a surgical mask and a gown at the time of the first incident. At that time Level 3 masks were being used by staff caring for suspect COVID and
COVID-19 patients. An N95 was required during intubating and aerosolizing procedures if patients were PUI (Patients Under Investigation) or were diagnosed with COVID-19. The nurse that had the PAPR taken away had an N95 at that time. The nurse did not actually need the PAPR.

ITEM 8: There were covid positives on the 4N and 4C so far on the hospital’s OSHA 300 log, all on this unit.

RESPONSE: Four employees had been denoted on the OSHA 300 log that had tested positive for covid from 4N and 4C.

ITEM 9: Multiple RNs have been out sick with covid like symptoms in March and April on multiple units. Tests don’t always come back positive and so they are not logged on the OSHA 300 log.

RESPONSE: Employees are placed on the OSHA 300 Log once they have had a positive test to denote COVID-19 diagnosis. The employees also had to have a work place exposure to be logged on the OSHA 300 log.

ITEM 10: 4NC units are sister floating cluster units with 4W PCU and the ICUS, the RNs float if staff is needed. The covid cohort units are 4W PCU and MICU, but possible covid patients are allowed to be anywhere.

RESPONSE: The patients were being primarily cohorted to 4W PCU and MICU during this inspection. There were no citations regarding this complaint item. There are no longer Patients Under Investigation (PUI) units as testing is being conducted in the emergency room then employees are being sent to COVID units.

At the time of the inspection there is no standard regarding the Covid-19 virus. The conditions were not so great as to create a violation of OSHA standard(s). The employer had fit tested employees for N95 respirators. Few employees had been fit test at the Research Psychiatry Center but they had a smaller exposure of employees with COVID-19. As such, a citation for this item is not recommended.

Attached for your information is a copy of the Hazard Alert Letter which was issued to the employer. If you do not agree with our inspection results, you may contact me for a clarification of the matter.

Section 11(c) of the Occupational Safety and Health Act protects employees from being discriminated against because of their involvement in protected activities related to safety and health. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, because OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Please feel free to contact the office at (816) 483-9531 if you have any questions or concerns.

Your action on behalf of safety and health in the workplace is sincerely appreciated.

Sincerely,

for Kimberly Robinson
Karena Lorek
Area Director

Enclosure(s)
Kansas City RNs to Hold Vigil in Memory of Research Medical RN Who Died of COVID-19

National Nurses Organizing Committee
April 22, 2020

Registered nurses from across the region will hold a candlelight vigil Thursday night at HCA's Research Medical Center (RMC) in Kansas City in memory of Celia Yap Banago, a longtime RMC RN who died this week of COVID-19 after caring for an infected patient at the hospital. To make the tragedy worse, Celia, who died Tuesday night, was scheduled next week to celebrate 40 years of service for Kansas City area patients at Research. She was one of many RNs at the hospital who have expressed concern over inadequate COVID-19 preparation at RMC.

Those concerns include insufficient supplies of the optimal personal protective equipment for RNs and other health care workers, delays in notifying nurses of being exposed to a suspected infected patients and staff and expected to continue reporting to work when exposed.

What: Candlelight Vigil in Honor of RN who Died of COVID-19
When: Thursday, April 23, 8 p.m.
Where: Research Medical Center, 2316 E Meyer Blvd, Kansas City

"Celia was an amazing nurse that dedicated her service for countless years at Research and a dear friend to all of us," said Research RN Charlene Carter. "I feel that I can speak for many nurses when I say that the loss of one of our dear fallen soldiers on the front line of this pandemic is more than devastating, it is a wake-up call."

Across the U.S. dozens of RNs have died from COVID-19, thousands more have been infected. On Tuesday, NNU members held a social distancing protest outside the White House demanding that the Occupational Safety and Health Administration (OSHA) promulgate an emergency temporary standard so that health care workers are provided with the optimal PPE.

"We honor the life and career of Celia who gave so much of herself for her patients," said NNU Executive Director Bonnie Castillo, RN. "No nurse, no health care worker, should have to put their lives, their health, and their safety at risk for the failure of hospitals and our elected leaders to provide the protection they need to safety care for patients."

"Nurses have an instinctive conduct of being so selfless that I believe others don’t realize. No nurse should have to sacrifice their life in exchange for conserved profits by the rationing of proper protective equipment," said Carter. "Nurses all over the country need proper protection every day so that we can continue to save patients’ lives while sparing our own."

Research RNs were among HCA nurses at 16 HCA facilities across the country who participated in shift change, social distancing protests, earlier this month warning a lack of preparedness by the nation’s largest hospital chain that they say places nurses, other staff, and patients at risk in the face of the coronavirus pandemic.

EMBARGOED UNTIL 9 a.m. on WEDNESDAY, MARCH 10

For immediate release: March 10, 2021
Contact: press@nationalnursesunited.org

National RN survey highlights continued hospital failures to prioritize nurse and patient safety during pandemic

Results show that at pandemic’s one-year marker, employers are still failing to provide safe staffing, optimal PPE, and testing

National Nurses United’s (NNU) new nationwide survey of more than 9,200 registered nurses reveals that a year into the pandemic, registered nurses are still being placed in harm’s way. RNs face continued issues ranging from unsafe staffing levels to hospital administrators failing to observe basic infection control and prevention measures – such as forced reuse of personal protective equipment (PPE) despite manufacturers confirming adequate supplies.

This survey is the fifth national survey of nurses during the pandemic by NNNU, the nation’s largest and fastest-growing union of registered nurses. NNNU’s latest survey also reveals that in addition to the unsafe reuse of single-use PPE, - nurses continue to experience challenges getting tested, are not being notified in a timely manner when they are exposed, are suffering mental health impacts, and enduring increasing workplace violence.

“We are a year into this deadly pandemic and hospitals are still failing to provide the vital resources needed to ensure safety for nurses, patients, and health care staff,” said NNNU Executive Director Bonnie Castillo, RN. “This survey shines light on how hospital administrators are continuing to jeopardize one of society’s most valuable workforces during Covid-19, registered nurses, by prioritizing profits over basic safety and infection control measures. Testing health care workers and patients for Covid-19, providing optimal PPE, and ensuring safe staffing is a no-brainer to help combat this pandemic.”

Short staffing remains a major problem in hospitals, with nearly 53 percent of nurses reporting that it is their top safety concern. Nearly half of hospital nurses (47 percent) report that staffing has gotten slightly or much worse recently. In addition, 26 percent of nurses report being reassigned to units where new skills or competencies are required, often without adequate training.
Employers fail to provide RNs with the optimal PPE to do their job safely. A total of 81 percent of nurses report they are forced to reuse single-use PPE, which is practically unchanged from the more than 80 percent who reported having to do so in our November survey. The virus that causes Covid-19 is transmitted through infectious aerosols that are emitted when Covid-positive individuals breathe, vocalize, cough, or sneeze. Optimal PPE—including respiratory protection at least as protective as an N95—is an essential measure to battle this pandemic. Recent reports indicate that there is substantial N95 supply; which means these survey data indicate that hospitals are choosing to maintain crisis standards of care in order to cut costs. The health care model should focus on human needs, not profit margins.

Slightly more than half of the RNs who work in hospitals (52 percent) report that all patients are screened for Covid-19. This falls short of the necessity that all patients should be screened for Covid-19. Hospitals are failing to implement proven measures to prevent the spread of Covid-19 within the facility: Only 66 percent of RNs who work in hospitals report that their facility has a dedicated Covid unit or area.

Nurses are still not all getting tested and they are not being informed in a timely manner when they are exposed to Covid-19 at work. Slightly more than half (54 percent) of RNs overall and over half (61 percent) of RNs in hospitals report that they have ever been tested for Covid-19. This is an increase from the last survey in November, when just a third of RNs overall reported being tested, but again still falls short of the regular and on-demand testing that nurses should be able to access. Administrators must take seriously the task of identifying and responding to exposures in a timely manner, including conducting contact tracing and informing staff of exposure. But less than a third of hospital nurses (32 percent) say their employers inform them of exposures in a timely manner.

Covid-19 continues to harm the mental health of nurses, with the survey signaling that huge numbers of nurses are suffering the moral distress and injury that comes from knowing the right thing to do but receiving no support from or even being prevented by employers from doing it.

- A total of 43 percent of hospital RNs say they have more trouble sleeping than before pandemic.
- More than 61 percent of hospital RNs report feeling more stressed than before the pandemic.
- A total of 57 percent of hospital RNs report feeling more anxious.
- 51 percent report feeling more sad or depressed.
- More than 56 percent of hospital nurses who answered the survey said they fear that they will contract the virus and infect a family member.

About 22 percent of nurses report facing increased workplace violence on the job, which they attribute to decreasing staffing levels, changes in the patient population, and visitor restrictions.

This data comes as the NNU recently endorsed the recent re-introduction of the Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 1309). The federal legislation, reintroduced by U.S. Rep. Joe Courtney (CT-2), would mandate that the federal Occupational Safety and
Health Administration (OSHA) create a national standard requiring health care and social service employers to develop and implement a comprehensive workplace violence prevention plan.

This legislation is especially important given that health care and social service workers faced extremely high rates of workplace violence prior to the pandemic, and growing rates during the pandemic.

NNU’s first survey in March focused on hospitals’ lack of preparedness for Covid-19; the second survey in May highlighted government and employers’ disregard for nurse and patient safety; and the third survey in July revealed the devastating impact of reopening too soon. The fourth survey in November showed hospitals and health care employers’ lack of preparation for the fall/winter surge, despite more knowledge about the dangers of the virus and effective measures to prevent spread. This fifth survey shows the continuing disregard that hospitals and health care employers show for the safety of nurses and health care workers as we mark the one-year anniversary of the Covid pandemic.

The survey results were gathered from both NNU unionized nurse members as well as non-union nurses in all 50 states plus Washington, D.C. and three U.S. territories. The preliminary results cover the period Feb. 2 to Feb. 28.

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PRESS RELEASE

Nurses, Unions, Allies Urge CDC to Acknowledge Covid-19 Aerosol Transmission to Help Bring Virus Under Control

*National Nurses United*

February 23, 2021

National Nurses United (NNU) and 44 allied unions and organizations, representing over 13 million members and their communities, are joining in coalition to urge the U.S. Centers for Disease Control and Prevention (CDC) to update its Covid-19 guidance to fully reflect the latest scientific evidence regarding SARS-CoV-2 transmission through aerosols that infected people emit when they breathe, speak, cough, sneeze, or sing.

Today, the undersigned unions and organizations delivered a [petition](#) with over 10,000 signatures, including scientific experts, urging the CDC to fully recognize Covid-19 aerosol transmission now.

The Biden administration has made a commitment to science and transparency in the efforts to combat the pandemic. Under the previous administration, the CDC’s refusal to recognize aerosol transmission of SARS-CoV-2 led to weak guidance, leaving workers and the public unprotected from Covid-19. As a result, countless workers in every industry—including health care, grocery, meatpacking and processing, warehousing, food service, education, transportation, and manufacturing—have been infected, hospitalized, and died from Covid-19 because their employers followed weak CDC guidance and they were not protected at work.
Fully recognizing aerosol transmission would require the CDC to update and strengthen its Covid-19 guidance to provide protection from inhalation of virus in the air, including through ventilation, filtration, and optimal respiratory protection, among other measures. It would also require the CDC to update its definition of “exposure,” which would improve the efficacy of contact tracing and case isolation. Recognizing the scientific evidence and making these improvements are essential and necessary steps to bringing the Covid-19 pandemic under control.

“Since the start of the pandemic, the nation’s nurses have demanded that the CDC’s guidelines be based on scientific evidence. Nurses know that to effectively battle this virus, we all need to get on the same page about how it spreads. The CDC’s failure up to this point to recognize aerosols as the primary mode of transmission hurts all other guidance and efforts that stem from this lack of understanding. We urge the Biden administration to honor its commitment to listen to experts in the battle against Covid-19, which includes having CDC and other federal agencies explicitly recognize aerosol transmission,” said Bonnie Castillo, RN and executive director of NNU.

“Ensuring strong COVID-19 protections for working people is key to preventing outbreaks, pulling us out of the pandemic and rebuilding our economy—and that starts with policies based on science. Workers’ lives and all of our lives depend on the CDC updating its guidelines and strengthening protections on the job,” said Richard Trumka, AFL-CIO President.

“Recognizing the ever-changing science of COVID-19 transmission is key to fighting the virus effectively, and keeping our nurses, healthcare professionals, educators and communities protected from further transmission. As it becomes increasingly clear that aerosol transmission – breathing, speaking, coughing, sneezing, and singing – can spread the virus, we urge the CDC to officially recognize this issue and offer the science-based guidance we have come to trust and expect from the agency,” said Randi Weingarten, President, American Federation of Teachers.

“We have hundreds of thousands of members considered essential workers and risking their lives every day to support us all. They and their employers depend on accurate science from CDC. And the science clearly shows the danger of aerosol transmission,” said Thomas M. Conway, International President, United Steelworkers.

“For the past year, the CDC guidance on COVID-19 has been ignoring science and health experts. The ATU has been saying aerosol transmission of SARS-CoV-2 is a problem on public transit as evidenced by our 135 brothers and sisters killed by this deadly virus and more than 4,600 infected. The ATU has been pushing for better airflow, more effective filtration systems on buses and trains, and improved PPE for transit workers and riders to help stop the spread of COVID-19 along with other safety measures. We are encouraged by the Biden Administration’s CDC Director Dr. Walensky’s call for a comprehensive review of all CDC guidance on COVID-19. We hope the CDC acknowledges the danger of aerosol transmission of this deadly virus and makes serious safety recommendations that will help save the lives of transit workers, riders and the public,” said John Costa, International President of the Amalgamated Transit Union, the largest union representing transit workers in the United States and Canada.

“The CDC’s failure to update their guidelines has life and death consequences. Workers are going into confined spaces every day without sufficient control measures and employers are justifying it by saying they are following CDC guidelines. If workers are going to be given the title “essential”, then they deserve the essential measures that keep them safe,” said Marcy Goldstein-Gelb, co-executive director of the National Council for Occupational Safety and Health (National COSH).

“We must remain vigilant as we continue to fight the pandemic. Recognizing COVID-19’s spread through aerosol transmission by the CDC is an important step that can slow the spread of this
deadly virus. This is an essential piece of a science-based response that will influence the way federal, state and local governments respond moving forward," said James Slevin, President of the Utility Workers Union of America.

"Nurses know this virus is spread through the air. We are literally face-to-face with our patients, and we have to continue working with masks, gloves, and gowns that have been contaminated after hours with patients. We even have to watch how we put on and take off our equipment so we don't infect ourselves. We need the law to follow the science that shows the virus is an airborne threat. We need the CDC to make sure our nurses and healthcare workers are safe," said Mary C. Turner, ICU nurse and Minnesota Nurses Association (MNA) President.

"Nurses in New York and around the country have been both relieved and hopeful that the Biden Administration has promised to follow the science on protection of the American workforce from COVID-19. The healthcare and other essential workforces have been devastated by COVID-19 infection and thousands have died due to their occupational exposure. Many of those exposures could have been avoided if the CDC had recognized the wealth of data that proves that SARS-CoV-2 is spread through inhalation of airborne virus particulates. The 42,000 members of NYSNA and essential workers everywhere deserve federal guidance that fully recognizes the risk of airborne exposure and recommends controls that effectively limit this exposure," said Pat Kane, RN, New York State Nurses Association (NYSNA) Executive Director.

"It's critical that the CDC recognize that COVID-19 can spread via infectious aerosols. For our members, the implications of the CDC not accepting aerosolized COVID-19 transmission poses grave risk as employers rely on the CDC's guidance to implement appropriate mitigation measures. We must follow the science and acknowledge how the virus spreads to adequately protect communities, particularly as the virus mutates and potentially more virulent strains spread," said Stuart Appelbaum, president of the Retail, Wholesale and Department Store Union.

"AFSCME 1526 believes that all workers are entitled to be treated with respect and dignity, and return home to their families alive and well. A primary focus by organizations has been on social distancing, cleaning and disinfecting, without taking into consideration the aerosol transmission of Covid-19. Having the CDC recognize Covid-19 aerosol transmission as a significant form of transmission will prompt changes in workplace protocols to reduce the overall spread of this virus. With strong CDC guidance, workplaces will be mandated to address one of the key ways workers are exposed through aerosol transmission of micro-droplets, which in turn will save lives," said Elissa G. Cadillac, President, AFSCME 1526, Boston Public Library Employees Union.

"Throughout the pandemic, HPAE members have been exposed and sickened in the workplace due to a lack of protection against this deadly virus. Some have died. No wonder our healthcare workers frequently report feeling "disposable". Now is the time for the CDC to abolish guidance that would continue to leave our workers exposed and at risk, and to establish safer standards that would provide the necessary protections," said Debbie White, President, Health Professionals and Allied Employees.

"The Nurses of MercyOne Siouxland and members of the UFCW Local 222 feel that seeing the CDC take the step to recognize SARS-CoV-2 as an aerosol transmission would validate an exhaustive year and place trust back into the institution that is the CDC. As a nation we look towards the CDC for guidance to keep frontline healthcare workers and patients safe. Recognizing SARS-CoV-2 as an aerosol transmission will be the first of many steps to rebuild the trust within the healthcare community. Seeing the CDC place the safety of our healthcare workers and the
patients they care for as a priority is long overdue, and absolutely necessary at this time," said UFCW Local 222.

"Workers deserve COVID-19 protection based on the best science available. Aerosol transmission is a significant danger that requires strengthened protection guidance from CDC and the National Institute for Occupational Safety and Health. The COVID-19 Emergency Temporary Standard being developed by OSHA must also include strong protections against aerosol transmission. A failure to follow the science is a failure to protect essential workers and a threat to economic growth," said Juley Fulcher, Public Citizen’s Worker Health and Safety Advocate.

"Some of the populations with the highest rates of COVID-19 infection are also populations that are hardest to reach with good culturally relevant information. We need the CDC to lead the way with clear, concise, and accurate messaging on aerosol transmission of COVID-19, so that community health workers, outreach workers, and health care providers around the country are supported in their work," said Migrant Clinicians Network.

"The continuing workplace outbreaks among workers in such industries as health care, retail, grocery, food processing, warehousing, among many others, points to the critical need for improved protections based on the latest science about airborne transmission. We urge the CDC to follow the science, fully recognize aerosol transmission, and update their guidance now," said Laura Stock, Executive Director, UC Berkeley Labor Occupational Health Program.

Unions and organizations that signed the petition urging the CDC to fully recognize aerosol transmission now (listed alphabetically):

AFL-CIO
AFSCME 1526, Boston Public Library Employees Union
Alaska Community Action on Toxics
Amalgamated Transit Union
American Federation of Teachers
Arts, Crafts & Theater Safety
Bakery, Confectionery, Tobacco Workers and Grain Millers’ International Union
Communications Workers of America (CWA)
Core Extension Health & Safety Company Ltd
COVID Action Group
Dr. Yolanda Whyte Pediatrics
Finding Your Balance Counseling
Franchimon ICM
Government Accountability Project
Health Professionals & Allied Employees (Debbie White, President, RN)
HEALTHY SCHOOLS NETWORK
Immigrant Service Providers Group/Health
International Association of Machinists and Aerospace Workers
International Chemical Workers Union Council
International Federation of Professional and Technical Engineers
International Union of Bricklayers & Allied Craftworkers
Jacobs Institute of Women’s Health
Kids for Saving Earth
Labor Occupational Health Program
LEGACY-The Landscape Connection
MassCOSH
Migrant Clinicians Network
Minnesota Nurses Association
National Center for Health Research
National Council for Occupational Safety and Health
National Nurses United
New York State Nurses Association
NYS Public Employees Federation
Occupational Health Management Services Inc
Pennsylvania Association of Staff Nurses and Allied Professionals
Public Citizen
Quality First EHS, Inc.
Retail, Wholesale and Department Store Union
SafeWork Washington
Sheet Metal Occupational Health Institute Trust Inc.
Transport Workers Union of America
UFCW Local 222
United Steelworkers
Utility Workers Union of America

Nurses’ Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic

Since the Covid-19 pandemic began in the United States in January 2020, our country has been in crisis. Despite clear scientific and public health consensus on interventions that could slow the spread of the virus and reduce illness, suffering, and death, the outgoing Trump Administration has failed to take the necessary steps to control the pandemic.

Nearly a year into the worst public health crisis in recent history, nurses and other health care workers continue to care for Covid-19 patients and other patients without access to optimal personal protective equipment (PPE), testing, safe staffing levels, and other sound infection control policies.

Up to this point, the federal government’s response has been one of denial and abandonment, racing to prioritize business interests over the lives and health of the people. We have seen the impact of a patchwork response from states and local areas—more than 15 million infections and nearly 300,000 deaths from Covid-19. We need a comprehensive federal response that is based in science and prioritizes health.

On behalf of more than 170,000 registered nurses, National Nurses United, the largest labor union and professional association for registered nurses in the United States, urges the incoming Biden Administration to take immediate, decisive action to mitigate the catastrophic death and suffering caused by the Covid-19 pandemic.

The following is a detailed proposal for a comprehensive federal plan to combat the Covid-19 pandemic, based on the expertise and experiences of registered nurses.

Protect Nurses and Other Essential Workers

1. Increase production and ensure efficient distribution of personal protective equipment and other medical supplies.

   On day 1, invoke the Defense Production Act of 1950 (DPA) to significantly increase production of critical medical supplies and PPE, including respirators, and create a comprehensive medical supply chain management system that is coordinated, efficient, and transparent.
Nurses and health care workers across the country still do not have the necessary PPE to provide care to their patients safely. This failure to ensure that PPE stock and supply is immediately accessible at each facility leaves nurses exposed to Covid-19, which has had deadly consequences for nurses, their patients, and their families.

It is essential that the DPA is fully invoked on day one to dramatically ramp up production and distribution of medical equipment and PPE in needed quantities to consistently provide optimal protections against Covid-19 exposure to nurses and other health care workers. As this novel coronavirus is transmitted via aerosols, the invocation of the DPA must ensure that the manufacturing of respiratory protection is scaled up. This life-saving PPE must include:

- Respirators, including powered air-purifying respirators (PAPRs, the highest protective standard), elastomeric respirators, and N95 filtering facepiece respirators
- Viral impervious coveralls
- Fluid-resistant isolation gowns
- Goggles
- Face shields
- Medical-grade gloves

We recommend early identification (before inauguration) of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE. Nurses are in dire need of PPE supplies right now, and we need the medical supply chain to be improved and expanded as rapidly as possible. To expand the manufacture of needed PPE and medical supplies, we recommend the following actions:

- Continued identification of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE.
- Direct increased production of critical medical supplies and PPE for existing manufacturing facilities that produce such supplies and PPE, which could include the use of the DPA Fund to increase the capacity of these manufacturing facilities, which could include expanding production hours, expanding manufacturing facilities, or hiring additional workers.
- Direct other manufacturing facilities to transition to production of the critical medical supplies and PPE needed for the Covid-19 response, which could include using the DPA Fund to procure and install the necessary equipment needed for these manufacturing facilities.
• Generate manufacturing purchase orders, issue loan guarantees, and support the installation of needed manufacturing equipment in manufacturing facilities to ensure the most expedient production of critical medical supplies and PPE.

In order to manufacture enough medical equipment to effectively respond to the pandemic, estimates on needed quantities must be based on optimal infection control—not on crisis standards of care. Federal guidance and hospital policies have allowed for the use of non-protective equipment, the reuse of single-use PPE, and for the use of faulty “decontamination” processes for N95s. Every time that single-use PPE is reused, nurses and patients are put at increased risk of exposure. Throughout the course of the pandemic, both state and federal government agencies have assumed the reuse and “decontamination” of single-use PPE when calculating needed PPE supplies, resulting in severe underestimates. This practice must end immediately.

Over the course of the pandemic, it has become increasingly clear that the national medical supply chain is broken. It will not be enough to simply invoke the DPA to increase production of critical medical supplies. It is imperative that the new administration builds a comprehensive medical supply chain system that is coordinated, transparent, effective, and efficient in both manufacturing and distributing PPE. The supply chain must be sufficiently robust to produce and distribute needed PPE for both the short- and long-term. To achieve this, we recommend the following actions:

• Create a coordinator to oversee all efforts of the federal government related to the supply and distribution of critical medical supplies and equipment.

• Establish a comprehensive oversight program to monitor the administration’s supply chain logistics and coordination.

• Conduct national assessments of critical medical supplies and PPE, made on a weekly basis, to determine the supply requirements across the country.

• Establish transparent reporting requirements on the distribution of supplies.

• Improve the strategic national stockpile including quickly replenishing stock and creating new and improved transparent processes for requests and distribution of the stockpile.

• Ensure the immediate and continued release and distribution of critical medical supplies and PPE, including from the strategic national stockpile, and restrict the hoarding of critical medical supplies and PPE.
More detailed policy plans on how to rebuild our national medical supply chain can be found in the Medical Supply Transparency and Delivery Act (S. 3627 / H.R. 6711), and in the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (HR 6800 - see specifically Sec 30511, Sec 30531 - Sec 30536, Section 110101).

2. Create and enforce strong national standards to protect nurses and other workers.

   On day one, issue strong Emergency Temporary Standards (ETS) to ensure that health care workers and workers in other industries are protected from Covid-19 in their workplaces.

The Occupational Safety and Health Administration (OSHA) does not currently have a standard on infectious disease outbreaks. As a result, over the course of this pandemic, employers have neglected their duty to ensure the health and safety of workers, placing nurses and other essential workers at high risk of infection and death. Protecting nurses and other health care workers is essential—both to protect their health and also to protect their families, their communities, and our health care capacity. Strong, well-enforced national standards are needed to ensure that employers are taking the necessary steps to prevent transmission and protect their employees from Covid-19.

The OSHA ETS for Health Care Workers (hereafter referred to as “the OSHA ETS”) must be constructed based on the precautionary principle, which states that taking protective action should not await scientific certainty. The California Division of Occupational Safety and Health’s Aerosol Transmissible Diseases Standard should serve as the framework and be the minimum standard of protection for the federal OSHA ETS.

The OSHA ETS must require health care employers to do the following:

- Establish, implement, and maintain a written exposure control plan, created with employee and union involvement and following the precautionary principle.

- Conduct hazard assessments to identify all places, jobs, and tasks that involve risk of exposure to SARS-CoV-2. The hazard assessments and definition of exposure must be based upon the scientific evidence that this virus is transmitted via respiratory aerosols that are emitted by infected individuals, regardless of the presence of symptoms.

- Create and implement protocols to screen every patient before or upon arrival at the facility by screening for signs and symptoms congruent with Covid-19 and recent exposure history and conducting reliable diagnostic testing.
- Implement effective, optimal engineering and work practice controls to minimize and prevent employee exposure to SARS-CoV-2, including at minimum the following:
  - Establish separate and dedicated areas for Covid-positive, potentially infectious, and non-Covid patients in all areas of the facility. (When patients who do not have Covid-19 are mixed with confirmed and possible Covid-19 patients, the potential for transmission of the virus to patients and staff increases significantly.)
  - Place confirmed and suspected Covid-19 patients in airborne infection isolation rooms that prevent recirculation of air and improve ventilation in other areas of facilities. Implement protocols for removing isolation precautions for these patients following the precautionary principle.
  - Implement work practice controls that include an opt-out process for employees at high risk of serious illness from Covid-19, screening and restricting visitors, thorough environmental cleaning and disinfection, source control procedures including universal use of face coverings, and temporary scrubs and shower facilities for employees.
  - Provide safe staffing, including clinical competency for staff floating to a different unit, no mixing of Covid and non-Covid assignments, and shorter shifts in dedicated Covid-19 units.

- Provide optimal PPE to employees where these engineering and work practice controls do not prevent exposure. Optimal PPE for Covid-19 includes a PAPR, viral-impervious coveralls that incorporate head and shoe coverings, and medical-grade gloves. Requirements for providing PPE for Covid-19 should include:
  - Ensuring that all employees with contact activities have optimal PPE for Covid-19 available to them at all times.
  - Ensuring that all employees who provide care to or otherwise are in contact with suspected and Covid-19 patients are provided optimal PPE for every patient encounter.
  - Providing for breaks and relief so that no employee is expected to wear tight-fitting PPE for more than two hours without at least a fifteen-minute break.
  - Prohibiting crisis standards including reuse and decontamination of single-use N95 filtering facepiece respirators and other PPE. (Reuse of single-use N95 respirators and other single-use PPE is unsafe and should not be employed. PPE becomes contaminated during use and repeated
donning of contaminated PPE poses risk of exposure to staff. Single-use PPE can become damaged during reuse and may no longer provide protection. Decontamination methods have not been shown to be safe or effective and some appear to be ineffective, damage N95s, or introduce a new hazard to wearers of N95s.)

○ Prohibiting rationing of N95 filtering facepiece respirators and other PPE. (Rationing use of N95s for only specific types of procedures, e.g., aerosol-generating procedures, is unsafe and reflects a refusal to acknowledge the growing scientific evidence that the virus that causes Covid-19 is aerosol transmitted.)

○ Creating and implementing a respiratory protection program as required by 29 CFR 1910.134.

• Create and implement systems to actively identify and respond to all employee exposures to Covid-19. Response to an employee exposure to Covid-19 should include:

○ Open and continuous communication with workers about any potential exposure, including requirements to provide notice of potential exposures within 12 hours.

○ Placing employees exposed to Covid-19 on precautionary leave for at least 14 days from time of most recent exposure. Employers shall ensure there is no loss in employees’ earnings, seniority, or any employee rights and benefits, as if the employee had not been removed from their job.

○ Providing Covid-19 testing at no cost to employees during their working hours to all employees who had potential Covid-19 exposure in the workplace. Testing shall be performed, at minimum, at the end of the 14-day precautionary leave. Results should be returned in a timely manner, within 48 hours.

○ Conducting an investigation and implementing changes to prevent similar exposures from occurring in the future.

○ Returning staff to work after a positive Covid-19 test only after their symptoms, if any, have resolved and after they have received two negative tests at least 24 hours apart. Asymptomatic positive staff should not be treated differently from symptomatic positive staff.

○ Providing medical services at no cost to employees with occupational exposure to SARS-CoV-2.
• Create and implement programs for ongoing weekly surveillance testing of all employees, regardless of symptom status, to identify and prevent facility outbreaks. If an employee develops signs or symptoms of Covid-19, they shall receive prompt, free diagnostic testing, regardless of occupational exposure status.

• Create and implement plans to respond to outbreaks in the facility.

• Create plans and prepare to respond to a surge of patients with Covid-19 or other infectious diseases (e.g., influenza), including expanding bed capacity, ventilator capacity, PPE stockpile, and other medical equipment. Preparation shall also include at least preparing separate waiting areas such as surge tents, ensuring staff are aware of surge plans before implementation, establishing plans to respond if significant numbers of healthcare workers are exposed or sick and unable to work. When there is an increase in Covid-19 patients or other patients with infectious diseases, employers shall implement their surge preparation protocols and plans. If employers are unable to effectively implement all necessary safety precautions to prevent transmission within the facility and to protect nurses, other health care workers, and patients from exposure, then the employer shall delay non-life threatening elective procedures.

• Provide training and education to employees regarding their exposure control plans, surge preparedness plans, and other Covid-19-related protocols required under the OSHA ETS.

• Review the effectiveness of the exposure control plan at least every three months during the Covid-19 pandemic. Employees and their representatives should be involved in the review.

• Prohibit employers from retaliating against an employee for reporting exposure to Covid-19, symptoms of Covid-19, a positive Covid-19 test result, or any other information or concerns about Covid-19 or the employer’s exposure control plan.

• Create a Covid-19 log to record and track all Covid-19 cases among employees.

• Create and maintain records of implementation of the exposure control plan, including records of reviews, exposure incidents, inspections, testing, maintenance of engineering controls including ventilation, the respiratory protection program, training records, and any other records as appropriate under the OSHA ETS, which must maintain confidentiality of medical information as required by law and be made available to employees and their representatives upon request.
• Report information about Covid-19 cases at the workplace to the local health department and Covid-19-related in-patient hospitalizations or deaths that occur among employees within 24 hours or within 8 hours, respectively, of learning of them.

Throughout the Covid-19 pandemic, OSHA has neglected its duty to protect the lives and health of working people in this country. As of December 9th, federal OSHA reports it has received 11,312 complaints from workers since the beginning of the pandemic and reports having opened a mere 294 inspections in response to complaints (2.6%). We strongly urge the Administration to increase the number of OSHA inspectors, and to ensure that the OSHA ETS is strongly enforced with penalties for non-compliance.

3. **Ensure that federal guidance is science based and prioritizes health and safety.**

   Overhaul weak U.S. Centers for Disease Control and Prevention (CDC) guidance that allows health care employers to defend dangerous practices that expose nurses, other health care workers, and patients to Covid-19.

The CDC has established a pattern during this pandemic of prioritizing business interests over science and protecting public health. CDC guidance has been downgraded multiple times in direct contradiction to the available science and has ignored the precautionary principle—which states that we should implement protections even in the face of scientific uncertainty about harm.

This must change. The CDC must prioritize health and safety. CDC guidance and other federal guidance must be overhauled and rewritten so that it is based on the precautionary principle and the available science.

The following CDC guidance documents must immediately be rewritten to reflect the precautionary principle and the available science on Covid-19 transmission, infection controls, and occupational safety and health:

• Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
• Using Personal Protective Equipment (PPE)
• Optimizing Supply of PPE and Other Equipment during Shortages
• Strategies for Optimizing the Supply of N95 Respirators
• Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators
• Strategies for Optimizing the Supply of Facemasks
• Strategies for Optimizing the Supply of Eye Protection
• Strategies for Optimizing the Supply of Isolation Gowns
4. **End unsafe crisis standards and waivers.**

*The federal government must end all waivers of regulation or oversight and must require employers to end unsafe crisis standards of care. The U.S. Food and Drug Administration (FDA) must revoke emergency use authorizations for dangerous, unproven practices to reuse and decontaminate N95 filtering facepiece respirators and other single-use PPE. The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.*

During the Covid-19 pandemic, health care employers and government agencies have introduced and embraced crisis standards. Many of these crisis standards allow health care employers to further focus on cost, at the expense of patient care and the health and safety of nurses, health care workers, and patients. Employers, aided and abetted by government agencies, maintained these crisis standards even as local Covid-19 cases decreased during the summer.

These unsafe crisis standards must end. Crisis standards of care, by definition, are unsafe and unsustainable. These standards fail to deliver safe, competent, and effective care. Careful planning, preparation, and coordination would prevent the need for crisis standards to be utilized at all. Health care employers should be prepared for public health emergencies. Government agencies must end the following unsafe crisis standards and, instead, advance effective protections and preparation measures to combat the Covid-19 pandemic and to protect nurses, other health care workers, and their patients:

- The FDA must revoke all emergency use authorizations on reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Further, the federal government, through an OSHA ETS and overhauled CDC guidance, should ban reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Reuse of single-use PPE is not safe and puts nurses and patients at increased risk of exposure to Covid-19. Decontamination methods are neither safe nor effective and should never have been implemented. Instead, health care employers and government agencies
should implement safely reusable, more protective respirators, including PAPRs and elastomeric respirators.

- The FDA must institute strict oversight of performance, manufacturing, and distribution of diagnostic and serological tests.
- The FDA must revoke emergency use authorizations on all medical devices that may harm patients or undermine hands-on patient care.
- HHS must revoke both waivers that expand the use of remote patient monitoring technologies which have been deployed in healthcare facilities and for use by patients at home as well as waivers of Medicare conditions of participation that allow for patients to be cared for in non-hospital facilities, including the home, without appropriate staffing, emergency equipment, and other capabilities needed to provide patient care safely.
- The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.
- End crisis nurse staffing models in health care facilities, including the use of nurse extender models. These crisis nurse staffing models undermine quality patient care and put patients and nurses at risk.
- End the crisis utilization of unlicensed students and retirees who have not recently been engaged in clinical care in place of actively licensed nurses.

5. Include measures to reduce negative impacts of the pandemic on nurses and other health care workers.

Ensure that nurses and other health care workers have access to paid sick and family leave, paid time during isolation due to exposures, and essential worker pay. Provide long-term health and survivor benefits for workers and their families.

Paid leave specific to Covid-19 is critical for those working during the pandemic and, in particular, for nurses who are exposed to Covid-19 as a result of inadequate workplace health and safety protections. Only 23 percent of health care and social assistance workers in private industry have any form of paid family leave, though 85 percent have at least minimal paid sick leave available. Federal Covid-19 legislation passed earlier in 2020 explicitly excluded nurses and other health care workers from these mandatory workplace benefits. It is important for the safety of their patients and coworkers for nurses and other health care workers to be able to stay home when they are sick.
Similarly, paid time covering isolation after every work-related exposure is essential to combating this pandemic. No worker should have to use their accrued sick or other paid leave to cover a workplace exposure that occurred because their employer failed to protect them.

Increasingly, we are learning about long-term health impacts of Covid-19, including long-term lung and heart damage, fatigue, and neurological impacts. Nurses and other health care workers who contract Covid-19 should have access to long-term health benefits. There should be no barriers to accessing any benefit programs for the long-term health impacts of Covid-19 for nurses and other essential workers.

More than 2,298 health care workers have died from Covid-19, including more than 265 registered nurses, as of December 9th, 2020. Families of nurses and other health care workers who have died from Covid-19 should have survivor benefits.

Nurses always deserve fair and equitable wages. During the pandemic, an essential worker pay differential is meant to compensate workers who have been excluded from governmental orders and public health guidance to stay at home because their work has been deemed “essential” or “critical.” These workers are, thus, forced to risk exposure to Covid-19 that is higher than the government has prescribed as safe. The labor of nurses and other essential workers is vital to our collective well-being and working during a pandemic adds complexity and danger for them and their families compared to those sheltering at home. These workers deserve to be paid more. Fairness demands providing additional compensation to people who, by virtue of being required to work outside their homes during a pandemic, are exposed to extreme working conditions. However, essential worker pay should never be a replacement for a safe workplace.

**Build Effective and Comprehensive Public Health Infrastructure and Programs**

6. **Increase health care capacity and improve preparedness.**

A comprehensive plan to combat Covid-19 must include measures to increase health care capacity and hold health care facilities accountable to being prepared to respond effectively to surges in Covid-19 cases.

Hospitals across the country are overwhelmed in capacity while many caregivers who have been putting their lives on the line are being infected and dying. Nurses are facing burnout, unimaginable stress, and some are resigning. Many nurses are still not being provided proper PPE and hospitals have failed to implement appropriate infection control measures throughout their facilities, which significantly increase both their risk of infection and their stress and anxiety. During the current surge, nurses are seeing
patients die who could have been saved, if their employers had the proper staffing and supplies.

When the pandemic first began, physical distancing and stay-at-home measures were imposed in some cities and states, in an effort to slow down potential surges and allow the health care system to increase capacity to handle the virus. Unfortunately, both the federal government and the hospital industry have squandered the lead time that could have been used to increase health care capacity.

Decades of hospital industry safety cuts have led to many of the current staffing and capacity crises. For many years, hospital industry executives have recklessly eliminated “less profitable” patient services, reduced staffing of registered nurses and other frontline caregivers, and minimized inventory of essential supplies from medicine to PPE. Now, in the midst of the accelerating Covid-19 pandemic, we are seeing the inevitable consequence of these profit-driven schemes.

A comprehensive plan to combat Covid-19 necessarily must expand health care capacity and hold employers accountable to preparedness for surges in Covid-19 patients. The following steps should be taken:

- National public hospital and health care infrastructure capacity must be made available including through the Federal Emergency Management Agency, the Army Corps of Engineers, and by reversing privatization of the Veterans Health Administration.

- The private health care sector must be required to be fully prepared to respond safely to future surges. This preparation must include expanding staffing and bed capacity and increasing the stock and supply of PPE, ventilators, medications, and other necessary equipment.

- The federal government must collect real-time data on hospital capacity, PPE and medical equipment supplies, and other vital data. This information must be made publicly available.

- The federal government must guarantee sufficient hospitals and staffing in rural and underserved areas to provide geographically accessible and timely care. Federal funding should be appropriated to reopen hospitals that have been closed and to prevent closure of hospitals. Such hospitals should be publicly owned, and the workforce should be afforded full collective bargaining rights.

- Commissioning of the Ready Reserve Corps funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act should be accelerated. The federal government should fully fund paid, additional benefitted permanent and reserve
positions with full collective bargaining rights to provide surge staffing when needed.

- All workers must have PPE and other needed health and safety protections to protect their lives and to prevent transmission within health care facilities.

7. **Ensure testing, contact tracing, and case isolation.**

   The federal government must create a comprehensive national plan to identify, isolate, and trace close contacts of Covid-19 cases. To do so, the new administration must heavily invest in the resources, staffing, supplies, and coordination necessary for a robust testing, tracing, and case isolation program.

Other countries have effectively controlled the spread of this virus since the beginning of the pandemic because they have a robust public health infrastructure that enables widespread surveillance, identification and strict isolation of cases, and thorough contact tracing and isolation of contacts. The current pandemic response model, which has failed to include a robust federal testing program, has hindered our ability to combat the spread of this virus.

A comprehensive plan to improve the testing, tracing, and case isolation must:

- Be fully staffed, supplied, and provided space to enable robust surveillance, widespread testing, effective contact tracing, and prompt case isolation.

- Make free at the point of service, reliable diagnostic testing widely available, including to low-income communities and communities of color, regardless of known exposure or symptom status.

- Provide for ongoing surveillance, with repeated random population surveys of asymptomatic people and syndromic surveillance that includes early detection of comparable indicators (e.g., influenza-like illness) before a diagnosis is made.

- Ensure thorough contact tracing to identify all contacts who could have been infected by each case (i.e., forward contact tracing) and to identify other individuals who may have been exposed in the same place as the case (i.e., backwards contact tracing). Case identification, contact tracing, and isolation need to be conducted in workplaces as well as in community settings. Contact tracing programs cannot rely solely upon technology—which, at best, may provide exposure notification, just one aspect of contact tracing. Effective contract tracing requires human interaction.

Clear and reliable data, free of corporate influence, must be collected and made publicly available for an effective federal response to the Covid-19 pandemic.

Throughout the pandemic, federal and state governments have neglected, hidden, and manipulated Covid-19 data. Federal data collection on key health indicators was insufficient before the pandemic, and our experiences with Covid-19 have underscored the need for improved data collection and transparent reporting. Detailed, consistent data is necessary to understand how and where the virus is spreading, who is most vulnerable to infection, and whether interventions are effective. This data is necessary to learn valuable lessons in mitigating the spread of future pandemics.

To collect reliable data and make it transparently, publicly available, the following steps must be taken:

- Immediately restore hospital Covid-19 data reporting to the CDC. The CDC must then strengthen, improve, and expand its data tracking, free of any political or corporate influence.

- Standardize data reporting. Data must be updated and reported in a timely fashion. A lag time of even a week can delay an effective response.

- Collect and publicly report at least the following data:
  - Diagnostic testing and case counts at national, state, and county/local levels. This data, as well as cumulative totals, must be reported daily, and must include the following details:
    - Case reporting of probable cases, not just those confirmed through testing.
    - Gender/sex, race/ethnicity, age, and occupation breakdowns for cases.
    - Diagnostic testing data, including the number of tests performed and the types of tests used. This data must provide clarity on the number of tests conducted and the number of people tested.
    - Timing of testing data, including both the time from symptom onset/exposure to testing and the turnaround time for tests (time between swabbing and test result).
  - Case isolation and contact tracing data, including the time to isolate cases from identification, the time to trace contacts, and data regarding cases resulting from different types of exposures (including isolated cases and types of contact such as workplaces, public establishment, gatherings, etc.).
○ Establishment-level data about outbreaks, including workplaces.

○ Data on health care worker infections and deaths at an establishment-level. This data must be reported daily and must also include cumulative totals.

○ Syndromic surveillance data must be reported at national, state, and county/local levels (influenza-like illness and Covid-like illness).

○ Data on hospitalizations and deaths must be reported at national, state, and county/local levels. This data must be reported daily and must include the following details:
  ■ Probable cases, not just those confirmed with testing.
  ■ Gender/sex, race/ethnicity, age, and occupation data for hospitalizations and deaths.

○ Hospital capacity data must be reported at national, state, and county/local levels. This data must be updated in real time and must include total and available hospital beds by type (e.g., ICU, medical/surgical, telemetry, etc.), staffing, health care worker exposures and infections, and nosocomial patient infections.

○ Data on the stock and supply chain of essential PPE and other supplies must be reported at national, state, and county/local levels. This data must be updated in real time and must include:
  ■ Data on actual stock of PPE, ventilators, and other essential equipment and supplies held by health care facilities, national and state stockpiles, and others.
  ■ Data on actual supply from manufacturers of PPE, ventilators, and other essential equipment and supplies.
  ■ Data on need at hospital level of PPE, ventilators, and other essential supplies.

Addressing Health Inequities

9. Immediately disburse comprehensive economic stimulus and other supports to all people in need.

_The new administration must immediately work with Congress to pass a comprehensive economic relief bill that will address the widespread economic_
inequalities that have worsened due to this pandemic. These economic inequalities result in worsening health disparities.

The economic devastation that has accompanied this catastrophic pandemic has only furthered the deep economic and health inequalities in our nation. As a result of the pandemic, tens of millions of people have lost their jobs and their health insurance. Many are struggling to feed their families, pay their rent, and pay for health care.

Under the outgoing administration, the American people have not received the economic stimulus and supports that they direly need, leaving millions of people to suffer.

A comprehensive economic stimulus package must include:

- The extension of supplemental unemployment benefits through the end of the pandemic, of at least $600 a week.
- One-time stimulus payment checks of at least $1200 for every adult and $500 for every child.
- The extension of the eviction moratorium.
- Premium pay, or essential worker pay, for all essential workers including registered nurses and federal workers.
- At least $1 trillion in appropriations for state and local governments for Covid-19 response programs.
- Appropriations to ensure that all health care services are provided free at the point of service to everyone during the pandemic.
- Funding for the United States Postal Service of at least $25 Billion.

10. Make vaccines and treatments available to all both domestically and globally.

Any treatments or vaccines that are shown to be safe and effective must be distributed equitably, and made available free, at the point of service, to all people.

With the possibility of new treatments or vaccines that are safe and effective being available in the near future, it is critical that our public health infrastructure is improved to allow for the efficient, safe, and equitable roll-out of these treatments or vaccines.

Domestically, the next administration must ensure that any vaccine that is scientifically shown to be safe and effective is made available at no cost to all people who would like to receive the vaccine. The administration must also ensure that the necessary administrative and health care supports are in place to ensure timely follow up care if needed for any patient that has received a vaccine.
The United States must also play a leadership role in ensuring that any treatment or vaccine is made available equitably in the rest of the world. This virus does not recognize borders, and our nation has the opportunity to play an important role on the world stage to ensure that low and middle-income countries have access to these treatments and vaccines at a low-cost.

The new administration should engage with the World Health Organization and the World Trade Organization to waive patents on Covid-19 medicines or vaccines so that they can be manufactured and distributed in low and middle-income countries.

Ms. ADAMS. Thank you very much. Ok thank you. I’m going to go vote now on the floor and Mr. Scott will you please assume the gavel?

Mr. SCOTT.[Presiding] I will thank you.

Our next witness is Mr. Rath.
STATEMENT OF MANESH RATH, PARTNER, KELLER AND HECKMAN LLP, WASHINGTON, D.C.

Mr. RATH. Thank you very much. Good morning Chair Adams, Mr. Scott. Thank you Ranking Member Keller and Members of this subcommittee. I'm grateful for the opportunity to speak before this subcommittee on this issue today, Clearing the Air Science Based Strategies to Protect Workers from COVID–19 Infections.

I'm Manesh Rath. I'm a partner at the law firm Keller and Heckman LLP, here in Washington, DC. I work with employers to develop effective improvements in workplace safety and health. In my testimony today I'm expressing only my own understanding of an experience in the field of occupational safety and health law and administrative law, and I'm not here as a representative of any other entity.

Today I will address some of the efforts that I have seen employers undertake in response to COVID–19 during the pandemic this past year, and some of the conclusions that employers have drawn from their experiences. During this pandemic, employers with whom I have worked have engaged in a continuous cycle of evaluation and improvement as scientific and healthcare understanding about COVID–19 has evolved. Employers have implemented fundamentally for interventions, and some simple interventions have endured because they work, for example universal use of face masks, hand washing, disinfecting frequently touched surfaces, and distancing where achievable, and installation of temporary barriers which distancing is not achievable.

We have also seen creative solutions that only the private sector could have developed, and could not have emanated from government. For example, employers have deployed private transportation networks for workers to isolate them from public transportation exposures. One, a manufacturer with whom we’ve worked, fabricated cooling booths, equipping those booths with air-conditioning to allow manufacturing workers to take periodic maskless, heat stress breaks.

We've seen employer deploy temporary portable adjunct space for additional meeting and brake rooms. Several employers we've worked with have increased their janitorial staff substantially. A couple of employers I've worked with have even engaged their own epidemiologists in order to respond more rapidly than could be seen from OSHA or the Centers for Disease Control and Prevention to adapt to changing science about COVID–19.

In addition, we've seen employers that have willingly tried interventions that have had diminishing value. For example, employers early in the pandemic quarantined inventory for 24 hours if the inventory may have been exposed to positive workers, positive cases. We now see that that's been used less and less frequently, and even the CDC has recently opined in October 2020 that contaminated surfaces comprise an uncommon transmission vector.

In another example, every employer I've worked with implements symptom screening and temperature check at the beginning of every shift for every employee, and yet we now see evolving science demonstrate that asymptomatic and pre-symptomatic cases comprise a significant fraction of transmission spread.
The many changes we’ve seen at the CDC have also taught us the importance of a flexible guidance-based approach to COVID–19 in the workplace. For example, on April 6, 2020 the CDC recommended avoiding all non-essential travel, even intra-city. Within 48 hours the CDC revoked that guidance, and again updated it in February 2021.

We’ve seen on February 10, 2021 the CDC released an updated mask recommendation recommending both a disposable mask, and on top of that a cloth mask. So even a year after the onset of the pandemic the CDC’s guidance has been updated on something as simple as masks based on data-driven science.

If OSHA had implemented any of these recommendations in an emergency temporary standard a year ago, those requirements would have been quickly antiquated by science, dismissed by the public, and a discredit to the agency. In its wisdom, OSHA chose instead to issue guidance documents, and indeed in a one-month period issued 13 guidance documents, some of which were industry specific, all of which could be rapidly revised to meet the changing conditions and science of the pandemic.

As with the examples I have discussed, employers have already demonstrated the ability to quickly adapt and implement new interventions faster than government can develop policy. For the same reason, agency guidance that can be rapidly updated, is better suited to our evolving understanding of COVID–19 than emergency regulations could be.

Thank you for the opportunity to appear before you, and I look forward to addressing any questions you may have.

[The prepared Statement of Mr. Rath follows:]
Good morning, Chair Adams, Ranking Member Keller, and members of this Subcommittee. I am grateful for the opportunity to speak before this Subcommittee on this issue today.

I am Manesh Rath, and I am a partner at the law firm Keller and Heckman LLP, here in Washington, D.C. In large part, my practice is focused on occupational safety and health (OSHA) law. I have represented industry groups and employers in collaborating with labor, professional associations, the scientific community, and government to develop and maintain a safer and more healthful workplace. I have taught several thousand safety and health professionals, labor-management professionals, attorneys, and university students on matters involving OSHA law, litigation, employment and labor law, and legal ethics. With a few esteemed OSHA law attorneys, I have co-authored and edited two authoritative books in the field of OSHA law.

For over twenty-six years, I have dedicated my life’s work to the proposition that well-intentioned employers are uniquely well-positioned to implement rapid adaptations to improve the welfare, safety, and health of the American workforce.

In my testimony today, I am expressing only my own understanding of, and experience in, the fields of occupational safety and health law and administrative law, and I am not here as a representative of any other entity.

Today I will address some of the efforts we have seen employers undertake in response to COVID-19 and some of the conclusions that we have drawn in the past year by working with the employer community.
1. Employers Have Already Implemented a Variety of Interventions to Reduce the Transmission of COVID-19 at the Workplace

During this pandemic, employers with whom I have worked have engaged in a continuous cycle of evaluation and improvement as scientific and healthcare understanding about COVID-19 has evolved.

A. Employers Have Implemented Fundamental Interventions.

Some simple interventions implemented from the beginning have endured because they work: universal use of face masks, hand washing, disinfecting frequently touched surfaces, and social distancing where achievable.

B. Employers Have Also Willingly Undertaken More Complex Interventions.

Many employers have also implemented more complex and costlier interventions – some of which have also proven effective. These include: work-from-home policies, isolation and quarantine, generous symptom-based leave policies, and travel policies.

At the worksite, many employers I have worked with have shut down alternating workstations, created one-way traffic flow, and, where distancing is not feasible, installed temporary barriers. Some employers have created private transportation services for workers as an alternative to higher-exposure public transportation options.

C. We Have Seen Creative Solutions That Only The Private Sector Could Have Developed.

Then there are employer innovations that have gone beyond the reasonable scope of government guidance because they were intuitive, sensible, and responsive to real-life risks. For example, we have worked with employers that have imposed a capacity limit on break rooms. We have seen instances where employers have provided catered boxed lunches to protect workers from having to venture into the community during their lunch breaks, where a few workers’ exposure at local lunch vendors could have created risks for the whole workforce. One employer fabricated cooling booths, equipped with air conditioning, allowing manufacturing workers to take periodic maskless heat-stress breaks.

Many employers significantly increased their janitorial staff, thus adding to their communities’ employment opportunities. Some employers we have worked with brought in temporary portable adjunct space for meetings and additional break rooms. Employers have deployed wearable proximity sensors, otherwise used in traffic safety, to help maintain distancing.

D. In Addition, Employers Have Willingly Tried Interventions Of Diminishing Prominence.

Other interventions have had their moment, and then were overcome by new scientific studies and greater data. For example, initially employers would quarantine inventory for 24 hours if it
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may have been exposed to a positive worker.\(^1\) This is a practice that is no longer widely considered necessary, effective, or cost-effective, in part because the CDC later stated that contaminated surfaces comprise an uncommon transmission vector.\(^2\) In another example, while the CDC still identifies a “runny nose” as a symptom of coronavirus,\(^3\) some employers have discontinued them on their symptom screening questionnaires in the belief that it is non-specific or less predictive for Covid-19.\(^4\)

And while employers are still dedicating considerable resources to symptom screening and temperature checking at worksites nationwide, recent studies now provide better data about the asymptomatic and pre-symptomatic fraction of all positive cases\(^1\) and their contribution to disease spread – thus we have observed that fewer employers still believe that symptom questionnaires can achieve the same reductive effects as universal face masks, handwashing, distancing, and remote work.

II. Our Observations: Elementary Employer Interventions and Universal Employee Participation Have been the Most Effective Means of Reducing the Transmission of COVID-19 in the Workplace

Employers with whom we have worked have observed over time that the fundamentals of infectious disease control – facemasks, distancing, and handwashing – have been the most effective interventions, and they can be rapidly deployed and individually tailored to fit the unique needs of each workplace. These only work through daily diligence and universal adoption – that is, when everyone at the worksite is scrupulous about doing their part.

One example illustrates this point well. I observed a manufacturer for the past year; they have over two dozen manufacturing sites around the nation. All of their establishments have adopted the same policies and protocols for coronavirus management. Some establishments have seen high case rates even though their surrounding community had low transmission rates at the time; other plants were the opposite, experiencing zero or very low case rates even though the surrounding community was experiencing a conflagration of positive cases. That manufacturer concluded that variations between plants - the workers’ dedication to the daily regimens of mask usage, distancing, handwashing, and self-reporting of symptoms - resulted in their significantly different experiences.

\(^1\) Centers for Disease Control and Prevention. Cleaning and Disinfecting Your Facility (April 1, 2020).
\(^2\) Centers for Disease Control and Prevention, How COVID-19 Spreads, (October 28, 2020) (stating that “spread from touching surfaces is not thought to be a common way that COVID-19 spreads”).
\(^3\) Centers for Disease Control and Prevention, Symptoms of Coronavirus (updated Feb. 21, 2021).
\(^4\) Narayan, S., Emerson Hospital, Allergies, Cold, Flu or COVID-19? How to Tell the Difference (Oct. 16, 2020) (identifying “runny nose” and “sneezing” as symptoms associated with the common cold and with allergies but designating them as “rarely” symptomatic of COVID-19.).
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This demonstrates that an establishment with unacceptable case rates will experience the most gains by rededicating the workforce towards universal adoption of basic interventions, not by compounding its burden with additional and more complex regulatory requirements.

III. Emergency Standards are Immutable and Ill-Adapted to Evolving Conditions. A Countervailing Example: The California Emergency Standard

On November 30, 2020, the State of California’s Occupational Safety and Health Standards Board adopted an emergency standard on COVID-19 prevention. The emergency standard was hastily approved, and stakeholders were prevented from assisting in making the standard more workable or more effective. The California emergency standard requires employers to take the place of public health agencies: to conduct continuous testing, engage in contact tracing, provide paid time off during quarantine, and reduce density in housing and transportation. The California emergency standard went into immediate effect without adequate review or time to prepare for compliance.

After California published its emergency standard, the state realized that it had to release multiple additional guidance documents – Frequently Asked Questions that were revised three times, a Fact Sheet that was revised once, a Model COVID-19 Prevention Program, and two Press Releases to clarify ambiguities noted by stakeholders who could have helped address these unfortunate defects in the first place.

Two industry groups filed lawsuits challenging the emergency standard in the Superior Court of California. In addition to the standard’s legal and procedural deficiencies, the plaintiffs noted that California rushed an emergency standard and then promptly issued clarifications, some of which contradict the standard itself.

IV. Congress Intended That OSHA Promulgate Emergency Temporary Standards With Restraint Because They Exclude Stakeholder Involvement

When Congress passed the Occupational Safety and Health Act, in its wisdom it required the Occupational Safety and Health Administration to promulgate standards only after publishing a

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8 8 C.C.R. §3295, et seq.
9 The COVID-19 Emergency Temporary Standards Frequently Asked Questions were released on December 1, 2020, and updated on January 8, January 26, and February 26, 2021.
13 National Retail Federation et al. v. California Department of Industrial Relations et al., Case No. CGC-20-588567; Western Growers Association et al. v. California Occupational Safety and Health Standards Board et al., Case No. CPF-21-517344.
14 29 U.S.C. § 655(b)
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notice about a proposed rule, and to consider comments from affected stakeholders, including small businesses. These features also appear in the Administrative Procedure Act and the Small Business Regulatory Enforcement Fairness Act (SBREFA).

Congress also empowered OSHA to promulgate an Emergency Temporary Standard (ETS), permitting the Agency to bypass these critical notice and comment requirements, but only under a strict set of conditions: a.) that an ETS remain in effect for only 180 days; b.) that it be implemented only in cases where employees are exposed to a grave danger; and c.) that only an Emergency Temporary Standard will suffice to protect employees from such danger.

The Fifth Circuit of the United States Court of Appeals noted that the Agency must establish data that shows with certainty, and not speculation, that the Emergency Temporary Standard will reduce fatalities, injuries, or illnesses during the 180 days of its efficacy.

V. The Numerosity of Changes in the CDC Coronavirus Guidance Teaches Us That an Emergency Temporary Standard, in Its Intransigence, Is Less Suiited to Success Than Employer Initiatives and Agency Guidance

The Centers for Disease Control and Prevention (CDC) has revised its COVID-19 guidance many times. This has taught the employer community that an evolving scientific and medical understanding of the coronavirus is best met by Agency guidance that can be published and revised quickly and iteratively. By contrast, an emergency temporary standard, once set, is intransigent against evolving data.

For example, on April 6, 2020, the CDC recommended avoiding all non-essential travel within the United States, regardless of destination. Within 48 hours, the CDC replaced this with its pre-April 6 guidance, recommending against travel to spots with higher case rates, and the use of precautions when travelling. This guidance was updated again on February 16, 2021, wherein the CDC issued stronger language requiring air passengers to have a negative COVID-19 test result or documentation of recovery, and requiring masks on planes, buses, and trains.

On February 10, 2021, the CDC released an updated mask recommendation in which it recommended wearing a disposable mask underneath a cloth mask. Even a full year after the onset of the pandemic, the CDC’s data-driven guidance about something as simple as mask wearing continues to evolve.

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17 Centers for Disease Control and Prevention, Coronavirus and Travel in the United States (April 6, 2020).  
The CDC recommendation for how long an individual should spend in quarantine has changed from seven to ten to fourteen days, and then back to ten.\(^{20}\)

The CDC’s list of COVID-19 symptoms has expanded, been bifurcated into two levels of specificity, and compressed into a single list again.\(^{19}\)

Increasing access to vaccination is now the next workplace frontier in COVID-19 management. Employers with whom I work now look to the CDC to provide guidance to employers on matters such as isolation and quarantine, ending remote work, business travel, and the types of tasks that can be safely performed as employees sort into three cohorts: those that have been vaccinated, those with naturally acquired immunological response, and those who decline vaccination.

If OSHA had adopted strict standards on any of these issues in an Emergency Temporary Standard a year ago, those requirements would have quickly become antiquated by science; dismissed by the public; and a discredit to the Agency. In its wisdom, OSHA recognized the inadequacy of an Emergency Temporary Standard in the face of a rapidly evolving knowledge set and elected instead to issue guidance documents. From April 3\(^{rd}\) to April 26\(^{th}\), OSHA issued 13 guidance documents, some of which were industry-specific, all of which could be quickly reevaluated and revised as necessary to meet changing conditions in the pandemic.\(^{22}\)

\section*{IV. Conclusion}

An Emergency Temporary Standard is not a suitable vehicle for government intervention in a continuously changing dynamic such as the COVID-19 pandemic. First, an ETS is only permitted when the Agency has certainty that its ETS requirements will have a reductive effect during the 180-day efficacy period. Second, the many changes we have already seen in CDC guidance teach us that an ETS is intransigent to evolution in data-driven science. Third, as with the examples I discussed above, employers have already demonstrated an ability to quickly adapt and implement new interventions faster than government can develop policy. Fourth, employers that have failed in keeping case rates down have often been challenged in implementing the most fundamental interventions with universality. An ETS, by its nature cannot solve the problem of coronavirus in the workplace. Employers will prevail against coronavirus spread through rapid adoption of evolving scientific and healthcare data, commitment to basic and effective interventions, and universal adoption by all workers.

Thank you for the opportunity to appear before you, I look forward to addressing any questions you may have.


Mr. Scott. Thank you.

Dr. Michaels.

STATEMENT OF DR. DAVID MICHAELS, Ph.D., PROFESSOR OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, THE GEORGE WASHINGTON UNIVERSITY, FORMER ASSISTANT SECRETARY OF OSHA, WASHINGTON, DC

Dr. Michaels. Thank you Chairman Scott, Ranking Member Foxx, Ranking Member Keller, Members of the subcommittee for inviting me to testify today. My name is David Michaels. I'm an Epidemiologist and Professor at the Milken Institute School of Public Health at the George Washington University.

From 2009 to January 2017 I served as assistant Secretary of Labor for the Occupational Safety and Health Administration, OSHA. I was also a member of the Biden Harris Transition COVID–19 Advisory Board. Workers are at the core of this pandemic. Millions work 8 or more hours a day in close proximity to coworkers or members of the public in poorly ventilated settings with inadequate protection performing the activities necessary to maintain the economy and social functioning.

They can’t avoid exposure to the virus which has sickened or killed an enormously large number of them. These workers bring the virus home to their families and communities, helping drive the disproportionate and tragic impact COVID–19 has had on communities of color. This is the crisis for which Congress enacted the Occupational Safety and Health Act 50 years ago, but OSHA was missing in action during the Trump administration.

It failed to take the steps necessary to require employers to protect workers from the virus. It did few inspections, and it issued miniscule fines. At one meat factory for example, where hundreds of workers were sickened and six died, OSHA issued a $15,000.00 penalty, not even a slap on the wrist for a multi-billion dollar corporation.

Fortunately, the Biden administration has committed to reinvigorating OSHA. The agency is expected to soon issue an emergency temporary standard that will require employers to assess the risks of exposure in their workplaces, and take steps appropriate to each workplace to limit it.

President Biden has famously promised that his administration will “follow the science”. To do so as Dr. Marr has just testified, the CDC must update its guidance, acknowledge the danger of inhaling infectious particles, and advise employers to take appropriate measures, and OSHA’s forthcoming standard must reflect the newest science on COVID transmission and worker protection.

There is still much to be done. After thousands of cases, and hundreds of deaths, workers in meat and poultry plants are still forced to work shoulder to shoulder instead of being provided improved ventilation, filtration, and adequate distancing. Many meat and poultry firms hang plastic sheathing between workers who are standing on cutting lines elbow to elbow even though that sheathing is ineffective in stopping exposure.

And astonishingly, we have seen some Governors and all mask and density mandates, these ill-advised actions will likely conflict with OSHA’s forthcoming regulation, and is expected to require
employers whose workers come in close contact with other workers or customers or the public, to mandate facial covering for all people in the workplace.

The nation also needs to do more to ensure that front line workers are prioritized for vaccinations. Unfortunately, many States have no plan to do so, or they're conducting insufficient outreach to help those workers get vaccinated.

Needed is a national plan for increasing vaccinations among these workers, especially those who are more difficult to reach because of language or cultural barriers, or the nature of their jobs. And despite the huge impact on this Nation’s workers, there are a few, if any, sources of complete accurate data on the impact of the virus on workers in any industry or occupation.

There's no centralized effort to compile a census of workers who have been affected or died of the disease. Now this is truly a lost opportunity because there are enormous lessons to be learned about preventing transmission in future pandemics. The Federal Government needs to make concerted efforts to collect these data. While it may be too late to conduct a census of deaths, other types of studies could be launched that would help understand the actual toll of the pandemic on the Nation's workers and how to prevent future pandemics.

Now while hospitals have hailed nurses and other medical staff as heroes, these workers remain vulnerable to workplace assaults. I strongly support the Workplace Violence Prevention for Healthcare and Social Services Workers Act, H.R. 1195 and grateful to Representative Joseph Courtney who reintroduced the bill last month with bipartisan support.

In addition, the accurate reporting of workplace injuries and illnesses by employers is vital to help OSHA target the most hazardous workplaces. I strongly support H.R. 1180, the Accurate Workplace Injury and Illness Record Restoration Act, which Representative Mark Takano introduced to restore OSHA’s ability to cite employers who systematically fail to record workplace injuries and illnesses.

Thank you for this opportunity to testify. I look forward to your questions.

[The prepared Statement of Dr. Michaels follows:]
Testimony of
Professor David Michaels
The George Washington University

Hearing Before the United States House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections

Clearing the Air:
Science-Based Strategies to Protect Workers from COVID-19 Infections

March 11, 2021

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Clearing the Air:
Science-Based Strategies to Protect Workers from COVID-19 Infections

Thank you, Chairman Scott, Chairman Adams, Ranking Member Foxx, Ranking Member Keller, members of the Subcommittee for inviting me to testify at this important hearing addressing the COVID-19 pandemic, one of the most pressing and difficult issues facing the nation today.

My name is David Michaels. I am an epidemiologist and Professor of Environmental and Occupational Health at the Milken Institute School of Public Health of George Washington University. The views expressed in my testimony are my own and do not represent the views of George Washington University.

From 2009 until January 2017, I served as Assistant Secretary of Labor for the Occupational Safety and Health Administration (OSHA), the longest serving Assistant Secretary in OSHA’s history. From 1998 to 2001, I was Assistant Secretary of Energy for Environment, Safety and Health, charged with protecting the workers, community residents and environment in and around the nation’s nuclear weapons facilities. I am currently a member of the Board of Scientific Counselors of the US National Toxicology Program, appointed by Health and Human Services Secretary Alex M. Azar in 2019.

Since the COVID-19 pandemic began, much of my work has focused on improving the protection of workers exposed to SARS-CoV-2.1-2 I was a member of the Biden-Harris Transition COVID-19 Advisory Board; served on the National Academy of Sciences, Engineering and Medicine’s expert panel that developed a Framework for Equitable Allocation of Vaccine for the Novel Coronavirus; and am a member of the Lancet COVID-19 Commission’s Task Force on Safe Work, Safe School, and Safe Travel. Finally, I am one of the scientists who wrote the letter “Immediate Action is Needed to Address SARS-CoV-2 Inhalation Exposure” urging the Centers for Disease Control and Prevention (CDC) and OSHA to take immediate steps to better protect workers and the public from exposure to this deadly virus that is spread through the air by infectious particles.3

Introduction
My testimony today summarizes much of what I observed in my work, and what I have recommended to federal agencies, employers and the public.
Workers are at the core of this pandemic. To protect them, we need guidance from the Centers for Disease Control and Prevention (CDC) and enforceable standards from the Occupational Safety and Health Administration (OSHA) that reflect the best, most current science on how COVID-19 is transmitted and how workers must be protected.

Millions of workers in this country work eight or more hours a day, in close proximity to co-workers or members of the public, in poorly ventilated workplaces with inadequate protection, performing the activities necessary to maintain the economy and social functioning. Under these conditions, they cannot avoid exposure to the SARS-CoV-2 virus and an enormously large but unknown number of them have been sickened by it, and many killed. These workers bring the virus home to their families and communities, helping prolong the pandemic. The often low-wage workers who risk their lives performing these essential jobs are disproportionately Black and Brown. This is one of the primary reasons that the pandemic is so much more severe in minority communities. OSHA, the agency invented to ensure the safety of the nation’s workers, was missing in action during the Trump Administration. It failed to take the steps necessary to require employers to protect workers from the virus, doing few inspections and issuing minuscule fines.

Fortunately, the Biden Administration has committed to reinvigorating OSHA in order to save worker lives and to help stem this pandemic. To accomplish this, OSHA needs to issue and enforce stronger preventive measures, starting with an Emergency Temporary Standard (ETS) that will require employers to implement workplace protections. Right now, OSHA is increasing its enforcement activities and making it clear to the nation’s employers they no longer have a pass from the government – they must implement improved protections.

Without an ETS, it is very difficult for OSHA to require employers to implement preventive measures. Different measures are appropriate for different industries, so OSHA’s ETS will likely base their requirements on OSHA and CDC recommendations applicable to each worksite. However, CDC guidelines and recommendations are out of date and were distorted by the political directives of the previous administration, and this will impact the effectiveness of OSHA’s actions if they are not updated.

Although there is a scientific consensus that inhalation of infectious particles containing the SARS-CoV-2 virus is a primary means of exposure, the CDC’s guidelines only focus on the prevention of exposure to large droplet propulsion into the nose, mouth and eyes of someone nearby which is thought to occur within relatively short distances. Prevention of droplet spray exposure can be accomplished through distancing and by use of cloth barrier face coverings and surgical masks. However, these interventions will not adequately protect against inhalation of infectious particles that can occur both near and farther from an infected person and that can be dispersed throughout a shared space. Such exposures require interventions that minimize both the concentration of particles and the duration of time spent in a space.

President Biden has famously promised that his Administration will “follow the science”.4 To do so, CDC must update its guidance, acknowledging the importance of inhalation exposure to infectious particles and advising employers to take appropriate measures. In many indoor
settings where workers are at increased risk, employers will have to improve ventilation and filtration systems, and, in places where workers are at high risk, may have to provide N95 filtering facepiece or other types of certified respirators.

COVID-19: An Unprecedented Worker Safety Crisis

The COVID-19 pandemic is a massive, unprecedented worker safety crisis. As the pandemic has continued to devastate the nation, millions of workers continue to risk their lives by continuing to go into work to care for the nation’s sick and elderly, to help families put food on their tables, to ensure public safety and to get people to and from work and to destinations near and far. The toll on these workers—and on their families and communities—has been enormous. Yet, before the Biden Administration, efforts made by the federal government to protect these workers were tragically inadequate.

This is the crisis for which Congress enacted the Occupational Safety and Health Act almost exactly 50 years ago. The nation, especially the nation’s workers, desperately need OSHA to use all of its authority to stop workplace exposures and save worker lives. Under the previous Administration, it failed to do that, and many thousands of workers have been sickened or killed.

The Trump Administration told workers “you are on your own.” It made little effort to protect workers, handcuffing rather than invigorating OSHA. The White House and the leadership of the Department of Labor under then Secretary Eugene Scalia blocked OSHA from applying COVID-19 emergency workplace safety measures. Most importantly, OSHA was forced to stop working on a comprehensive infectious disease standard in 2017 — a process that was launched during the H1N1 pandemic of 2009 — and was not allowed to issue a COVID-19 Emergency Temporary Standard (ETS). I have no doubt that an ETS issued early in the pandemic would have saved many workers’ lives.

President Biden has promised to reinvigorate OSHA to dramatically increase efforts to protect workers from virus exposure and to stem the pandemic. The agency is expected to soon issue an ETS for COVID-19 that will require employers to assess the risks of exposure in their workplace and take steps to limit it.

OSHA health standards are never “one size fits all” — they allow employers flexibility to apply measures appropriate for their workplaces. To protect workers from exposure to the SARS-CoV-2 virus, employers will look to recommendations made by OSHA and CDC.

To save lives, it is critical that these recommendations be based on the best science. We now understand that masks and distance are important, but not enough to prevent exposure. COVID-19 spreads through inhalation of infectious particles that accumulate in the air of indoor spaces where people are congregate and travel on air currents.

Unfortunately, many of the recommendations issued by CDC do not reflect this scientific consensus. It is vitally important that CDC update its recommendations and acknowledge that exposure by inhalation of infectious particles at close and far range must be addressed to stop disease transmission. In workplaces where large numbers of workers and others congregate, this will require employers to take steps to limit exposure. These are likely to include increased
ventilation and filtration, and, in some cases providing workers with respirators (like N95 filtering facepiece or elastomeric respirators) rather than barrier face coverings or surgical masks.

Even though COVID-19 continues to spread, with tens of thousands of new cases and hundreds of deaths reported each day and over 500,000 deaths so far, across the country businesses are re-opening or expanding. Furthermore, there are now several virus variants that are more infectious and appear to more virulent that the primary strain that has already killed so many people in the US. This poses additional risk to workers and the public. The many essential workers who never have had the opportunity to protect themselves by working remotely are now being joined by others newly returning to worksites—many of them now exposed to potentially dangerous conditions. All these workers need to be protected. If workplace exposures are not controlled, more workers—alone with members of their families and communities—will be infected, causing more illness and death, and threatening the ability of the nation to resume economic growth.

COVID-19 has had a disproportionate and tragic impact on communities of color: working-age African Americans and Latinx people are at greatly increased risk of the COVID-19 disease and death. Much of this increase is driven by employment patterns: Racial and ethnic minorities are overrepresented in the “essential” jobs which cannot be done by teleworking from home. The jobs held by these workers put them in close contact with other workers and the public; and are often given inadequate or no personal protective equipment (PPE). Many of these workers travel to and from work in crowded public or semi-private transportation. Since the virus does not stop at the door of the factory or nursing home or prison or subway car, these workers bring the epidemic into their homes and communities.

The toll on workers to date has been enormous, with outbreaks of COVID-19 occurring in workplaces in many industries. Perhaps the best-known outbreaks have occurred in meat and poultry processing factories. Even before the COVID-19 pandemic, workers in meat and poultry plants were at high risk of occupational injury and illness. These workers do their jobs in very tight conditions, elbow to elbow, cutting pieces of pork or beef or chicken that move rapidly past them on assembly lines. The buildings are like giant refrigerators—kept cold to reduce spoilage, with little fresh air flow—an environment conducive to virus spread. Workers report the processing lines run so fast that they do not have time to cover their face with their arms when they sneeze or cough. The efforts to combat virus transmission at food processing plants have been dangerously inadequate. Meat companies responsible for bulk of meat production have failed to implement safe work practices resulting in workplaces where hundreds of workers have been infected by the virus.6

OSHA Must Be Reinvigorated

With COVID-19, the Occupational Safety Health Administration (OSHA) faces the most significant challenge in its history. The agency’s mission is to assure protection of the safety and health of the nation’s workers, and it must lead the federal government’s effort to stop workplace transmission of the virus. OSHA has never been more in the headlines; unfortunately, this national attention is more because of its failures during the Trump Administration than its successes in addressing the COVID-19 worker safety crisis.1,2
Under the Occupational Safety and Health Act, employers are required to provide workplaces free from recognized serious hazards. In other words, every worker has the right to a safe workplace, and OSHA’s job is to protect this right by ensuring that employers eliminate hazards that could injure or sicken workers. Stemming this pandemic will require employers to restructure and reorganize work settings to minimize transmission. OSHA should have made a substantial contribution to this effort nationally, but under the last administration, it chose to play a minor, advisory role providing safety tips and soft recommendations (see below), but never requiring employers to provide adequate protection for their employees.

The statistics on OSHA’s meager efforts last year are truly disheartening. In a recent report, the Department of Labor’s Office of Inspector General found that in 2020, OSHA received 15% more employee complaints but performed 50% fewer inspections than in 2019 (cite). The agency’s failures have undoubtedly contributed to the tremendous toll of disease and death among the nation’s workers. An investigation by the Wall Street Journal released last week identified more than 500 Covid-19 outbreaks involving some 6,000 infections at workplaces where employees had earlier complained to OSHA of unsafe conditions. The Journal also “found 180 worker deaths from Covid-19 that occurred four weeks or more after complaints to OSHA agencies that the agency didn’t investigate beyond corresponding with employers.”

At one meat plant where hundreds of workers were sickened and six died, OSHA issued a $15,615 penalty, not even a slap on the wrist for a multi-billion-dollar global corporation. The Greeley Tribune calculated that, since JBS’s net revenue in 2019 was $51.7 billion in 2019, the fine represented 0.00003% of last year’s profits: “the equivalent of fining someone making $50,000 a year — an approximate salary for a meat cutter at the Greeley plant — one-and-a-half cents.” The family of one of the workers who died reported that the cost of the funeral was more than the OSHA fine.

To Better Protect Workers, CDC Science Must Embrace the Newest Science

One year into the pandemic, and after more than a half a million deaths in the United States, our understanding of how COVID-19 spreads has grown and changed significantly. President Biden has asserted that “the policy of my Administration [is] to listen to the science.” We now know that inhaling infectious particles is a major way people are infected; strong measures to limit small particle inhalation, including ventilation and respiratory protection are therefore needed for workers at increased risk. But much of the guidance from the CDC is based on old science and is in desperate need of updating.

This updating is particularly urgent to protect frontline workers in essential industries like healthcare and long-term care, meat packing, grocery stores, corrections and public transportation, where workers face prolonged or repeated contact with the public or co-workers, putting them at much greater risk of infection and death, and of spreading infection to their families and communities.

At the beginning of the pandemic, the most common routes of virus transmission were thought to be droplet spray (the propulsion of large droplets into the face, nose, eyes and mouth of someone nearby) or by touch (transferring respiratory fluids by hand to your eyes or mouth from surfaces
where they have deposited). Since droplets are heavy and generally don’t travel far before they fall, CDC recommended staying six feet apart, frequent handwashing and surface disinfection. When it became clear that the virus could spread by asymptomatic persons, CDC added the recommendation to wear masks when near other people.

While it is still important to prevent person-to-person transmission via droplet spray, there is now a large body of scientific evidence that particles much smaller than droplets can also spread the virus. These tiny particles are emitted by infected people during breathing, talking and singing, and waft away in plumes of exhaled breath. The particles are so small they stay aloft for minutes to hours and can be carried distances by air currents.

In indoor enclosed spaces, these particles can accumulate, particularly if the ventilation is poor and the air is not filtered. There are now numerous studies of people infected with COVID-19 due to small particle inhalation, at distances far greater than the few feet that droplets travel.

Recognizing this, experts in aerosol science, infectious disease, occupational safety, and many related fields from across the world have recently urged national public health agencies to immediately update their COVID-19 control recommendations. In the last few weeks, leading physicians and scientists from the United States, United Kingdom, Canada and Australia and elsewhere have written public letters to their governments requesting that agencies fully recognize inhalation exposure as an important source of virus transmission and incorporate the recognition and prevention of exposure to infectious particles. The letter from the US scientists, including Dr. Marr and myself, and four who were members of the Biden Transition COVID-19 Advisory Board, is appended to this testimony. I commend the leadership of the Education and Labor Committee and the Workforce Protection Subcommittee for sending their own letter to Biden Administration Officials raising these same concerns and urging the Administration to take immediate steps to ensure better protections for virus-exposed workers.

The best model for thinking about how particles travel in air is cigarette smoke. If you are next to a smoker, you get a big dose. But even ten or twenty feet away, you can still smell the smoke. If there are many smokers, even more smoke will fill the air. Small particles containing SARS-CoV-2 behave similarly, giving the biggest dose and most infections to people within a few feet, potentially infecting some people at a greater distance from the source. If there are more infected people in one room or an infected person is talking loudly or singing, the danger increases because more virus is likely to be in the air.

Surgical masks and cloth face coverings stop almost all droplet spray from getting into or out of masks, but only block a portion of smaller particles, depending on filter efficiency and fit. It may be fine to rely on a surgical mask or barrier face covering while also observing six feet of separation for a quick trip to the store, but not for workers who spend many hours in crowded indoor settings, especially settings with inadequate ventilation and jobs that involve being close to other people.

These conditions continue to drive the high rates of COVID-19 among workers in nursing homes, correctional facilities, transportation, food processing, grocery stores, and similar jobs involving long hours in poorly ventilated spaces. These jobs are ones in which people of color
are over-represented, contributing to elevated risk of COVID-19 disease and death among Blacks, Latinos and other racial and ethnic minorities.

The fundamental workplace safety and health principle that employers must apply in order to best protect their workers is called the hierarchy of controls. This principle underpins all OSHA health standards, is the system of determining how to implement feasible and effective control solutions in order to best protect workers from workplace hazards. There are many CDC documents that reference and link to NIOSH’s Hierarchy of Control webpage, but I was not able to find any discussion in CDC (including NIOSH) documents and webpages on how the hierarchy is applied to protecting workers from COVID-19.

Years of research, investigation, and OSHA enforcement efforts during disease outbreaks associated with influenza, coronaviruses, and other infectious respiratory pathogens have taught us a great deal about how to prevent workplace transmission of COVID-19.

The most effective way to protect workers from on-the-job virus exposure is to ensure that no potentially infectious people enter the workplace. Employees who are infected or had been exposed should be provided sick pay in order to stay home until it is certain they are not spreading the virus. However, because many infected people are asymptomatic, and members of the public enter workplaces as customers, contractors, patients, or visitors, additional steps must be taken to reduce the likelihood of virus exposure.

Until we can be confident that people who are shedding virus are completely stopped from entering workplaces, it is necessary to apply a series of preventive measures, no single one of which is adequate by itself. These measures include screening, isolation of infected/likely infected/close-contact workers, enhanced ventilation, physical distancing, respiratory and other personal protective equipment (PPE), sanitation, and disinfection.

Even if infected people are in the workplace, maximizing the amount of clean, virus-free air plays a vital role in making workplaces safe. Little disease transmission occurs in the outdoors: air currents constantly dilute the concentration of virus to which people are exposed. Employers need to try to make the inside air as much like the outside as possible. Portable air cleaners equipped with High Efficiency Particulate Air (HEPA) filters can also be very effective at removing the virus and increasing the amount of air circulation in an indoor space.

The wearing of barrier face coverings and surgical masks also reduces the concentration of infectious particles in the air. And increasing distance between any potentially infectious people in the workplace reduces risk as well. As a last resort, a worker who spends long periods in poorly ventilated settings or in close contact with many other people may need a NIOSH-approved respirator, like an N95 filtering facepiece respirator, instead of a surgical mask or barrier face covering.

Face coverings and surgical masks are useful because they reduce the virus in the air. They do a good job blocking large droplets but are much less effective at preventing exhalation or inhalation of small particles, and do not provide sufficient protection for someone exposed to infectious particles for longer periods of times. Respirators, on the other hand, which provide a high level of filtration and fit tightly don’t just block the virus from getting into the air, but also
filter out the virus, including small particles that carry the virus, from the air that the wearer breathes. Bus riders, for example, should wear face coverings to help reduce virus exposure to everyone on the bus, but the bus driver, who all day inhaled other people’s exhaled breath which may contain the virus, should wear a respirator.

It appears that many employers are still ignoring the scientific consensus on infectious particle transmission by inhalation. After thousands of cases and hundreds of deaths, workers in meat and poultry plants are still forced to work shoulder to shoulder and elbow to elbow, instead of being provided with improved ventilation and filtration and adequate distancing. Many of meat and poultry firms have hung plastic sheeting along the sides of workers congregated together on production lines. Here is an example of this type of effort.13

Workers at Tyson’s Camilla, Georgia, poultry processing plant. Photograph: Tyson/AP

There is extensive evidence that plexiglass or polyurea barriers meant to stop droplets are ineffective in stopping exposure to exposure to virus-carrying particles. As noted above, distance is useful, since exposure to exhaled particles is higher the closer you are to the person exhaling the particles. With distance, the particle concentration in the air is diluted. But these particles travel with the airflow around physical barriers that are designed to stop droplet sprays. To protect these workers, meat and poultry firms should make the air workers breathe as virus-free as possible, using improved ventilation and filtration and greater distances between workers. If this is not adequate, these workers should be given NIOSH-approved respirators, like N95s or elastomeric respirators.
It is imperative that both CDC recommendations and OSHA standards reflect the most recent, up-to-date science. As was made clear in our letter, there is now a clear scientific consensus that infectious particle inhalation leads to virus transmission. CDC can and must support OSHA’s efforts by updating its guidance to make clear that small particle inhalation is a major source of COVID-19 transmission.

Failure to provide a consistent science-based explanation of how the virus spreads will lead to more confusion about what measures are needed to control it and why they are important and will undermine public acceptance of CDC recommendations and OSHA requirements. It will also mean that employers’ efforts to protect workers are more likely to be ineffective and lead to more COVID-19 infections and more worker deaths.

Finally, we have seen governors of a few states have ended mask and density requirements. However, since the worker protection measures that will be required by OSHA’s expected ETS will be based on the latest scientific understanding of COVID-19 transmission, it is likely that OSHA will require employers, especially ones who have workers in close contact with other workers or customers, to mandate facial covering for all people in the worksite. Failure to require masks of all persons in the vicinity of workers, as well as to limit density in establishments, increases the risk that workers could be exposed to the virus and could lead to an OSHA penalty.

As we have seen, there is a strong scientific justification for these provisions of the ETS, which will cover many retail establishments, as well as factories, warehouses and fulfillment centers where workers are in close contact. Once they are applied, they will no doubt prevent many cases of COVID-19 among workers, but also among customers and others in these establishments. If we are truly interested in protecting workers and stemming this pandemic, these efforts by OSHA should be strongly supported.

While the country moves as quickly as possible to vaccinate the public, it is critical that we do all we can to reduce workplace and community exposures to prevent further spread of COVID-19, as the Biden administration is urging. Recognizing and acknowledging the importance of inhalation exposure and issuing guidelines and standards to control infectious particles is necessary to achieve this goal.

**Vaccination Programs Need to Be Improved**

In the first year of the pandemic, thousands of frontline workers have been sickened or killed by the virus. Black and Brown workers are over-represented in many of the jobs that are necessary to maintain economic and social function, jobs in which workers cannot telework but must be in close proximity to potentially infectious people. This over-representation of minority workers in jobs at nursing homes and meat and poultry plants, on farms and public transportation systems, is one of the reasons that the pandemic has hit communities of color far harder than predominantly white communities.

The National Academy of Sciences, Engineering and Medicine’s expert panel that developed a [Framework for Equitable Allocation of Vaccine for the Novel Coronavirus](https://www.nas.edu) recommended that
frontline workers who are at increased risk of COVID-19 because they are doing ne prioritized in vaccine distribution. This recommendation has been repeated by the CDC’s Advisory Committee on Immunization Practices. Unfortunately, many states have not followed these recommendations, and either declared that they simply would not prioritize frontline workers or said they would but have made insufficient outreach to assist these workers in getting into the vaccine distribution system.

The Biden Administration is making tremendous efforts to increase vaccine supply, as well as to make the distribution of vaccines more equitable. I fully support these very worthwhile efforts. However, there still is no concerted national effort to vaccinate those frontline workers who continue to risk their lives performing jobs essential to the economy and social functioning.

Needed is a national plan for increasing the vaccination rate among workers doing essential jobs, especially those who are more difficult to reach because of language or cultural barriers or the nature of their jobs. If states are unwilling to prioritize high risk workers, the federal government should provide additional vaccines to local providers, like community and migrant clinics, that are able to engage those communities in which many of these workers live. In addition, I recommend the federal government facilitate vaccination programs for workers involved in interstate commerce, like flight attendants and seafarers, who are often far from home and whose jobs involve increased risk of virus exposure. While this is a significant concern for many transportation workers, it is a particularly intractable problem for seafarers, who are at elevated risk of workplace exposure and disease, and who have little ability to register for and receive a vaccination in their home state in a timely manner.

**Better Data About Workplace Cases and Deaths Are Needed**

While it is tragically clear that hundreds of thousands of workers have been sickened by workplace exposures, and thousands have likely died, there are few if any sources of complete, accurate data on the impact of the virus on workers in any industry or occupation. With a few exceptions, the data we have are either incomplete or anecdotal.

One worker population about which we should have reasonably complete and accurate data on the impact of COVID-19 is healthcare workers, but even for them, there is a severe shortage of data. CDC reports that, as of March 8, more than 420,000 healthcare workers have been infected with the virus and almost 1400 have died. But CDC was able to obtain healthcare personnel status for less than 20% of all the nation’s COVID-19 cases, suggesting the actual numbers are far higher.

In some cases, state and local health departments collect information about COVID-19 outbreaks at individual workplaces and the COVID-19 emergency standards issued by both Cal OSHA and Virginia OSHA require that employers report outbreaks of three or more COVID-19 cases to these state job safety agencies. But there is no centralized federal effort to collect this information or to compile even a census of workers who have died of the disease. Federal OSHA should require the reporting all COVID-19 workplace outbreaks under any OSHA emergency standard so that at least going forward, this workplace-based information can be collected.
There is no doubt that measuring the impact of COVID-19 on workers will be challenging, between identifying in what workplace workers have been infected and how many of those infections can be traced to work. Nevertheless, there are enormous lessons to be learned about how to prevent transmission in future pandemics by understanding where and why workers were infected. There needs to be a component of a national strategy to characterize the impact if the pandemic on the nation’s workers.

In spite of all this, the Bureau of Labor Statistics has decided that COVID-19 deaths will not be included in the Census of Fatal Occupational Injuries and that the Survey of Occupational Injuries and Illnesses will not produce estimates specifically covering COVID-19 illnesses. 20 Ironically, given the decline in economic activity last year, 2020 will likely appear as one of the safest on record for workers, despite the clear, but uncounted toll of COVID-19.

Definitively determining that a virus exposure that resulted in an infection occurred at work, home or elsewhere without genomic sequencing is difficult. While investigations of workplace outbreaks have demonstrated the role of workplace exposures in transmission at work and from there to the community,21 many employers almost automatically attribute COVID-19 cases among their workers to community exposure – in this case community means anywhere but the workplace.

This is likely being driven by efforts by employers to avoid stigma and to avoid paying workers’ compensation benefits to sick workers or the families of workers who have died from COVID-19. It has been reported that more than 900 meat factory workers in Minnesota alone have been denied workers’ compensation by their employers.22 The two largest meat factory worker outbreaks in Minnesota were at plants owned by JBS, the Brazilian-owned multibillion dollar corporation. JBS is also fighting workers compensation claims from sick workers employed at their plant in Greeley Colorado, where six workers died of COVID, and hundreds were infected.23

OSHA has only added confusion to this problem. OSHA regulations have long required employers to maintain a log of work-related injuries and illnesses. Early in the epidemic, as large numbers of COVID-19 cases were first being reported in workplaces across the country, OSHA told all employers, other than those in the health care sector, that they did not have to record COVID-19 cases among their employees as work-related, which translates to telling employers there was no requirement to investigate if the infection could have been the result of an on the job exposure.24 After much criticism, OSHA reversed this directive a month later, and employers now are required to record cases.25 Subsequently, OSHA did very little to remind them that all potential cases should be recorded on the log.

OSHA regulations also require employers to report work-related deaths and hospitalizations to OSHA. In the middle of the pandemic, OSHA re-interpreted its hospitalization reporting requirements so that employers would have to report COVID-19 only if the hospitalization occurred within 24 hours of the exposure, something that never occurs.26

There is no question that there are private sector sources of data that should be made public. For example, the meat industry is reluctant to provide data it has collected; the most complete
information on workers in meat and poultry factories comes from an investigative group which compiles state and local health department reports. The Food and Environment Reporting Network (FERN) reports that there have been more than 57,000 cases of COVID-19 among meat and poultry workers and almost 300 have died. This is undoubtedly an underestimate, since FERN only has access to publicly available data.

Oddly, in its recent statement that new infections among workers in meat factories is lower than the national average, the North American Meat Institute (NAMI), the industry’s trade association, used the publicly available data from FERN, rather than data their own members are undoubtedly compiling.

More complete and comprehensive data from employers and local public health departments on the distribution of COVID-19 cases would be very useful in understanding workplace exposure and targeting enforcement and consultation programs to increase disease prevention. But right now, these data are lacking for any industry or occupation and no effort is being made to collect data while they are available. It will be a challenge to collect more complete and accurate data now but going back to try to do this after the pandemic will be extremely difficult.

The federal government needs to make concerted efforts to collect these data. It may be too late to conduct a census of deaths, like CFOI, but other types of studies could be launched in the very near future that would help estimate the actual toll of the pandemic on the nation’s workers. To assist these efforts, Congress should strongly employers like those who are members of NAMI to provide CDC and other federal agencies with actual data on COVID-19 infections and deaths among its employees.

While it may be too late to conduct a census of all deaths, federal agencies with statistical expertise statistical could collaborate with state and local health departments in surveying a sample of COVID-related cases and deaths to better understand workplace exposures. I urge the appropriate government agencies, including BLS and NIOSH, to immediately begin the process of developing one or more studies, and that Congress provide generous funding for this effort, as well as the requirement that private sector employers provide information requested by the agencies for this effort.

**Healthcare Workers Must Also Be Protected From Workplace Violence**

Healthcare workers are at the center of the nation’s effort to care for the victims of the pandemic, and these workers are paying a tremendous price for that work. But exposure to the SARS-CoV-2 virus is only one of the very significant and sometimes deadly hazards healthcare workers face in the course of their work.

While hospitals have hailed nurses and other medical staff as heroes of the pandemic, for decades they have left them vulnerable to abuse and assaults, extracting a tremendous toll on workers whose job it is to care for persons who are sick or need of assistance. Health care and social service workers suffered 22 percent of all workplace violence injuries caused by persons in 2018 and are nearly 5 times as likely to suffer a workplace violence injury than workers...
In addition to the life-altering impact of these injuries on nurses and other healthcare workers, the elevated incidence of injuries, and the constant looming threat of injuries, is driving badly needed skilled, compassionate workers away from jobs where they are so badly needed.

In 2016, unions representing healthcare and social service workers petitioned OSHA to issue a regulation protecting workers in these settings. OSHA held a public meeting where injured workers and their representatives described instance after instance where dedicated healthcare providers suffered serious and, in some cases, life-threatening workplace violence injuries in the course of performing their work caring for patients.

As OSHA’s administrator, I attended that meeting and remember being close to tears listening to these powerful stories. After reviewing the very extensive and compelling evidence for the need for a regulation, I granted the petitions and announced OSHA would immediately commence the rule-making process.

Unfortunately, the Trump Administration decided not to move forward with the rulemaking. As a result, many healthcare workers must still face the possibility of violence as they are providing care for COVID-19 patients and others in need of their services.

Healthcare and social service workers, along with their patients and clients, desperately need help to prevent more violence and enable the caregivers to do their jobs safely. Normally, it takes OSHA a decade or more to issue a health standard; with its new challenges arising from the pandemic, OSHA could need substantially more time to finish its rulemaking.

These heroic workers should not have to wait. I strongly support the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195) and am grateful to Rep. Joseph Courtney who re-introduced the bill last month with bipartisan support. H.R. 1195 would require OSHA to issue a workplace violence standard within 42 months. A similar bill passed the House in the 116th Congress by a vote of 251 to 158. I urge the Congress to repass this vitally important legislation as soon as possible.

**OSHA Recordkeeping Rules Must Be Made More Effective**

With the COVID epidemic, the importance of employers accurately and completely recording and reporting workplace injuries and illnesses to OSHA has never been clearer. Yet the rules that govern OSHA’s ability to require accurate and complete data have been severely weakened.

The accurate recording of workplace injuries and illness by employers is an important component of any workplace safety program. Injury and illness logs are a roadmap to preventing future injuries and illnesses; the point employers, workers, OSHA inspectors and now the public to the existence of hazards, often the initiation of efforts to eliminate those hazards.

One of the first acts of the Trump administration and Republican Congress in 2017 was to pass a Congressional Review Act (CRA) Resolution of Disapproval that invalidated OSHA’s recordkeeping rule. This rule, known as the “Volks Rule”—authorized OSHA to cite employers for continuing injury and illnesses recordkeeping violations if the violations continued past the six-month statute of limitations in the OSHA Act. With the elimination of the Volks Rule, OSHA
has little ability to issue a citation and penalty against an employer who fails to include an injury or illness on the OSHA log. A citation can only be issued if an inspector discovers that an injury occurred and it was not entered within six months of the occurrence. Previously, there was a five-and-a-half-year window in OSHA could issue a citation for the failure to record an injury or illness. Employers know that the likelihood of being inspected and an OSHA inspector discovering a recent unrecorded injury or illness is very low.

It is therefore not surprising that a recent report from the Government Accountability Office found that OSHA citations for record-keeping violations have dropped significantly in recent years. In addition, over the past three years, fewer than half of employers have submitted to OSHA summaries of their injury and illnesses logs as required by OSHA regulation.30

I strongly support H.R. 1180, The Accurate Workplace Injury and Illness Record Restoration Act, which Rep. Mark Takano introduced last month. This bill would restore OSHA’s ability to cite employers who systematically fail to record workplace injuries and illnesses and overturn the CRA Resolution of Disapproval. Passage of this legislation will undoubtedly contribute to safer workplaces and healthier workers.

Thank you for this opportunity to testify before you today. I look forward to your questions.
References


13. These letters are available at https://drive.google.com/drive/folders/16gP7T7UF76hDYaYb4f9QD5aVbY9LwM7


February 15, 2021

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Re: Immediate Action is Needed to Address SARS-CoV-2 Inhalation Exposure

Dear Mr. Zients, Dr. Walensky and Dr. Fauci:

We write as physicians and scientists with expertise in aerosol science, occupational health and infectious disease to commend the Biden Administration’s National Strategy for the COVID-19 Response and Pandemic Preparedness and to urge strong immediate action to strengthen measures to limit inhalation exposure to SARS-CoV-2 as a cornerstone of this plan.

The Biden Administration COVID-19 plan ramps up and expands the availability of life saving vaccines and calls for widespread use of masks, stronger measures to protect workers and updated and more protective guidelines for the public. Importantly, the plan highlights the disproportionate impacts of COVID-19 on Blacks, Latinos and other vulnerable high-risk groups and outlines actions to protect them.

There is a pressing and urgent need for action. COVID-19 infections and deaths recently reached record levels. The roll-out of vaccines that started out in December rocky and slow is now improving, but it will be months before most of the population is vaccinated. In the meantime, more transmissible variants are projected to become the dominant strains by March and may pose significant challenges to the efficacy of first-generation vaccines and monoclonal antibodies. While COVID-19 infections and deaths have started to decline in recent weeks, they remain at a very high level and, unless strengthened, precautionary measures are implemented, the new variants will likely bring an explosion in new infections.

Stronger protective measures are needed immediately to limit exposure and transmission of the SARS-CoV-2 virus to control and end the COVID-19 pandemic. Action is needed to better protect workers and the public against inhalation exposure to the virus. Germany, Austria and France have all recently taken action by mandating respiratory protection equivalent to N95 filtering facepiece respirators (FFRs) and higher quality
masks for workers and members of the public and have recommended enhanced ventilation in indoor settings [1–3].

The United States should take similar strong actions to control the COVID-19 pandemic.

For many months it has been clear that transmission through inhalation of small aerosol particles is an important and significant mode of SARS-CoV-2 virus transmission. The gravity of this problem was emphasized this week by an editorial in the journal Nature [4]. Numerous studies have demonstrated that aerosols produced through breathing, talking, and singing are concentrated close to the infected person, can remain in air and viable for long periods of time and travel long distances within a room and sometimes farther [5–7]. Gatherings in indoor spaces without adequate ventilation place participants at particularly high risk, an important component of which is driven by asymptomatic and pre-symptomatic viral shedding of infected individuals [8].

In October, the CDC recognized inhalation as a route of exposure that should be controlled to protect against COVID-19 [9], but most CDC guidance and recommendations have not yet been updated or strengthened to address and limit inhalation exposure to small aerosol particles. CDC continues to use the outdated and confusing term “respiratory droplets” to describe both larger propelled droplet sprays and smaller inhalable aerosol particles. It also confuses matters with “airborne transmission” to indicate inhalation exposure exclusively at long distances and does not consider inhalation exposure via the same aerosols at short distances.

This artificial distinction needs to be replaced with up-to-date terminology [10], as advocated by the National Academies workshop on Airborne Transmission [11]; focused on routes of exposure via a) touch, b) large droplets sprayed onto the body, and c) inhalation of small aerosol particles [12].

CDC guidance and recommendations do not include the control measures necessary for protecting the public and workers from inhalation exposure to SARS-CoV-2. Most recommendations from other agencies are also out of date.

For example, CDC continues to recommend surgical masks for most healthcare workers and limits the use of NIOSH-certified respirators only to direct patient care or aerosol generating procedures with COVID-19 patients. It is now well documented that healthcare workers in non-COVID-19 patient care and support positions are also at high risk of infection [13–17] and should be wearing respirators.

Similarly, for non-healthcare workers – even those at very high risk of exposure and infection such as in food processing, prisons and security - CDC and OSHA recommend only face coverings that do not protect against small particle aerosol inhalation. Even the most recent CDC guidelines on face coverings, issued February 11, 2021, focus on prevention of exposure to droplets and state unequivocally “CDC does not recommend the use of N95 respirators for protection against COVID-19 in non-healthcare settings” [18].

CDC has cited shortages of N95 FFRs as a key reason for limiting their use outside of healthcare, but in recent months the supply and availability of these and other NIOSH-approved respirators has increased as new manufacturers enter the market. Millions of NIOSH-approved N95 FFRs are now available and sitting in warehouses, with many employers reluctant to buy from new producers or believing there is no need for their use [19]. Without clear guidance and direction on the need for enhanced protection, there is no demand for these N95 FFRs and some of these new manufacturers may go out of business.
CDC and OSHA must recommend and require the use of respiratory protection, such as N95 FFRs, to protect all workers at high risk of exposure and infection.

CDC and OSHA guidelines fail to follow or recommend an objective risk assessment approach built on well-understood principles, such as exposure being a function of aerosol concentration and contact time or a control hierarchy that emphasizes source and pathway interventions over receptor controls (personal protective equipment). A risk-based control-hierarchy model developed and published by CDC and NIOSH investigators designed specifically for conserving personal protective equipment resources during an aerosol-transmissible infectious disease pandemic [20], updated specifically for COVID-19 [21,22] was not employed and represents a major missed opportunity that could have saved lives.

The failure to address inhalation exposure to SARS-CoV-2 continues to put workers and the public at serious risk of infection. People of color, many of whom work on the front lines in essential jobs, have suffered -- and continue to suffer -- the greatest impacts of the COVID-19 pandemic [23,24].

In assuming the directorship of CDC, Dr. Walensky recognized that many of the agency’s recommendations did not reflect the latest science and she committed the agency to reviewing and updating them. On January 20, 2021, Dr. Walensky issued the following statement:

CDC’s Principal Deputy Director Anne Schuchat will begin leading a comprehensive review of all existing guidance related to COVID-19. Wherever needed, this guidance will be updated so that people can make decisions and take action based upon the best available evidence [25].

We applaud this much-needed focus on science to inform public health guidance and encourage the Administration and its agencies to focus on aerosol inhalation.

To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:

- Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to small inhalable particles from infectious sources at close, mid and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first, followed by respiratory protection. Workers in the highest risk categories, including all healthcare workers and other workers with prolonged, close contact with infectious people, must also be provided respiratory protection.

- A year into the pandemic with a re-established supply chain that includes increased US production, CDC must direct healthcare organizations to stop all contingency and crisis practices (e.g. decontamination of N95 FFRs and use of non-respirator facepieces such as surgical masks in place of respiratory protection), and expand its recommendations for respiratory protection to include all workers in healthcare and related sectors, not just those with direct care of COVID-19 patients.

- Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls. The standard should address requirements for effective respiratory protection for all healthcare and other workers at high risk of exposure to COVID-19. Workers at lower
exposure risks should be offered high-performing barrier face coverings tested to the ASTM F3502-21 Standard Specification for Barrier Face Coverings with at least 80% filter efficiency, no more than 15 mm H2O air flow resistance and total inward leakage of no more than 5% on a panel of at least 10 subjects.

- Update CDC recommendations and adopt standards for barrier face coverings for the public with high levels of filter efficiency, low breathing resistance and low inward and outward leakage to ensure both source control and personal protection from small particle inhalation, following the test methods described in ASTM F3502-21 Standard Specification for Barrier Face Coverings [26].

- Coordinate a national effort to enhance and distribute the supply of NIOSH-certified respirators and ASTM barrier face coverings for worker protection. Immediately identify existing supplies and help distribute them where they are most needed. Existing supplies of respirators need to be made available and used now, not allowed to sit in warehouses and in supply rooms.

- Use the Defense Production Act to ramp up production of N95 FFRs (particularly models already certified and in wide use), elastomeric respirators, powered air purifying respirators and high-quality barrier face coverings. Provide funding and enter contracts with manufacturers to increase supplies. Coordinate the supply chain and require the purchase of US-manufactured respirators.

As we have emphasized, immediate action is needed to address inhalation exposure risks in order to bring the COVID-19 pandemic under control. We stand ready to assist the administration in these efforts.

We thank you, President Biden, and the entire administration for your strong leadership and efforts to protect the American public and workers from this deadly virus.

Sincerely,

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Anne Schuchat, MD, Principal Deputy Director, Centers for Disease Control and Prevention
Timothy Manning, Supply Coordinator, White House COVID-19 Response
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Literature Cited


Mr. SCOTT. Thank you. Now we’ll have Member questions and I’ll begin with myself. I recognize myself for five minutes.

Dr. Michaels we heard a comment about the problem of incorporating guidance in an ETS, and if the guidance changed, the ETS changes. How complicated and confusing, would that be if at all?

Dr. MICHAELS. Thank you for that question Chairman Scott, and thank you for your work in this area. You know that’s a caricature of an OSHA standard, and it’s totally wrong. The key part of the emergency temporary standard as I understand it, what we might expect to see is essentially telling employers, look. Assess what’s going on in your workplace. Do a hazard assessment, and then look at the guidance that comes out of CDC. Look at what we under-
stand about how workplace transmission takes place, and take steps accordingly.

Now I very much agree with Mr. Rath that we don’t need to be doing you know major disinfection. And that really turned out not to be effective, and it’s really I believe that if CDC changes their guidance on that, you know, employers will do much less of that.

So right now the problem is CDC guidelines are out of date, and whatever the OSHA standard is, it’s going to say use that CDC standard. And when CDC standard’s change, workers get better protection because CDC has improved their thinking about how to protect workers.

Mr. SCOTT. Thank you. And Dr. Michaels are you familiar with the Virginia ETS and now permanent standard?

Dr. MICHAELS. I am. Virginia was the first State to issue an ETS, and the first State to issue a permanent standard to protect workers from airborne infectious diseases.

Mr. SCOTT. And how effective is that standard, and how burdensome is it?

Dr. MICHAELS. Well I believe it’s very effective. Look, you know as you’ve heard from Mr. Rath, some employers do the right thing without being required to, but many employers don’t. And that’s why Virginia issued the standard. I think it’s been very effective in making sure that those employers who wouldn’t normally have made those steps to protect workers are now doing so.

They know they have to provide social distancing. They have to provide masks in workplace. And they’ve also given information to the Virginia government that’s really important. There’s a requirement to notify the Virginia State Health Department when cases are found and when there’s a cluster at a workplace, Virginia OSHA is told, so they can actually go out and do some inspections.

Mr. SCOTT. Now did you follow the regulatory adoption of that standard.

Dr. MICHAELS. Yes I did. The Virginia Board included representatives workers of workers, of employers in the public, voted on it and it was passed by a large majority.

Mr. SCOTT. Did that include the employer representatives?

Dr. MICHAELS. Yes it did.

Mr. SCOTT. Thank you. You were at OSHA before. Can you tell us the importance of accurately recording data so that under Mr. Takano’s bill, what difference does accurate recording of data—what difference does that make?

Dr. MICHAELS. Oh. That is such an important question. You know OSHA requires most employers to keep track of injuries and illnesses, and that information is really important for that employer, for the workers in that workplace, because recording injuries and illnesses accurately and completely provides a roadmap to prevent future injuries from occurring.

Unfortunately, we’ve gotten into a situation where there really is no enforceable requirement for employers to record data accurately, and the result of that is many of these OSHA logs are incomplete, and so it’s hard to actually figure out the best way to prevent future injuries.

Mr. SCOTT. And finally, Mr. Courtney’s bill on violence prevention essentially requires employers to have a plan to deal with vio-
Mr. Scott. Thank you very much. My time has expired. Mr. Keller you’re recognized for five minutes.

Mr. Keller. Thank you. Mr. Rath since the COVID-19 pandemic was declared and became a threat to the U.S. workplaces in early 2020, the scientific understanding of the virus has dramatically changed, and continues to do so. Can you explain how the public health guidance for preventing the spread of COVID-19 in the workplace from CDC and OSHA has evolved since the early days of the virus, and how employers have responded to adopt the necessary precautions over time.

Mr. Rath. Thank you for your question Ranking Member Keller. This is a good question. What we’ve seen over the past year at the employer level is that they have spent an enormous amount of energy rightly so, trying to stay up to date with changes in our science, and our healthcare understanding of COVID-19, and its transmission at the workplace.

Some of those developing standards or guidance’s that have come from the CDC have been helpful and at some point they were rolling out changes multiple times a week and employers were doing their best to keep up with those changes, and contemplate and implement changes in the workplace accordingly, including the questions of what are the symptoms?

That list was rapidly developing in the early months. We saw the list expand, we bifurcated into higher and lower levels of specificity and then be compressed into a singular list again, how long people should be quarantined, or isolated if they were positive or came in close contact with a positive case.

And employers have done an excellent job that I’ve worked with in trying to implement well-intentioned policies to keep up with that science. That science has been changing, and it continues to change, and as I mentioned earlier just a month ago the CDC revised its view on mask wearing to State its recommendation that two masks be worn—a disposable mask underneath a cloth mask.

These are data-driven changes from the Centers for Disease Control, and employers have continued to very rapidly, make changes in the workplace accordingly. Far more rapidly we’ve seen employ-
ers make changes, and then later on we've seen the Centers for Disease Control, or OSHA-issued guidance for example, two employers I've worked with have engaged their own epidemiologists, and have looked directly to scientific studies, bypassing, much more rapidly bypassing, the implementation of a change of policy at the Centers for Disease Control and Prevention, and far more rapidly still than guidance could be issued by OSHA.

Once OSHA issues an emergency temporary standard it has one chance to do so, and then that is immutable and intransigent against successive evolutions in science. And so that has been a success story with the employers with whom I've worked.

Mr. KELLER. So, some of the employers have taken it upon themselves to make sure when they've investigated and found a better way to do things, they've been ahead of OSHA and CDC in some cases?

Mr. RATH. In several instances that's correct. They've looked directly to the scientific journals and scientific studies as soon as they've been published, evaluated those studies and made changes quickly, and then you've seen those changes manifest themselves in CDC guidance, and then far later still sometimes through OSHA guidance.

Mr. KELLER. Thank you. And another question Mr. Rath, Ranking Member Foxx and I sent a letter to acting Secretary of Labor Al Stewart asking the department to consider the impact that a one-size-fits-all OSHA regulation could have on small businesses. Can you explain the customary process in which OSHA fulfills its small business feedback related to regulatory initiatives?

Mr. RATH. That's an excellent question Ranking Member Keller, thank you for asking it. Under traditional rulemaking there is a step in the rulemaking process where the agency has to solicit the input of small businesses, small business representative entities, and it has to also separately, evaluate the impact of a regulation on small businesses.

That in addition to scientific data. Scientific data cannot write a regulation. It has to be alloyed with this small business impact consideration as well as technical and economic feasibility considerations. All rules have to go through these processes. And if you go through an emergency temporary standard, that would exclude the small business stakeholders from being able to contribute comments as to how it would impact small businesses.

Mr. KELLER. So an emergency temporary standard would bypass America's small businesses which are the backbone of our economy?

Mr. RATH. That's correct. It would go straight to developing a rule without small business input.

Mr. KELLER. Thank you. And how important do you think it is to solicit the feedback from small businesses before an emergency temporary standard related to COVID–19 is contemplated?

Mr. RATH. Small businesses are a special case because they comprise the largest fraction of the work force, and safety and health in small businesses is therefore just as important or more so, than the large employers that comprise a much lesser fraction of the total work force.
Mr. KELLER. Thank you. And I just want to make the point. I worked in a factory and my experience was that employers do value and appreciate the people that come to work every day. And for us not to consider all of America's small business, they're innovators, our neighbors, the people that make our communities so great. I think it would be a huge mistake by our government to discount and not hear their voices, so thank you and I yield back.

Mr. SCOTT. Thank you. The gentlemen's time has expired. Mr. Takano are you there?
[No response.]
Mr. SCOTT. Mr. Norcross?
[No response.]
Mr. SCOTT. Ms. Jayapal?
[No response.]
Ms. JAYAPAL. Thank you Mr. Chairman.
Mr. SCOTT. Ms. Jayapal you're recognized for five minutes.
Ms. JAYAPAL. Thank you Mr. Chairman. Estimates from the CDC put the total number of COVID cases at over 28 million, and over half a million people have died. I think we have a real duty in Congress to learn what we can from the stories of people, particularly the workers that have suffered the worst of the pandemic, and to confront the stories they tell us about inequalities that are tearing our society apart.

I think we have to learn what we can to turn the tide against this virus, and to ensure that our country leaves future generations better prepared. Dr. Michaels, is it true that the Federal Government has no comprehensive system to track worker deaths or infections from COVID–19?
Dr. MICHAELS. Representative Jayapal. Unfortunately, that is correct. Essentially the Federal Government leaves it up to the States to even classify cases and deaths being work-related, not even work-related, but to collect information about industry and occupation.

And the States have inadequate resources, and have not been able to do that. There really has been no effort made to have an overall number. I'll give you an example. We know that you know hundreds of thousands, 400,000 healthcare workers have reported to become infected. But we have actually the status of their healthcare workers are less than 20 percent of all cases. So the number could be far, far higher.

And while the number is important, more important is understanding why people were exposed. What happens to them after they're exposed? What happens to their communities? And while there have been some studies being done, there really aren't that many, and the feds have not stepped up to the plate to do this.

Ms. JAYAPAL. Thank you. I think it is incredibly important for all those reasons for us to have that national strategy, and to do the research that you're talking about. It seems like we could start by paying attention to the COVID–19 related whistleblower complaints from workers who face retaliation when exercising their workplace health and safety rights.

In your opinion has OSHA's response to whistleblower complaints been adequate, and if not, what do you recommend that the subcommittee or Congress do about it?
Dr. Michaels. You know this is a complicated question in that I mean there's no question that OSHA's response has not been adequate. OSHA received thousands of complaints of whistleblowers during the last year of workers who have complained that they've been retaliated against for raising concerns.

OSHA has attempted to close some of those cases, and they've been overwhelmed. In addition to I think the lack of commitment of the previous administration, the whistleblower protection provisions of the OSHA law are miserably weak, and there were many hearings on this. I certainly testified in front of Congress several times.

A whistleblower who is retaliated against for calling OSHA for example, has only 30 days to apply for—to complain to OSHA, and OSHA has limited availability to get them back to work. They have to go to court if the employer doesn't agree.

So I think the thing that we should be thinking about is how to improve the protections of workers so they can raise concerns about their health and safety, or their coworkers, and really get the protection that they need to have.

Ms. JAYAPAL. Thank you. Let me stay on this topic of whistleblowers for a second. Miss Muhindura thank you so much for your service on the front lines, taking care of people every day, and in such difficult circumstances. We are truly grateful to you and nurses across the country.

In your experience, what does it mean for black, brown, and immigrant workers when whistleblower complaints don't receive an adequate response?

Ms. MUHINDURA. Congressman Jayapal thank you so much for the question. There's a large percentage of brown and black immigrant workers who are on the frontline. And so when employers do not give us the protection that we need it is upsetting, it makes us feel that we're disposable.

In addition to having the CDC and OSHA abandon us, it was extremely disappointing, and it adds to the anxiety and the traumatic experience that we are already experiencing because of COVID.

Ms. JAYAPAL. And do you have statistics on the disparities that you want to put before us and enter into the record beyond what you said in your testimony?

Ms. MUHINDURA. I do not.

Ms. JAYAPAL. Thank you. I've looked at some of the data on this, and it seems to me that this is you know these disparities are shameful. We have a real obligation to address them, and I think the lack of reliable data on workplace infections, because we don't have this national strategy and these things in place, the research that Dr. Michaels was talking about, it puts all workers at risk, and particularly those who are black, brown, immigrant, who lack the other workplace protections that are really essential.

So I look forward to working with all of my colleagues to ensure that the CDC and OSHA adopt the latest scientific means to stop the spread of COVID–19 at work, and I thank you Mr. Chairman and yield back.

Mr. SCOTT. Thank you. I see that the Chair has returned. Madam Chair the Ranking Member is the next to be recognized,
Dr. Foxx, so if you could recognize her then you’ll be given a list from there on.

Ms. ADAMS. Thank you very much Mr. Scott. I want to recognize the gentlelady from North Carolina, Dr. Foxx.

Ms. FOXX. Thank you Madam Chairman and thank you Mr. Scott. Mr. Rath if the Federal Government adds additional mandates on employers related to COVID–19 without considering the real-world feasibility of such a decree, what impact would this have on keeping workplaces safe during the pandemic?

Mr. RATH. Thank you Ms. Foxx for this question. It’s a good question. Two things emerge to mind immediately. The first is that if an emergency temporary standard was the vehicle by which OSHA decided to regulate the subject, the science which has continued to evolve will evolve over the top of that emergency standard, and it will quickly become outdated, and the agency will have little means by which to update it.

Whereas, by contrast guidance documents can be updated quickly and iteratively any number of times to meet changes in our scientific understanding. The second thing I’d say is that the stakeholders have expertise.

They have developed an acquired experience and learning about what works and what doesn’t, and their input would yield a substantially better set of policies by the agency and at the workplace than an emergency temporary standard which excludes and disenfranchises the expertise of employers, scientists, the healthcare community and employee representative groups.

Ms. FOXX. Thank you Mr. Rath. Another question. Ranking Member Keller and I sent a letter to acting Secretary of Labor Al Stewart on February 25th inquiring about the steps the agency’s has taken to determine whether an OSHA emergency temporary standard is necessary to protect workers from COVID–19, and encouraging the agency to solicit feedback from businesses and workers before they made that determination.

I’m a strong proponent of evidence-based policymaking. In your view would feedback from employers and workers who have been on the front lines of keeping workplaces safe over the last year, be helpful to the Labor Department in making this determination?

Mr. RATH. Thank you for that question Representative Foxx. That is an excellent question, and the answer is yes, clearly employees and employers have acquired a substantial amount of valuable experience and knowledge, not only as to what works in terms of interventions, but what hasn’t worked, and what hasn’t been effective.

And as well, the scientific community and the healthcare community should be provided the opportunity to comment and that is the value of traditional rulemaking. It is a part of administrative law that we’ve recognized for between 80 and 90 years, and shouldn’t be lightly dispensed with during the pandemic.

Ms. FOXX. A followup. What impact would new and complex regulatory requirements from OSHA which would override the guidance issued by the CDC and State public health agencies have on the universal adoption of basic health measures in preventing the spread of COVID–19 in the workplace?
Mr. Rath. Thank you for that question. I'll limit myself to my experience, which is strictly as an attorney representing employers in the field of occupational safety and health law. And I would suggest that employers who have carefully examined the experience that they're witnessing at the workplace, have been better able to identify the kinds of interventions that work and don't work.

And that their consultation with epidemiologists and healthcare, members of healthcare industry, has fashioned better policies and practices of workplace at the workplaces that I've been able to collaborate with employers.

Ms. Foxx. Well it's my experience that employers want very much to protect their employees. They care for their employees. In many cases they're like families to them. And unfortunately, our friends on the other side of the aisle don't see things that way.

One more followup. Over the last year employers have made significant efforts and investments to adopt health and safety precautions to protect their workers and prevent the spread of COVID in the workplace.

You eluded to this, but what have been some of the most innovative measures adopted by employers, and how effective have they been in ensuring safe workplaces?

Mr. Rath. Thank you for that question Representative Foxx. We've worked with employers who as I said before have engaged their own epidemiologists on engagement so that they can stay up to date with current science.

We've worked with employers who have rolled in temporary adjunct space so that they could have additional space for breaks. One employer has manufactured separate cooling stations so that manufacturing workers on the plant floor could take mask less breaks.

I'll add to what we've discussed before. When we talked to an employer who has developed their own testing capacity, so that they can engage in more rapid testing on a regular basis of their work staff to keep the work force going, healthy, safe, and the business running.

Ms. Foxx. Thank you Mr. Rath and again, I know employers want to keep their employees safe and healthy. And that's the attitude we should have. How can we help them do better with what they know to do, but they're smart people and they'll do it. Thank you Madam Chairman I yield back.

Ms. Adams. Thank you very much. I want to recognize myself now for five minutes. Mr. Rath let me just cut right to the heart of the issue. Do you think that COVID–19 presents a grave danger to workers? Can you give me a yes or no?

Mr. Rath. Thank you for that question Miss Chair. Yes. There's no question that COVID–19 presents a health and safety risk to the work force. It is also a community risk.

Ms. Adams. Thank you.

Mr. Rath. And employers have a substantial role in it, but not of course the only role in a community spread environment.

Ms. Adams. All right let me move on. I've got five questions. Thank you. Dr. Michaels, do you think COVID–19 presents a grave danger to workers? A yes or no?

Dr. Michaels. Yes.
Ms. ADAMS. OK. Miss Muhindura what about you? Do you think COVID–19 presents a grave danger to workers? Yes or no?

Ms. MUHINDURA. Totally yes.

Ms. ADAMS. Thank you. Dr. Marr can you describe some of the overwhelming evidence that inhalation of virus containing aerosols is the main route of transmission for COVID–19?

Dr. MARR. Dr. Adams thank you for the question. Yes. The first piece of evidence is super spreading events. We’ve heard of these. The choir practice where 53 out of 61 attendees became sick and two of them died. Gym classes where 55 out of 81 people became sick, even though they were six feet apart. Inhalation of aerosols in shared air is the best explanation for these types of events which can also happen in workplaces, as clearly not everyone has spent 15 minutes close to the infected person.

There’s also we know transmission by people who are infected, but who do not yet have symptoms, asymptomatic or pre-symptomatic. They’re not coughing. They can transmit anyway because the virus is released in aerosols that come out when we just breathe and talk.

We see substantial indoor transmission, almost no outdoor transmission. That means that’s because these aerosols are rapidly diluted in outdoor area. In a study that traced over 7,000 cases of disease there was only one instance of transmission that occurred outdoors, and then there have been many scientific studies where we look at, collect virus samples, or air samples in hospitals. We know the various survive for many hours in the air. I could go on, but I don’t want to take up all of your time.

Ms. ADAMS. Thank you very much. Thank you. Miss Muhindura you testified that you and every nurse on your unit became infected with COVID–19. Can you describe your experience?

Ms. Muhindura. Yes. When I tested positive for COVID, it was a terrifying experience. I was very anxious. I was lucky to have relatively mild symptoms, but my anxiety came from the fact that I had been caring for extremely sick patients that had been infected with COVID.

So that was always in the back of my mind what would happen if I got that sick. I was also angry because I knew I got sick because I wasn’t protected at work. And to make matters worse it was the week of Thanksgiving and I missed my daughter’s birthday because of that because I was under quarantine, so yes.

Ms. ADAMS. So OSHA refused to cite your hospital despite obviously preventable hazards that led to the death of a nurse, and their excuse was that there was no OSHA standard. Instead they sent your hospital voluntary recommendations in a hazard alert letter that told your employer that you may voluntarily provide this area office with progress reports on your efforts to address COVID–19 hazards in your workplace.

So what effect did this hazard alert letter have on improving conditions in your workplace?

Ms. Muhindura. Thank you so much for the question. I believe the hazard letter was sent sometime in February of this year, and fortunately, I’m part of the National Nurses United, and I feel like most of the measures that have been implemented, were imple-
mented because of the advocacy that we had been doing since last March.

And I don’t particularly see a lot of changes that have come out of the hazard letter.

Ms. ADAMS. So if your management, your hospital would have taken safety more seriously if there had been an enforceable OSHA standard, do you think that they would have taken it more seriously, you think?

Ms. MUHINDURA. Yes. I definitely think after reading the OSHA response it was clear that OSHA could not site my employer because OSHA doesn’t have a standard. So as long as OSHA doesn’t have a standard, our employers were not being held accountable for putting the employees at risk. So I definitely think an OSHA standard would enforce that.

Ms. ADAMS. Thank you very much. Thank you for your testimony. I’m going to recognize Miss Stefanik from New York. You’re recognized ma’am. Oh she’s not here. Mrs. Miller-Meeks of Iowa you’re recognized.

Ms. MILLER-MEEKS. I’m trying to unmute. There we go.

Ms. ADAMS. OK.

Ms. MILLER-MEEKS. I was trying to unmute myself. Thank you so much Chair Adams and Ranking Member Foxx. So you know I’m a physician, former nurse, so Miss Muhindura, thank you very much for your activities as a nurse. Also former Director of the Iowa Department of Public Health.

So it is new information to me that there is vast aerosolization of COVID–19, and I think that’s why it’s not on the CDC site, so with all due respect to the science, and in addition to which I don’t think on the CDC site there’s also recommendations for improving your immune system such as Vitamin C, Vitamin D and Zinc, which I have actually started taking myself at the beginning of the pandemic.

We certainly know, and I think was asked about COVID–19 and representing a risk to workers, and workers are not in isolation. Workers live within a community, so the only place where COVID–19 is contracted is certainly not at the workplace which leads to my question.

Dr. Michaels, a yes or no question. Have you visited a meat processing facility during the pandemic?

Dr. MICHAELS. Not during the pandemic. Previously I have. I haven’t left my house much during the pandemic.

Ms. MILLER-MEEKS. Thank you for that. I have not been able to visit the meat processing facilities in Iowa in my congressional district or in my Senate district, but working with our public health departments, our county public health departments, and our meat processing facilities very early in the pandemic, we went through changing shift work, adding additional shifts, separating workers, putting up barriers, temperature checking on infants, separate dining facilities, altering the rotation for when people could dine, separating utensils not to have any reusable utensils, or grabbing utensils out of a common container.

And also even limiting, not putting salt and pepper shakers there so people could not contract COVID–19 through that. So it seems
to me that because this is a public health issue in our communities, not just a workplace safety issue, it’s hard to determine.

And I have worked in fact with my local health departments on testing and contact tracing, that it’s difficult to determine where an individual contracted COVID–19. So Mr. Rath what is OSHA’s current policy on recording of COVID–19 cases on employer, and on employer injury and illness logs, and what are the challenges in trying to determine where an individual contracted COVID–19?

Mr. Rath. Thank you for that question. Employers are required by OSHA to record work related injuries and illnesses, and this includes illnesses through COVID–19. So there is a requirement to record COVID–19 cases in the injury and illness record keeping form.

There is a problem for employers. As you note this is a community spread phenomenon and so employers are challenged. And they struggle, even with the best of intentions it’s difficult to know which cases are contracted in the workplace and which ones come from community spread.

This is a disease that is inherently idiopathic in its etiology. And the presumption of work relatedness is certainly a starting point, but knowing that employees in 75 percent of their work week are outside of the workplace makes it difficult to know which cases are work related, and which cases are non-work related.

Therefore the data, given all the confounding factors, is of necessarily limited value, but it is important to make those record entries nevertheless, to see if the data will yield something of any benefit.

Ms. Miller-Meeks. Thank you. And again Mr. Rath, now that vaccines are available, and when we’re looking at where an individual contracted COVID–19 and perhaps they’re looking to their workplace for workman’s compensation. If an individual refuses a vaccine should that play into if COVID–19 was contracted, and you can’t prove where it was contracted from, how do you think that that interplay will occur if an employee does refuse or decline vaccination, especially if offered at the workplace.

Mr. Rath. Thank you for that question. The question you’re asking essentially goes to the intersection between occupational and safety health law, as well as several other areas of workplace law. For example, an employee may have declined a vaccination out of a generally held, or sincerely held religious belief, and there may be a medical opinion for that particular employee that’s an underlying condition which would qualify for coverage under the Americans With Disabilities Act, may motivate the employee not to take a vaccination.

And so employers have to find opportunities to understand whether or not they need to accommodate those particular circumstances before rendering a workplace decision on merely the mere fact of a declination for a vaccination.

Ms. Miller-Meeks. Thank you Chair Adams. I yield back my time.

Ms. Adams. Thank you very much. The gentleman from California, Mr. Takano you are recognized.

Mr. Takano. I’m trying to unmute myself Madam Chair. Thank you. Thank you Madam Chair. I’d like to hone in on Mr. Michaels,
Dr. Michaels question that Chairman Scott began to ask you. Can you tell me what the Volks rule is, what the Volks rule was?

Dr. Michaels. Yes. The Volks rule was a regulation that we put out when I was running OSHA that essentially said that employers have to maintain a complete and accurate log for five years, actually five and a half years after the injury occurred. It was in response to a court decision that said that the previous rule that OSHA had was not well-written.

They need to be essentially fixed. OSHA long has had the policy that employers must keep track of injuries for five years. That means its on their premises, so they can use it, workers can see it, and OSHA inspectors can see it. The Volks rule was overturned by Congress in a congressional review act, and so essentially OSHA has no ability to issue a fine against the employer if they find an injury was not on the log if 6 months after the injury occurred.

Mr. Takano. Thank you Mr. Volk—thank you Dr. Michaels. This rule also would have required them to record illnesses as well, is that right?

Dr. Michaels. Absolutely.

Mr. Takano. OK. And I want to be clear this was overturned by a congressional review act in 2017 by the republican controlled Congress and signed by President Trump.

Dr. Michaels. Yes that’s correct.

Mr. Takano. So tell me why this rule was so important.

Dr. Michaels. Well you know we’ve seen that employers realize if they’re never going to get caught by OSHA, there’s no reason to record the injuries and illnesses. Now some employers always want to do the right thing and have very accurate records because they know that helps them prevent the injuries and illnesses in the future.

But not all employers are like that, and many take the low road and try to avoid that. In addition we have a regulation that says that employers have to provide OSHA with summary data, and that is going to be made public. And so they don’t want people to know if things are really bad at their work place, they don’t want people to know that.

And so this is the opportunity to essentially to lie about that. So it’s really a problem.

Mr. Takano. Mr. Rath do you agree that it’s important for employers to keep records? I think you in your response to Dr. Miller-Meeks you said you know it’s not necessarily determinative that an illness occurred at the workplace, but it’s important to have that data. You would agree with that?

Mr. Rath. Yes and that’s a good question. Thank you. There are four constituents that would want that data, employers who want to define a story, a pattern from the data, employees who have a right to know. Government should want to see the data, should have access to the data if it wants to see it, and researchers should also have access to that data.

This is important, but the question at stake is whether or not an omission or an error from more than 180 days ago constitutes a continuing violation. It does not. It is well accepted, and that’s what Congress said 40 years ago when they had enacted the OSH
Act that it was a discreet moment of violation and not a continual violation.

Mr. TAKANO. Well it’s still important necessarily, you would concede that it’s important to keep these records. Employees have a right to know whether illnesses are occurring at workplace. Health officials need to know whether it’s a pattern for a number of reasons. Dr. Michaels as you know I have legislation which I’ve introduced, H.R. 1180, the Accurate Workplace Injury and Illness Record Restoration Act, which would restore OSHA’s ability to cite employers who systematically fail to record workplace injuries and illnesses.

Do you think this is an important tool for OSHA to have in order to be able to provide safety for workers in the workplace?

Dr. MICHAELS. There is no question. It is a vital tool, and that’s why I’m a strong supporter of H.R. 1180. You know OSHA citations for recordkeeping violations have dropped by more than 50 percent in recent years.

And that means data isn’t accurate. No one really knows what’s going on in workplaces, and we can’t prevent injuries and illnesses if we don’t know what’s going on.

Mr. TAKANO. Well thank you. Very quickly Dr. Marr. Why is it that you think, do you have an opinion about why the CDC hasn’t taken a firm stand on aerosol or particle transmission of COVID–19 standards?

Dr. MARR. Thank you that’s a great question. On March 5, 2020 over a year ago I tweeted out let’s talk about airborne transmission of SARS–CoV–2 and other viruses and explained how it works. There is a reluctance though among the medical community to acknowledge this because I think you can’t see aerosols, so they’re harder to understand.

There’s been a long-standing bias against transmission of viruses through the air. There’s also a concern in hospitals because the word airborne has a special meaning. And then last early in the pandemic there were concerns about limited supplies of N95’s and so that drove some of the messaging.

Mr. TAKANO. I wish I could ask some more questions, but I yield back Madam Chair. Thank you.

Ms. ADAMS. Thank you Mr. Takano. I want to recognize the gentleman from Utah, from Virginia I’m sorry, Mr. Good from Virginia. You’re recognized sir.

Mr. GOOD. Thank you Madam Chair. It’s great to be with all of you this morning and I appreciate this opportunity to talk with our witnesses. And my questions are going to be directed to Mr. Rath. Mr. Rath with the House Oversight Committee reporting that over 13,000 regulatory guidance documents have been issued just since 2008, I would hope that we could all agree that a high threshold should be reached before we subject businesses to more regulations that are difficult and costly to comply with, and that are disruptive to their essential operations.

Furthermore, since the communication regarding the effectiveness of mask mandates has been inconsistent at best, it even seems to contradict decades of pre-COVID lockdown studies, we should be cautious to say the least about continuing, let alone increasing re-
lated regulations, restrictions and mandates on citizens and businesses.

We know that masks can help with large droplets, but there's conflicting reports regarding whether they truly help with small aerosol droplets such as those which transmit the viruses. And it seems that we're unable to prevent those small aerosol droplets from circulating in a normal course of life which is needed for all of us to survive and prosper.

Most of us were already practicing social distancing in the workplace, and frequently washing our hands pre-COVID, and now we're even more aware of course of that importance with the COVID virus, and those with other health factors, or working in higher risk professions need to take greater precautions.

Furthermore, we have seen reports that some 70 percent of COVID infections actually take place among family members, or those living together at home, while only 1 percent of infections have come from people visiting a public place such as a bar or restaurant.

Now that said Mr. Rath, are you aware of any documented cases of anyone contracting or transmitting the virus while visiting a business without a mask?

Mr. Rath. Well that's a good question Congressman, I have not had access in my capacity as an occupational safety and health law attorney to understand that level of data. And I think that that data may be properly the sphere of public health agencies, or of the employer themselves.

But I will say that when employers that I've worked with look at the questions of which interventions to interpose, they look for opportunities to achieve the greatest gains in safety and health the most quickly in order to preserve the greatest number of employees health and lives, and that has been something that every employer I've worked with has been sincerely committed to, and that's the question that they debate every day when it comes to universal adoption of masks, universal adoption of hand-washing and distancing, where distancing is not possible the installation of barriers, et cetera.

Mr. Good. Well thank you, and again your answer was that you were not aware of any case—any documented case, of someone contracting or transmitting the virus while visiting a business without a mask. How about are you aware of any documented case of anyone contracting or transmitting the virus to or from a coworker because of the failure of one or both to wear a mask?

Mr. Rath. Well Representative, that's a very good question and again as an occupational safety and health attorney I don't have the access to that kind of data. What we do work with employers on is how to make sure that that kind of transmission happens as infrequently as possible or not at all.

Mr. Good. Are you aware of any documented case of a customer contracting or transmitting the virus to or from an employee because of a failure of one or both to wear a mask?

Mr. Rath. That's a good question. That question the understanding of how a customer and worker might transmit the disease is inherently unknowable because of the high degree of—high num-
ber of confounding factors such as the conduct behavior and exposures of both parties outside of their brief interchange.

Mr. GOOD. How about if we take that a little bit broader rather than going individually. Can you point to any conclusive data, or scientific evidence showing higher COVID virus contraction or transmission rates based on whether customers or employees were required to wear masks in general. Can we point to any data, any evidence of that?

Mr. RATH. I would not have in my role any access to that kind of data. But we do know that the employers we’ve worked with without any exception, have embraced and stringently adopted a universal mask requirement in order to preserve the health of their work force.

Mr. GOOD. Well we understand that people might embrace that, or people might choose to apply that, but take it even broader. Can you point to any conclusive comparison data regarding the virus transmission rates for companies or organizations, counties within a State, States themselves, or even countries.

So conclusive comparison data regarding the virus transmission rates for again, for a company or organization, for a county within a State, for a State itself, or a country, based on the degree of mask restrictions, mandates or compliance?

Mr. RATH. I personally am not aware of any such data.

Mr. GOOD. So each of these questions that I’ve asked you have been answered in the negative that we don’t have any data that we can point to, any documentation that we can point to, to justify mandates, regulations, restrictions being forced upon companies and organizations. And so I thank you for your answer, and I yield the balance of my time.

Ms. ADAMS. Thank you very much. I want to recognize Mr. Jones from New York.

Mr. JONES. Well thank you Madam Chair, and thank you to the witnesses for their testimony today. I am struck by some of the issues you have highlighted. As you know New York was the epicenter of the COVID–19 pandemic last spring in my district, which covers parts of Westchester and all of Rockland County was hit especially hard during that extremely difficult time.

Even today Rockland County has the highest rate of COVID–19 infection of any county in the entire State of New York. Mr. Rath, I’m going to start with you. You testified about the great things some employers are doing to protect their workers, but we’ve heard testimony today that many other employers have been ignoring measures to protect their workers.

Isn’t it obvious that national standards would ensure more employers protect their workers?

Mr. RATH. That’s a very good question Representative Jones. Thank you for the question. The problem with a universal national standard is that as we’ve already seen in the past year, science quickly evolves, and rules over standard making the intransigent standard unable to adopt or adapt to our newfound science, or healthcare understanding of the disease. And for that reason guidance is a more effective policy instrument.
Mr. Jones. Mr. Rath, but couldn’t there be a rule or a standard that allows for new scientific information to be uncovered and to adapt accordingly?

Mr. Rath. That’s a great question. Unfortunately, we see OSHA has issued public Statements numerous times complaining that the standards that it passed in the 1970’s and the 1980’s have become outdated, and that the rulemaking process to revise that is not only time-consuming and resource-consuming, but it won’t be implemented quickly enough to make the difference that employers can make, and that agencies like CDC and OSHA can make through guidance.

Mr. Jones. I’m reclaiming my time. Thank you so much. You said in your testimony that an emergency temporary standard is not a suitable vehicle for government intervention in the pandemic, and that employers will prevail against the spread of Coronavirus. But respectively sir, I think we see how the thoughts and prayers approach plays out in for example the gun violence context, where the government literally does nothing to address that epidemic, thankfully, by the way today House democrats are doing something about gun violence.

But also your approach to addressing COVID–19 in the workplace is in line with the previous administration’s position. The Trump administration downplayed the danger COVID–19 posed to workers and the general public. The administration even failed to protect its own staff.

We know that from September to January as many as 48 White House staff and associates tested positive for Coronavirus, including top officials in the President’s inner circle, all of this while the President told Americans to drink breach.

And so today marks one year since the World Health Organization declared a global pandemic. Nearly 550,000 people have died in this country since then, many of them essential workers on the frontlines and their family members.

Unfortunately, we don’t know how many of those who died contracted COVID–19 in the workplace. I’ll grant you that. But as we’ve heard in this hearing there have been outbreaks in workplaces across many industries, and workplaces like at JBS and Smithfield Foods meat packing facilities.

And we’ve seen companies take retaliatory actions against workers who raise safety concerns around COVID–19. In my home State of New York, we saw an incident in which an employee at an Amazon fulfillment center was fired for demanding better protections.

That’s the previous administration’s record on workplace safety in the pandemic. And most Americans understand we need that to change. We need OSHA to issue an enforceable standard to ensure people can be safe at work because the problem sir, with voluntary guidelines is that there are too few volunteers. And so with my time remaining I’ll ask Miss Muhindura you know my district has around 20,000 nurses, many of whom have had to deal with the trauma of the COVID–19 pandemic as you have described it.

Can you briefly tell me about the nurses you work with. Who are these people?

Ms. Muhindura. Yes Congressman Jones. Thank you so much for the question. I work in level one trauma which is obviously the
highest traumas around the Kansas City area. And I have the privilege of working with some of the most amazing nurses that I have ever met.

Some of the strongest people I have ever met, physically and emotionally, but we have all been affected by this, by taking care of these patients because it’s taken a tremendous toll on us.

Mr. Jones. Thank you. You all deserve recognition for your incredible work on the frontlines, and Madam Chair I yield back.

Ms. Adams.

[Silence.]

Mr. Cawthorn. Madam Chair I believe I’m next up in the line. Do you mind if I go ahead and start? Dr. Adams I believe you’re muted.

Ms. Adams. Am I unmuted now?

Mr. Cawthorn. Yes ma’am.

Ms. Adams. OK. I apologize. I’m having some technical difficulties. Mr. Cawthorn go ahead, you’re recognized sir.

Mr. Cawthorn. Thank you very much ma’am. So to all the witnesses I genuinely appreciate all of you coming on. Mr. Rath I really thank you for everything that you’ve done, and also I’ve been—my life has been saved more times by nurses than it has by doctors, so I genuinely appreciate all the nurses that are on and representing.

Mr. Rath I’ve got a question for you. In your testimony you state that if OSHA had adopted strict standards on any of these issues in an emergency temporary standard a year ago, that these requirements would have quickly become antiquated by science, dismissed by the public, and that it would discredit the agency as you said.

So that’s the end of the quote, but you know we’ve heard a lot about science regarding preventing COVID-19 transmission. Chairwoman Adams in an eloquent opening statement she said we can’t properly respond to this pandemic unless we truly understand all of the data.

And so I’m wondering in your view what is the appropriate role of science in informing regulatory policy? More specifically, how do statutes such as the Administrative Procedural Act, you know, which governs the procedure—the process by which Federal agencies develop and issue regulations allow for related input when regulations are proposed. As we know science changes very often.

Mr. Rath. Thank you for that question Representative Cawthorn. The process of developing a rule at OSHA should start with sound data and the best available evidence. But that is merely the starting point.

All OSHA regulations have to start with the best available evidence and be alloyed with traditional rulemaking principles such as technical feasibility, economic feasibility, the impact on small businesses, consideration of flexible options in rulemaking, and then finally the experience and acquired wisdom of the stakeholder community, employee representatives, employers.

The scientific community and the healthcare community all can play a part in hammering out a better and more workable, and more effective standard at the end of the process that starts with science.
Mr. CAWTHORN. Mr. Rath thank you for that answer. But just to get a little more detail, is there a way that OSHA can be utilizing the information that’s on the ground? You know I always, the reason why I love State government so much more than the Federal Government is you know it’s closer to where the actual information is.

And I believe the information, the decisions are coming from where the information lies. I think that it works better for every single industry that OSHA touches. Is that something that’s possible to have OSHA receiving that input, you know, and the new scientific guidelines, and then to be flexible with it?

Mr. RATH. Yes. There’s no question that OSHA has used guidance’s over the past year and issued a number of helpful State-ments for the employer community that have adopted the evolving science. They refer specifically to the Centers for Disease Control and Prevention Guidance, which has been even more frequently updated.

And by that method employers have looked to the CDC’s guidance to figure out what the best practices in their unique work-places should be.

Mr. CAWTHORN. Fantastic. Well Mr. Rath thank you very much and all the witnesses. I do appreciate it. With that Madam Chair I yield back.

Ms. ADAMS. Thank you very much. I want to recognize Miss Stevens from Michigan. You’re recognized five minutes ma’am.

Ms. STEVENS. Thank you Madam Chair and thank you to our witnesses for this critical hearing and part of why I’m so delighted to be on this subcommittee under the great leadership of Chair Adams.

You might have seen last year, actually almost a year ago, it might have been 53 weeks ago, 54 weeks ago, I did a letter to the agencies asking for an interagency task force to report the real time, scientific guidelines as we were getting them right, with a novel virus to be communicated through the you know, the Secretary of HHS, the communications to our employers and employ-ees right.

A year ago this week. I’m with my chief of staff. This is the last time we were all fully in the office, and I said I have got to call the grocery stores, because all of a sudden they’re an essential workplace, you know, they’re like our general stores. Do they have what they need?

So just commending the work around the enforceable standards, an interagency approach. Part of what today’s hearing is doing is not only coming up with strategies to protect essential workers from COVID–19, but it’s also helping us think through what we do the next time a novel Coronavirus hits.

So Dr. Marr, you know, we’ve seen oh brother, you know some States recently lift their mask requirements all right. And last week, you know, the Retail Industry Leaders Association, you know they released a press Statement opposing the lifting of mask man-dates stating that relaxing common sense, non-intrusive, safety protocols like wearing masks is a mistake.

We see some friction with the private sector in some of these States that are lifting the mask mandates a little bit prematurely.
But Dr. Marr just for the record, can you share who is going to be most impacted by the removal of these requirements at this stage that we’re at in the pandemic if you don’t mind please?

Dr. Marr. Absolutely. There is no question that mask mandates work or universal masking works. This has been shown in many scientific studies. It’s hard to point to individual cases, but we can analyze population level data and showing that there is a decrease in the rate of number of cases with mask, greater masking.

The real victims of lifting of these mandates are the people who are going to contract COVID–19, some of whom will die, and because of the lifting of this, we’re going to have more cases and more deaths than we would otherwise, besides bringing tragedy to the families of those who died, this also places an additional burden on our already exhausted healthcare workers.

Ms. Stevens. Yes. And so would you say this has an effect on the safety of workers who are in frequent contact with the public for 8 or more hours a day? I just recently had a grocery store worker share with me you know they’re in contact with somewhere between 500 and 1,000 customers on a daily basis.

Do you have anymore information on the safety of workers who are in contact with the public for eight or more hours a day?

Dr. Marr. Sure. These individual interactions are brief in time, so they may not fall under the 15 minute rule for contact tracing, but they add up. And so over that 8 to 12 hour workday, the grocery store worker can be in contact. And we know with aerosols you don’t need to be close to that person.

So masks are effective as source control reducing the amount of virus that people release into the air. They may not know that they’re sick. If people are not wearing masks that could happen, and workers could be exposed. I’m worried about the workers who will now be exposed to much greater amounts of virus in the air than before if they lift the mask—if the mask mandate is lifted.

Ms. Stevens. Right, right, right, because it’s with our droplets. OK. So noted for the record. And you know Dr. Michael’s we were hearing from Mr. Rath his testimony casting doubt on whether the OSHA ETS would reduce the number of work-related illnesses and deaths. I know we’ve kind of been covering this in this testimony here in this hearing, and all of you are fabulous by the way, Pascaline you’re just shining today. We’re glad to have you and your fabulous background here as well.

But Dr. Michaels, do you think that an ETS would have a benefit of reducing infections during the 180 day efficacy period? Can we just say it again for the record.

Dr. Michaels. Of course. You know this idea of going through the long OSHA administrative procedure makes no sense in an emergency. We need to do this now. We need to do it you know, six months ago. But it will clearly make a difference because while not all employers are as exemplary as Mr. Rath’s clients, it will impact millions of employers and reduce exposure to many millions of workers and will save lives.

Ms. Stevens. Thank you. And I yield back Madam Chair.

Ms. Adams. Thank you very much. Is Miss Steel of California, a young lady from California you’re recognized.
Ms. Steel. Thank you Chairwoman Adams and all the witnesses today. Independently owned small businesses, including retail and restaurants are the backbone of our local communities. There are more than 22,000 small employer businesses in Orange County in California.

These businesses employ more than 183,000 people and generate almost 10 billion dollars in payroll for our community. These business owners and employees that are working hard to prevent the spread of COVID–19 and trying their best to keep their employees safe and employed.

But prolonged lockdowns have led to almost 50 percent of small businesses throughout the State of California at risk of closing, or never reopening. We need to work in collaboration with local businesses and hear their stories, not rush to implement one-size-fits-all OSHA regulations that could halt the safe re-openings that are already in process.

We need to empower our communities and help businesses thrive while also keeping customers and employees safe. That is why I have worked on the Fresh Air for Business Act to empower businesses to modernize their ventilation systems in order to reduce the transmission of airborne diseases including COVID–19.

Having set that Mr. Rath, thank you very much for coming out today. You mentioned how businesses in southern California were impacted when Cal OSHA hastily approved an emergency plan where stakeholders were preventing from weighing in and making the standard more workable or effective. We have both seen how local California business owners have been affected by Cal OSHA compliance.

So should the Federal Government rush misguided actions that could have long-lasting, unintended consequences to employers and employees, just rush burdensome standards?

Mr. Rath. Thank you for that question Representative Steel. Had California taken into account the feedback from the stakeholder community, employees and employers, they would have avoided unnecessary mistakes. For example, the California Emergency Temporary Standard imposes upon employers the duties that are traditionally associated with public health agencies like contract tracing, continuous testing, and paid leave, housing, transportation.

These kinds of mistakes could have been avoided. And since then the California OSHA has issued three revisions to its frequently asked questions, several press releases, fact sheets, to try and clarify ambiguities or Statements that they have made in their original emergency temporary standard that they quickly came to regret as having been poorly thought out.

Ms. Steel. So in your opinion, what does government have to do when we have you know, some emergency situations such as COVID–19.

Mr. Rath. Well I think it’s important to solicit the input from those with real experience, employee groups, employees, employee representative groups like the ones that Ms. Muhindura is a member of. The scientific community like Dr. Marr, and of course the agencies have a particular role to play as well.
But collectively, that input will fashion a better set of policies than an agency unilaterally driving policy by self.

Ms. STEEL. So you think that it’s going to be really helpful that you know, you prepare for this kind of pandemic, hopefully not in the future, but prepare those professional people just grouped together, and just to all get ready for the next pandemic or COVID–19, something like that coming in.

Mr. Rath. I think that there has been a tremendous amount of experience and knowledge and wisdom acquired in the workplace community that can contribute to being better prepared for the next pandemic should one ever develop.

Ms. STEEL. I really appreciate it. Madam Chair I yield back.

Ms. Adams. Thank you very much. I think if all committee Members have asked their questions, I believe they have, I want to now recognize Mr. Courtney of Connecticut.

Mr. Courtney. Thank you Chairwoman Adams, and thank you for again bringing H.R. 1195 onto this agenda again as Dr. Michaels indicated, this is the bill that we passed in the House last year by a rather healthy bipartisan majority, 251 votes in favor, again that dealt with what was then described as an epidemic by the CEO of the Mayo Clinic, namely Workplace Violence for Healthcare Workers and Social Workers.

Just a month ago we had another terrible tragic incident that took place in Buffalo, Minnesota where a disgruntled patient showed up at Alliance Health Clinic, shot dead one of the healthcare employees and three others were critically injured. Again, with no sort of early warning systems or measures in place, which OSHA had developed as voluntary guidelines for many, many years.

But again, because we don’t have a national standard, are just not being implemented. Ms. Muhindura again, thank you for your testimony today. Again, your organization has been a staunch advocate for workplace violence protections. And I was wondering if you could take a moment to talk about this other epidemic that again people who are going to work every day in the caring professions face.

Ms. Muhindura. Yes, thank you so much Congressman Courtney for the question. As nurses we’ve faced workplace violence for many years. Luckily, I’m part of a union that has fought very hard for the nurses and we have gained a lot of protection simply because of the advocacy that we can get through our union.

We have such things as panic buttons in our hospitals we can push if we have a violent intruder, or just a patient that becomes violent suddenly, and security is able to respond quickly. But unfortunately, not everyone has these protections throughout the country.

I used to work for a hospital that was not part of a union, and they had no such protections. And to add to that it feels like violence has gotten worse in the past year. You see an increase in anxiety and agitation in patients with COVID related to the strict isolation. So I feel like we could definitely use some more protection.

Mr. Courtney. Thank you for that because again there is some narrative well you know, because patient volume may have gone
down because of elective procedures that you know, the workplace violence issue has diminished, but in fact we’ve seen surveys that unfortunately, it continues unabated just like the incident that I just mentioned.

Dr. Michaels you know last year or 2 years ago when we debated this bill, you know we were assured, and I think in good faith by opponents of the bill that the Trump administration was moving forward with a rulemaking process. And unfortunately, every single initial hearing was postponed four consecutive times.

We are absolutely at ground zero in terms of any movements within the agency. Again Mr. Rath to his credited, note that OSHA moves slowly. And unfortunately, we’re talking about life or death issues in terms of protecting people in healthcare institutions and social work.

Again I wonder if you could just sort of talk about that, about whether you know given the gravity of this issue of workplace violence, as well as the pandemic, you know, whether or not you know we can just rely on the normal rulemaking process to do anything in a remotely timely fashion.

Dr. Michaels. Well these are exactly the right points Representative Courtney. OSHA takes 10 years or more to issue a standard. One of the last things I did when I was running OSHA was accept a petition from the National Nurses United, and from other unions telling OSHA, asking OSHA to move forward on this because the problem was so severe.

The stories we heard were heartbreaking. We cried at meetings when you heard what happened to healthcare workers and social service workers. But without Congress setting a deadline, it will take at least ten years for OSHA to get this thing out. That’s the normal route.

I mean we’ve already lost years and years because really nothing happened during the Trump administration. They said that it was going to move forward but it didn’t. And for your bill which gives OSHA 42 months to get it done, would be a huge step forward and really make a difference. It would make the lives better of nurses and others who provide this important work, but also it would make healthcare and social services better because people can’t work if they’re under threat of assault.

Everybody I talk to that works in an emergency room says yes, it impacts you when you’re always looking around to make sure no one is going to hit you. I mean this is just simple common sense, and OSHA standard would not be one-size-fits-all. It would say figure out how to address the problem in your community, in your workplace, and that’s what we really badly need.

Mr. COURTNEY. Thank you. And thank you to all the witnesses. I yield back.

Ms. ADAMS. Thank you Mr. Courtney. 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 end of business, the close of business on March 25, 2021.

Preferrable in Microsoft Word format. The material 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 hearing record. Documents are limited to 50 pages each, and documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Committee Clerk within the required timeframe, but please recognize that in the future that link may no longer work.

Pursuant to House rules and regulations, items for the record should be submitted to the Clerk 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. Now I want to again thank the witnesses for their participation today. Members of the subcommittee may have some additional questions for you, and we ask the witnesses to please respond to those questions in writing.

The hearing record will be held open for 14 days in order to receive those responses. I 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 want to recognize now the distinguished Ranking Member for his closing Statement.

Mr. KELLER. Thank you Madam Chair. I ask unanimous consent to place into the record a Statement from the American Hospital Association and letters from the Construction Industry Safety Coalition and the National Retail Federation raising concerns with the potential OSHA emergency temporary standard on COVID–19.

Ms. ADAMS. For.

Mr. KELLER. Thank you. The American economy is diverse, and it would be naïve for us to believe that broad mandates handed down from Washington, DC could ever accurately represent every workplace throughout the country. If we want to have a conversation about that, about what is best for our businesses and workers, then it only makes sense for them to be brought into the fold as part of the discussion.

I suspect the last thing Main Street America needs right now is more bureaucratic red tape and barriers dictating how to properly keep their workplaces and teams safe. I appreciate the majority calling this hearing and look forward to engaging with my colleagues on the other side of the aisle about how we can work together on smart policies that properly consider the realities of America's workplaces. Thank you and I yield back.

Ms. ADAMS. Thank you very much.

I now recognize myself for the purpose of making my closing Statement. What we heard today is that our Nation's workers need and deserve updated CDC guidance and a strong OSHA emergency temporary standard that reflect the best science. This committee has flagged the importance of considering airborne transmission of the virus in a March 1, 2021 letter to the administration. I ask unanimous consent to enter the letter into the record. So ordered. We have only recently emerged from a year of national crisis where OSHA, the only Federal agency with the authority to enforce safe working conditions left workers on their own. This was not just disappointing, this was a tragedy for tens of thousands of workers in
this country, and their families who were infected by COVID–19, and the thousands who died preventable deaths because they lacked adequate protections on the job.

Swift action to protect workers is exactly how the architects of the Occupational Safety and Health Act envision OSHA’s response during a work-related crisis. The Act tells OSHA that it shall issue an emergency temporary standard if it determines workers are exposed to a grave danger, or from new hazards and that a standard is necessary to protect workers from that hazard.

Now I think it’s clear that COVID–19 meets these two legal conditions. We welcome the Biden administration’s clearly Stated intention to act on that emergency authority. We also urge the administration to focus its efforts on a national strategy to ensure that vaccination of essential workers is prioritized, not only in principle, but that every effort is made to ensure that needles enter their arms as soon as possible.

Furthermore, in order to learn the lessons of this pandemic and ensure the safety of workers in the next pandemic, all relevant agencies of the Federal Government need to put their heads together to develop a way to quantify the impact of COVID–19 on this Nation’s work force.

And finally OSHA cannot effectively carry out its mission without resources. The number of inspectors is recovering from a record low. The number of safety and health complaints has piled up, and the backlog of whistleblower claims is daunting. The American Rescue Plan Act, H.R. 1319 passed by Congress yesterday sent to President Biden for his signature provides 200 million dollars to the Department of Labor for worker protection activities related to COVID–19.

Not less than half that amount, 100 million is directed to OSHA to meet this moment. I’d like to thank all of my colleagues in the House and Senate for making that happen. And I want to thank the witnesses again for their testimony. If there’s no further business without objection the subcommittee stands adjourned.
[Additional submission by Chairwoman Adams follow:]  

Congress of the United States  
Washington, D.C., 20515  

March 1, 2021  

Mr. Jeffery Zients  
Coordinator and Counselor to the President  
COVID-19 Pandemic Response  
The White House  
1600 Pennsylvania Ave., NW  
Washington, DC 20500  

Dr. Rochelle P. Walensky, MD, MPH  
Director  
Centers for Disease Control and Prevention  
1600 Clifton Rd., NE  
Atlanta, GA 30333  

Mr. Al Stewart  
Acting Secretary  
U.S. Department of Labor  
200 Constitution Ave., NW  
Washington, DC 20210  

Dear Mr. Zients, Dr. Walensky, and Mr. Stewart:  

We commend the Biden Administration for taking strong, science-based action to address the COVID-19 pandemic, including its directive to the Occupational Safety and Health Administration (OSHA) to adopt an Emergency Temporary Standard. However, serious questions about the adequacy of the current Centers for Disease Control and Prevention (CDC) Guidance regarding protections from aerosol transmission of the virus have been flagged in a February 15, 2021 letter to the Biden Administration by leading experts in aerosol science, occupational health, and infectious disease (Experts’ Letter).  

The Experts’ Letter recommends that the Biden Administration take immediate action to strengthen measures to address inhalation exposure to the virus. Their view is that updates are urgently needed to protect those who are at greatest risk of occupational exposure to the novel coronavirus and to ensure that OSHA’s emergency standards are consistent with the latest science and updated CDC guidance that fully recognizes airborne transmission hazards.  

In OSHA’s entire 50-year history, COVID-19 represents the single largest threat to worker health and safety. COVID-19 has taken a particularly devastating toll on workers across key sectors, including health care, meatpacking, transportation, and corrections. At least 57,493  

meatpacking workers have tested positive for COVID-19 and 284 have died.\textsuperscript{2} There have been 546,048 employees working at long term care facilities infected with COVID-19 and 1,590 related deaths, according to data from the Centers for Medicare & Medicaid Services (CMS) through February 14, 2021.\textsuperscript{3}

Throughout the pandemic, worker infections have fueled major outbreaks across the country. Many essential workers at the greatest risk of contracting and dying from COVID-19 are people of color.\textsuperscript{4}

To protect workers and reinvigorate the American economy, we must protect workers from exposure to this virus. The Experts’ Letter lays out the evidence that the major mode of exposure is inhalation of small aerosol particles that carry the virus:

For many months it has been clear that transmission through inhalation of small aerosol particles is an important and significant mode of SARS-CoV-2 virus transmission. The gravity of this problem was emphasized this week by an editorial in the journal Nature. Numerous studies have demonstrated that aerosols produced through breathing, talking, and singing are concentrated close to the infected person, can remain in air and viable for long periods of time and travel long distances within a room and sometimes farther. Gatherings in indoor spaces without adequate ventilation place participants at particularly high risk, an important component of which is driven by asymptomatic and pre-symptomatic viral shedding of infected individuals.\textsuperscript{5}

Despite numerous studies documenting the transmission risk via aerosol exposure, CDC guidance continues to rely on the view—which is outmoded according to the Experts’ Letter—that most COVID-19 infections are caused by contact with larger infectious droplets. In the view of the Experts’ Letter, up-to-date science needs to be reflected in updated policy if we are to effectively protect at-risk workers. Unless CDC scientists have persuasive evidence that contradicts the evidence presented in the Experts’ Letter, CDC and OSHA should delineate the recommended measures that need to be taken to prevent aerosol exposure—especially in workplaces. These include control measures that limit concentrations of the virus in the air, such as through better ventilation and air filtration, limiting the number of people and the time people spend in the workplace, and providing effective respiratory protection for workers with prolonged exposures or close contact with other workers, patients, or the public.


\textsuperscript{5} Bright, supra note 1.
As the Experts’ Letter points out:

CDC continues to recommend surgical masks for most healthcare workers and limits the use of NIOSH-certified respirators only to direct patient care or aerosol generating procedures with COVID-19 patients. It is now well documented that healthcare workers in non-COVID-19 patient care and support positions are also at high risk of infection and should be wearing respirators.5

To date, CDC and OSHA recommend only cloth face coverings that do not protect against small particle aerosol inhalation for non-health care workers, even those with high risk of aerosol exposure in food processing, prisons, and transportation.

To the extent that CDC guidance to health care employers was impacted by the severe supply issues that limited the nation’s ability to provide better respiratory protection at the beginning of the pandemic, such guidance should be updated given the partial abatement of shortages. Many health care employers continue to hoard available supplies and continue the use of questionable contingency and crisis practices such as the reuse of disposable respirators for multiple days, decontamination of N95 respirators, and use of surgical masks in place of effective respiratory protection. Millions of NIOSH-approved N95 full face respirators are now available, yet supplies are sitting in warehouses and storerooms, and many new respirator manufacturers cannot find buyers and are threatening to go out of business.7

To ensure that OSHA, with CDC’s support, issues an emergency standard that fully protects health care and other at-risk workers, we urge the Biden Administration to fully consider the evidence presented in the Experts’ Letter and, unless Administration scientists have persuasive evidence that contradicts the letter’s conclusions, consider adopting the following recommendations:

- Require CDC and OSHA to update and strengthen guidelines and standards to fully recognize inhalation exposure from small inhalable particles of the SARS-CoV-2 virus as a major source of transmission.
  - CDC should recommend control measures that focus first on reducing the concentration of the virus in the air through source controls such as ventilation and filtration as well as work practices, followed by respiratory protection for those workers who need it.
  - OSHA should adopt standards requiring the use of NIOSH-approved respirators—such as N95 respirators or better—for all healthcare workers as well as other workers at increased risk, including those in meat and poultry, corrections, and transit operations.

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5 Id.
Mr. Zients, Dr. Walensky, and Mr. Stewart  
March 1, 2021  
Page 4

- Require CDC to evaluate current supplies, and, as appropriate, direct healthcare organizations to stop contingency and crisis practices (e.g., decontamination of N95s and use of non-respirator facepieces such as surgical masks in place of respiratory protection). Where necessary to ensure adequate supplies as N95 use expands, implement the Defense Production Act to ramp up production of respirators and high-quality barrier face coverings in order ensure adequate supplies for all workers who are at increased risk.

- Direct OSHA to issue an emergency COVID-19 workplace standard that requires employers to conduct an assessment of inhalation risk and adoption of appropriate controls—including enhanced ventilation, physical distancing, effective respiratory protection for workers at increased risk, and high-quality barrier face coverings and masks for other workers exposed to the virus on the job.

Please advise us as soon as possible on the steps the Administration is taking to update the CDC guidance and to ensure that OSHA’s regulations are informed by the best available science. 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 the Committee’s Clerk, Tylease Alli, at tyleasealli@mail.house.gov.

Sincerely,

ROBERT C. “BOBBY” SCOTT  
Chairman  
Committee on Education and Labor

ROSA L. DELAURO  
Chair  
Committee on Appropriations

FRANK PALLONE, JR.  
Chairman  
Committee on Energy and Commerce

JAMES E. CLYBURN  
Chair  
Select Subcommittee on the Coronavirus Crisis  
Committee on Oversight and Reform

ALMA S. ADAMS, PH.D.  
Chair  
Subcommittee on Workforce Protections  
Committee on Education and Labor
Statement
of the
American Hospital Association
for the
Workforce Protections Subcommittee
of the
Committee on Education and Labor
of the
U.S. House of Representatives

“Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections”

March 11, 2021

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician 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 AHA appreciates the opportunity to submit for the record our comments on the importance of protecting health care workers who have been so critical to the nation’s response to the COVID-19 pandemic.

HOSPITALS’ AND HEALTH SYSTEMS’ COMMITMENT TO FOLLOW CDC SCIENCE-BASED GUIDANCE

The U.S. has experienced more than 29 million cases and more than 500,000 deaths due to COVID-19. Our health care workers continue to be our most vital resource and their health and safety always will be a top priority.

Hospitals and health systems have remained committed to adhering to the science-based guidance from the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS)
throughout the pandemic. Hospitals in order to participate in the Medicare and Medicaid programs must meet specific infection control requirements as set by the programs’ conditions of participation (CoP). Hospitals have already established robust infection control programs and invested significantly to assess and improve those programs.

The CDC has closely tracked the progression of COVID-19 as evidenced by the recent emergence of several variants around the world. As more has become known about these pathogens, CDC guidance has been updated regularly. The CDC continues to hold that COVID-19 is primarily spread through close contact, not airborne transmission, except when doing certain aerosolizing procedures. The CDC has acknowledged some specific circumstances outside of the hospital setting can generate COVID-19’s spread through aerosols, such as poor ventilation or prolonged exposure to respiratory particles generated through singing or shouting. For health care workers, CDC continues to recommend as appropriate the use of facemasks unless workers are performing aerosolizing procedures or procedures that require very close contact with patients with suspected or confirmed COVID-19 infection.

Hospitals remain concerned about the adequacy of supplies of N95 respirators and gloves. While the number of cases of COVID-19 and the number of hospitalizations in the U.S. are on the decline, hospitals remain keenly aware that the nation has experienced two previous declines followed by significant surges in cases, hospitalizations and deaths. At least three mutations of the virus are present in the U.S. that seem to be more transmissible, more deadly or both.

While efforts have been undertaken by the federal government to make the supply chain more resilient in times of crisis, no one seems confident that the problems that led to the substantial shortages of personal protective equipment (PPE) last spring are resolved. Thus, N95 respirators should be reserved only for those procedures in which they are necessary, such as aerosol-generating procedures, and for those performing close contact care on infected patients. For other care tasks, the CDC recommends facemasks be used in lieu of N95s and that, to the extent necessary, conservation practices be used to optimize the supply of PPE.

The CDC continues to update its guidance regularly and has provided new recommendations for hospitals and health systems since the beginning of this year. For example, the agency updated its “Facility Planning and Operations” materials on Feb. 8, 2021. That guidance spoke to practices of “Planning and Stayed Prepared” and “Operating Effectively” and provided a variety of checklists, scenarios and suggestions, including those to protect health care personnel.

CDC also issued guidance for “Strategies for Optimizing the Supply of N95 Respirators” as recently as Feb. 18, 2021. That guidance discussed a variety of strategies during conventional, contingency (expected shortages) and crisis (known shortages) conditions. Guidance in those situations included several engineering, administrative and PPE use controls. As has been the case throughout the pandemic, hospitals and health systems continue to work to implement this new science-based guidance.
Meanwhile, the Biden Administration recently released a series of Executive Orders (EOs) related to the COVID-19 pandemic. One EO includes provisions for the Department of Labor and the Occupational Safety and Health Administration (OSHA) to consider whether an Emergency Temporary Standard (ETS), including with respect to mask wearing, is necessary, and, if so, to issue an ETS by March 15. In addition, the EO instructs OSHA to launch a national program to focus enforcement efforts on violations that put the largest number of workers at serious risk or are contrary to anti-retaliation principles.

Hospitals and health systems employ health care workers in myriad settings that are not at the same risk of exposure to COVID-19. The varying levels of risk lead to different expectations and practices for providing protection. Those employed in administrative capacities, telehealth support or as equipment technicians are not at the same risk as front-line caregivers. Some workers at lesser risk can by protected with changes in the physical environment, such as by installing plexiglass barriers. Other caregivers in direct contact with patients might require full PPE, including N95 or even Powered Air Purifying Respirators.

A rigid new standard has real potential to add for hospitals and health systems a new layer of conflicting and impractical regulatory burden at precisely the wrong time. A new standard could lack the flexibility of ongoing guidance from the CDC and could easily fail to acknowledge ongoing surges in COVID-19 infections that can deplete the supply of PPE. Enacting these new standards could force hospitals and their staffs into a nearly impossible decision — to either not comply with the standards in order to treat all of the patients who need help or comply with the standards and stop treating patients when supplies of OSHA-required equipment are exhausted. Any new standard should be promulgated in a manner that would allow future updates, based on current CDC guidance, to be made automatically.

**Conclusion**

Health care workers have always been critical to the mission of hospitals and health systems. Their crucial life-saving role has never been more evident than during the course of the COVID-19 pandemic. The safety and protection of all health care workers remains a top priority. The AHA together with hospitals and health systems remain committed to following the science-based and sometimes quickly-evolving guidance issued by the CDC.
CONSTRUCTION INDUSTRY SAFETY COALITION

March 2, 2021

James “Jim” Frederick
Principal Deputy Assistant Secretary
U.S. Department of Labor
Occupational Safety and Health Administration
Room: S2315
200 Constitution Ave., NW
Washington, DC 20210

Re: Construction Industry Safety Coalition
Concerns with Issuance of Emergency Temporary Standard

Dear Mr. Frederick:

On behalf of the Construction Industry Safety Coalition (“CISC”), we write as a follow-up to our letter dated January 27, 2021, requesting a meeting with you and Occupational Safety and Health Administration (“OSHA”) officials as you consider how OSHA can best protect workers from workplace exposure to COVID-19. We were informed that OSHA is unable to accommodate individual meeting requests from stakeholders. While we are disappointed in this, we believe it is important to provide the Agency information regarding the experiences of the construction industry throughout the pandemic.

President Biden’s recent Executive Order 13999 on Protecting Worker Health and Safety directed OSHA to consider whether an Emergency Temporary Standard (“ETS”) is warranted to address COVID-19 in the workplace. The CISC is concerned with the possible issuance of an ETS at this time to address COVID-19 in the construction industry, particularly given the sharply declining case counts, the low risk nature of construction work, and the ever-changing nature of the pandemic. The CISC is also concerned that certain provisions OSHA might include in a COVID-19 standard would be unworkable in construction and would fail to take into account the unique characteristics of the construction industry.

A. Background on the CISC

The CISC is comprised of 30 trade associations representing virtually every aspect of the construction industry. The CISC was formed several years ago to provide data and information to OSHA on regulatory, interpretive, and policy initiatives. The CISC speaks for small, medium, and large contractors, general contractors, subcontractors, and union contractors alike. The CISC represents all sectors of the construction industry, including commercial building, heavy industrial production, home building, road repair, specialty trade contractors, construction equipment manufacturers, and material suppliers.

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B. The Construction Industry’s Proactive Efforts to Mitigate the Impact of COVID-19 on Construction Workers

Workplace safety and health is a priority for all members of the Coalition, and each is committed to helping create safer construction job sites for workers. From the outset of the pandemic, the construction industry has been deemed essential critical infrastructure by the Department of Homeland Security.\(^1\) Construction industry employers and employees have in large measure continued to work in states and localities across the country. As a result, the industry has been at the forefront of efforts to protect construction employees.

As we mentioned in our January 21, 2021, letter, the CISC developed a “COVID-19 Exposure Prevention Preparedness and Response Plan” (the “Response Plan”) in March of 2020, which has been made available in both English and Spanish and provided at no cost to the construction industry. The CISC updated the plan four times to account for changes in guidance from the Centers for Disease Control and Prevention (“CDC”).

The Response Plan provides a comprehensive approach for minimizing the risk of exposure to COVID-19 in the construction work environment. It sets responsibilities for managers and workers, provides key job site protective measures, and discusses personal protective equipment (“PPE”), work practice controls, use of face coverings, and how to handle employees who exhibit symptoms of COVID-19 or test positive. Sample forms and notifications are also included, along with a COVID-19 “Checklist” and “Toolbox Talk.”

The Response Plan is tailored to the construction environment, which OSHA has generally classified as low hazard. Early in the pandemic, the CISC felt that most of the guidance for businesses was directed at general industry and stationary work sites. The Response Plan developed by the CISC was one of the first comprehensive guidance documents directed specifically at the construction industry. Indeed, several states and localities took note and referenced the Response Plan in their COVID-19 orders and guidance documents.

In addition to the Response Plan, the CISC organized two safety stand downs related to COVID-19, one in April 2020 and the other just recently in January 2021. The most recent stand down was designed, in part, to reinforce that construction employers and employees must stay vigilant when complying with key prevention efforts.

C. OSHA’s Efforts Must Be Transparent

The CISC appreciates the Agency’s focus on protecting workers from COVID-19, but respectfully urges the Agency to meaningfully engage with the public and provide an opportunity for public input regarding the best approaches to protect workers from occupational transmission of COVID-19. While OSHA has conducted listening sessions allowing stakeholders to speak for three

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minutes, these listening sessions have not been widely advertised and are available only to stakeholders that receive a direct invitation from OSHA. This limits OSHA’s insights to only those groups with which it has already established lines of communication and bars other stakeholders from having an opportunity to provide input and feedback on OSHA’s regulatory process. Because the stakeholders invited to engage with OSHA through its listening sessions have been limited to three-minute oral presentations, these stakeholders also lack the opportunity to provide substantive or meaningful comment.

OSHA has also declined individual meetings and is not accepting written public comments. OSHA declined the CISC’s January 27, 2021, request to discuss appropriate measures to keep construction workers safe from COVID-19 in the workplace, citing a high volume of interest in the topic and desire from a variety of groups and private stakeholders to meet.

Respectfully, this is not a transparent process. By taking this position, OSHA is depriving itself of useful information from stakeholders with experience in dealing with the pandemic. Employers, workers, state agencies, and subject matter experts each have developed unique perspectives over the course of the past year of responding to the pandemic. This input would help OSHA craft an appropriate and targeted standard to provide the most effective protection for workers. We urge OSHA to reconsider its process.

The CISC requests that OSHA open a public docket and consult with the Advisory Committee on Construction Safety and Health (“ACCSH”). Complete transparency is critical. OSHA is considering changing its publicly-stated position from the first 11 months of the pandemic that an ETS was not needed to protect employees from COVID-19. It is unclear what would warrant such a change, particularly given the declining case counts.

Consulting ACCSH is particularly important in the CISC’s view. ACCSH was established by the Construction Safety Act to serve an advisory function for the Secretary of Labor in formulating safety standards applicable to the construction industry. As you know, OSHA’s own regulations require that the Assistant Secretary consult the ACCSH “whenever occupational safety or health standards are proposed.” It is critical that OSHA consult with its advisory committees, including ACCSH, to ensure any ETS reflects the advisory committees’ relevant expertise.

D. Concerns with Potential Provisions in a COVID-19 Standard

While OSHA has yet to release a public proposal on what should be included in a COVID-19 standard, certain approaches taken by states and localities have proven problematic. CISC members have continued operating during the pandemic and, thus, have important experience in working to comply with some provisions that OSHA may be considering in an ETS. Below we respectfully outline recommendations for OSHA’s consideration should it choose to issue a COVID-19 ETS.

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1 29 C.F.R. § 1912.3(a).
First, the very nature of COVID-19 is not conducive to a strict, static ETS. COVID-19 is commonly referred to as a “novel” coronavirus and what public health authorities know about the virus changes on an almost daily basis. The public health community is rigorously studying COVID-19 and, despite these efforts, its understanding of the risks and health effects is constantly evolving. As just a few examples, the CDC has changed its list of symptoms associated with COVID-19 at least five times. In December of 2020, the CDC also updated guidance concerning the duration that a “close contact” must quarantine, reducing the period from the previously recommended 14 days to a period of 10 days, or shorter in certain circumstances.

An ETS that does not account for the novel nature of the virus and the constantly changing public health knowledge would not be workable. This has become evident in the states that have adopted temporary or permanent COVID-19 standards, particularly California. California adopted its ETS effective November 30, 2020, and based many of its worker protection provisions on the CDC guidance in effect at that time. The CDC updated its guidance less than a week after California adopted its ETS with the result being that a key provision of the ETS was rendered obsolete. California’s ETS contains no mechanism to account for changes in CDC guidance. Therefore, the Governor of California had to issue an Executive Order amending the relevant provision of the ETS to correspond to the CDC’s revised guidance.

More recently, the CDC released guidance advising that fully vaccinated individuals who are exposed to an infected individual are not required to quarantine. Although Virginia and California have endorsed the CDC’s guidance, neither Virginia’s permanent standard nor California’s ETS incorporate the CDC’s new guidance. In fact Cal/OSHA’s latest ETS FAQs still state that “all prevention measures must continue to be implemented” after an employee is vaccinated. This means that, per the California ETS, employers must exclude a fully-vaccinated employee from work if the employee has been exposed to an infected individual, despite the CDC and state guidance stating the exact opposite. Such an inflexible approach illustrates why an ETS is not workable.

Second, OSHA should avoid a broad standard that is generally applicable to all industries, and instead should pursue a flexible approach that accommodates the unique needs of the wide variety of workplaces to which it would apply. As just one example, construction work is very different from general industry work, which is why construction has separate OSHA standards (29 Code of Federal Regulations (CFR) Part 1926). Construction work is frequently performed outside, in ever-changing conditions and varied work environments. A construction project can span for miles with work being performed at various stages along the span. Studies have shown that the

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2 The California ETS essentially set in stone a requirement that an asymptomatic employee who had been a “close contact” of an infected individual must be excluded from work for 14 days. On December 2, 2020, the CDC revised its guidance on this issue and advised that an asymptomatic individual who had been a “close contact” of an infected individual could end their quarantine after 10 days, or shorter in specific instances, instead of the previously recommended 14 days.

4 See https://www.cdph.ca.gov/COVID19FAQs.html#

3 See https://www.vdh.virginia.gov/covid-19-faq/vaccination/

5 See https://www.vdh.virginia.gov/covid-19-faq/vaccination/

6 See https://www.dfr.ca.gov/dosh/coronavirusCOVID19FAQs.html#vaccines

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risk of infection of a viral disease is greatest in indoor environments where there is a higher
likelihood of “possible buildup of the airborne virus-carrying droplets” and the virus likely has
“higher stability in indoor air.” As stated above, construction work often occurs outdoors with
continuous air flow and this could substantially impact an appropriate regulatory approach. Even
with construction work performed indoors, contractors have established mechanisms to protect
employees in practical, effective ways.

Third, OSHA should avoid any provisions that exceed appropriate engineering and work practice
controls, and PPE. The temporary and permanent standards adopted by various states include
excessive provisions, which have shown themselves to be unworkable. One such provision is a
mandatory testing requirement. California’s ETS includes robust COVID-19 testing requirements
covering all employees present in an exposed workplace during a COVID-19 outbreak. Such a
mandate is not sustainable. It has become clear that not every county has sufficient free testing
sites to provide the required testing. In those counties where there are insufficient free testing
sites, employers are required to pay upwards of $160 per test, meaning that large employers have
to spend hundreds of thousands of dollars for each round of required testing. Even in counties
with free testing sites, employees may wait four to five hours for a test only to find out that a
testing site ran out of tests and the employee must return the next day. This is unreasonable and
unsustainable, particularly for small businesses and their employees. The construction industry is
dominated by small entities with 90 percent of construction firms employing fewer than 20
employees. As OSHA knows, the impacts of its rules on small businesses may differ significantly
from the impacts of its rules on large employers, who are often more readily able to absorb
regulatory burdens in their operations.

The CISC is also concerned about the potential inclusion of paid leave provisions. Oregon’s ETS
and California’s ETS include provisions providing for job protected leave for employees who are
required to quarantine or isolate due to COVID-19. In Oregon, this protection is provided
regardless of whether the employee’s COVID-19 exposure is work-related. California’s ETS goes
one step further and includes a paid leave benefit for employees who are excluded from work
because of COVID-19. While employees are not entitled to this paid leave benefit if their exposure
is not work related, employers carry the burden of proving that the exposure is unrelated to work.
This raises serious concerns about how an employer can prove that a COVID-19 exposure is not
work related when the virus may be widely present in the community already and therefore
exposure could have occurred anywhere. In a transient industry such as construction, the impact
of these types of provisions would be particularly burdensome and unworkable.

One additional provision of concern would be the inclusion of quarantine requirements that do not
consider critical infrastructure employees. Per the current CDC guidance, an asymptomatic critical
infrastructure worker may continue to work after they are exposed to an infected individual

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1 Lidia Moranwka & Junji Cao, *Airborne transmission of SARS-CoV-2: The world should face the reality, Env. Int* 139 (2020) 105770, 


1650 Tysons Boulevard, Suite 700, Tysons Corner, VA 22102
provided that certain criteria are met.\(^8\) Only Michigan has expressly adopted the CDC’s guidance in this respect. Virginia’s permanent standard provides employers with a quasi-safe harbor provision when following CDC guidance instead of the standard’s guidance. California requires employees to obtain a waiver from the ETS’s return-to-work requirements and Oregon’s ETS does not appear to consider critical infrastructure employees whatsoever. This is of special concern to CISC members as the construction industry has been deemed essential critical infrastructure, as stated above. If construction workers are not permitted to continue working in accordance with CDC guidance, it could put a significant strain on the construction industry.

Finally, some have advocated a national requirement to report COVID-19 exposures in the workplace in order to better track outbreaks in the community and between industries. In the CISC’s view, however, this would use up resources while doing little to prevent COVID-19, and could lead to misleading statistics since the exact time and location of infection is impossible to track, particularly in places where there is active community spread. The ongoing COVID-19 pandemic is a unique situation involving a highly contagious virus with exposures inside and outside of the workplace. The significant numbers of cases over the past year demonstrate a large public health problem, but not necessarily driven by the work environment, and certainly not all work environments in all industries. As such, a broad national workplace reporting requirement would direct significant private and public resources towards tracking trends that would not necessarily lead to improved results for workers or the public at large and particularly given the current declining case counts.

E. The Need for a COVID-19 ETS Applicable to Construction

The CISC understands that OSHA is considering whether an ETS is warranted at this time to address the pandemic pursuant to President Biden’s recent Executive Order 13999. Notwithstanding the recommendations outlined above should OSHA choose to pursue an ETS, the CISC questions whether an ETS is justified at this time. An ETS is only appropriate where employees are exposed to grave danger and the ETS is necessary to protect employees from such danger.\(^9\) Current conditions do not meet these requirements, and do not support a change in OSHA’s nearly year-long position that existing standards are sufficient to enforce safety measures that protect workers from occupational transmission of COVID-19. In particular, based on the experience of CISC members, the issuance of such an “emergency” standard is not necessary at this time to protect construction workers from the transmission of COVID-19 in the workplace.

First, COVID-19 positive cases are declining precipitously in the United States.\(^11\) The United States experienced six straight weeks of a downward trend in daily COVID-19 cases, seeing an

\(^11\) Coronavirus in the U.S.: Latest Map and Case Count, N.Y. Times (Mar. 1, 2021), https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (showing a 26 percent decrease in the seven-day average number of reported COVID-19 cases between Feb. 14 and Feb. 28, 2021; a 21 percent decrease in the seven-day average number of reported COVID-19 deaths between Feb. 14 and Feb. 28, 2021; and a 30 percent decrease in the seven-day average number of reported COVID-19 hospitalizations between Feb. 14 and Feb. 28, 2021.)
almost 74 percent decline in the seven-day average of reported cases by the week ending on February 25, 2021.\textsuperscript{12} The percent of positive COVID-19 tests also continues to decline, with the seven-day nationwide average falling to near 5 percent as of February 25, 2021, and only four states remaining above a 10 percent average for positive test results. Showing similarly positive trends, both the nationwide rate of new hospital admissions for COVID-19 and the number of daily deaths from COVID-19 continue to decline.\textsuperscript{13} With no indication that COVID-19 is more transmissible in the workplace than by community spread, especially for low exposure risk occupations, the declining number of community infections in turn makes occupational transmission less of a threat.

Second, vaccine distribution is accelerating rapidly.\textsuperscript{14} The United States COVID-19 Vaccination Program began on December 14, 2020. Currently, three vaccines have been authorized for emergency use. Two of these vaccines are in distribution, with additional vaccines in Phase 3 of clinical trials.\textsuperscript{15} As of February 25, 2021, almost 14 percent of the United States population had received at least one dose of vaccine.\textsuperscript{16} We can expect these numbers to continue to increase as states, including at least eight states within the last two weeks, announce expansions of vaccine distribution eligibility.\textsuperscript{17} The CDC’s stated goal is for “everyone to be able easily to get a COVID-19 vaccination as soon as large quantities of vaccine are available.”\textsuperscript{18} As a result of these efforts, combined with the already accelerating decline in COVID-19 cases, it is not necessary for OSHA to rush an ETS at this time.

\begin{itemize}
\item \textsuperscript{12} COVID Data Tracker Weekly Review, CDC (last updated Feb. 26, 2021), \url{https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidxview/index.html}.
\item \textsuperscript{13} Id.
\item \textsuperscript{14} COVID-19 Vaccinations in the United States, CDC (last visited Mar. 1, 2021), \url{https://covid.cdc.gov/covid-data-tracker/#vaccinations} (showing a total of 75,236,003 vaccine doses administered nation-wide, and a total 24,779,920 people nation-wide received two doses).
\item \textsuperscript{15} Different COVID-19 Vaccines, CDC (last updated Jan. 15, 2021), \url{https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html}.
\item \textsuperscript{18} Frequently Asked Questions about COVID-19 Vaccination, CDC (last updated Feb. 25, 2021), \url{https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html}.
\end{itemize}
Third, appropriate standards to address workplace hazards caused by COVID-19 already exist and OSHA has been effectively enforcing and issuing citations under these standards.\textsuperscript{19} OSHA’s General Duty Clause as well as its standards for Respiratory Protection, Recording and Reporting Occupational Injuries and Illnesses, and Personal Protective Equipment each provide requirements to keep workplaces safe from hazards presented by COVID-19. OSHA has effectively enforced these standards in the COVID-19 context, with at least 369 of its inspections resulting in citations with initial penalties totaling over $4,000,000.\textsuperscript{20} 

Fourth, unlike other instances where OSHA has engaged in rulemaking, state and local authorities have been engaged in the pandemic response in an unprecedented way. State and local health departments have been heavily involved in workplace investigations and contact tracing protocols. Many have mandated requirements applicable to worksites as part of their general authority to protect public health. This is unlike other hazardous conditions that OSHA has regulated, where the hazard was specific to the work environment (e.g., respirable crystalline silica exposure in the work environment, or bloodborne pathogen exposures). The conditions did not include such a large workplace and public health component, which involved a multi-level public health response. The ubiquitous state and local orders regarding COVID-19 – which are more appropriate because they consider unique local circumstances of community spread – have the effect of already mitigating the risk that OSHA would seek to address through an ETS.

Indeed, numerous state and local jurisdictions have already implemented extensive measures to protect workers in all industries. Virginia, Michigan, Oregon, and California adopted ETSs applicable to nearly all employers in their respective states that address COVID-19 in the workplace. CISC member companies work in all of these jurisdictions and, as alluded to above, OSHA should take the opportunity to hear from these companies regarding their direct experience in complying with the state standards.

Virginia has since made its COVID-19 standard permanent and Oregon is in the process of doing the same. All four standards require covered employers to conduct job hazard assessments and most covered employers must prepare a COVID-19 response plan. Moreover, these standards, while not identical, contain many of the same worker protection requirements, such as ensuring physical distancing, implementing screening protocols, providing face coverings, improving ventilation, excluding employees and other individuals from the workplace who have been infected with COVID-19, implementing enhanced cleaning and sanitation practices, training employees on COVID-19 safety, and providing notification to workers who may have been exposed to COVID-19, among other things.

In the jurisdictions that have not issued a temporary or permanent COVID-19 standard, numerous state or local governments have issued executive orders with specific worker-protection requirements. Early on in the COVID-19 pandemic, all 50 states, the District of Columbia, 5


territories and at least 134 local municipalities implemented some version of either a shelter-in-place or stay-at-home order restricting their residents and visitors from certain activities. Currently, 47 states, the District of Columbia, Puerto Rico, and at least 364 local municipalities have issued orders either requiring or recommending that the general public wear face coverings while conducting certain activities or in public. Furthermore, 44 states, the District of Columbia, Puerto Rico, and at least 59 localities require or recommend that employees be screened for symptoms of COVID-19. Finally, at least 20 states, the District of Columbia, and Puerto Rico require certain employers to implement a written health and safety plan. Simply put, state and local governments are aggressively addressing the risk of COVID-19, and therefore additional rulemaking by OSHA is not needed.

Fifth, most construction operations have been deemed to be “low risk” by OSHA itself. Early in the pandemic, OSHA explained that the level of risk of occupational exposure to COVID-19 “depends in part on the industry type, need for contact within 6 feet of people known to be, or suspected of being, infected with SARS-CoV-2, or requirement for repeated or extended contact with persons known to be, or suspected of being, infected with SARS-CoV-2.” OSHA further explained that workers with a high risk of exposure are those in professions such as healthcare, where there is a high likelihood of exposure to known or suspected COVID-19 patients. Workers, such as construction workers, that have minimal occupational contact with the general public or other coworkers are generally considered to have a low exposure risk. OSHA established a webpage further analyzing when certain types of construction work fall into the various COVID-19 risk exposure categories. According to OSHA’s own assessment, most construction work poses “low exposure risk”; construction work only crosses into “high exposure risk” when it takes place at indoor work sites; and construction work is unlikely ever to pose a “very high exposure risk.”

F. Conclusion

To the extent that OSHA chooses to go forward with an ETS for COVID-19, the CISC recommends that OSHA adopt a specific approach for construction worksites modeled after the CISC’s COVID-19 Response Plan. The plan has been implemented throughout the industry and adopted by large and small contractors. The effectiveness of the Response Plan has already been recognized by several jurisdictions. In fact, on March 29, 2020, the County of Dallas, Texas, issued rules for the construction industry on how to prevent worker exposure to COVID-19. These rules required “all employers involved in construction activity [to] follow the requirements set forth in the COVID-19 Safety Recommendations issued by the Construction Industry Safety Coalition.” The Response Plan includes several components, including:

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• Responsibilities of managers, supervisors, and employees.
• Control and preventative guidance to all employees.
• Familiarization with the symptoms of COVID-19.
• Job site protective measures specific to construction.
• Personal Protective Equipment.
• Job site cleaning and disinfecting.

The CISC Response Plan is specifically geared to construction work, and will be more effective at protecting workers in the construction industry than a broad, generally-applicable standard created for traditional or indoor workspaces.

Thank you for considering this information. The CISC remains available to assist as you work to improve workplace safety and health throughout the construction industry. If you would find it helpful to discuss any of these matters with us, please contact Rob Matuga of the National Association of Home Builders at rmatuga@nahb.org or Kevin Cannon of the Associated General Contractors of America at kevin.cannon@agc.org.

Sincerely,

The Construction Industry Safety Coalition

American Road and Transportation Builders Association
American Society of Concrete Contractors
American Subcontractors Association
Associated Builders and Contractors
Associated General Contractors
Association of Equipment Manufacturers
Association of the Wall and Ceiling Industry
Concrete Sawing & Drilling Association
Construction & Demolition Recycling Association
Distribution Contractors Association
Independent Electrical Contractors Association
Interlocking Concrete Pavement Institute
International Council of Employers of Bricklayers and Allied Craftworkers
Leading Builders of America
Mason Contractors Association of America
Mechanical Contractors Association of America
National Asphalt Pavement Association
National Association of Home Builders

1650 Tysons Boulevard, Suite 700, Tysons Corner, VA 22102
National Association of the Remodeling Industry
National Demolition Association
National Electrical Contractors Association
National Framers Council
National Roofing Contractors Association
National Utility Contractors Association
Natural Stone Council
Natural Stone Institute
Sheet Metal & Air Conditioning Contractors’ National Association
Specialized Carriers & Rigging Association
The Association of Union Constructors
Tile Roofing Industry Alliance

c: Amanda Edens, Deputy Assistant Secretary
   Scott Ketcham, Director, Directorate of Construction
March 11, 2021

The Honorable Alma Adams  
Chair  
Subcommittee on Workforce Protections  
2176 Rayburn House Office Building  
Washington, DC 20515

The Honorable Fred Keller  
Ranking Member  
Subcommittee on Workforce Protections  
2101 Rayburn House Office Building  
Washington, DC 20515

The Honorable Bobby Scott  
Chair  
Committee on Education and Labor  
2176 Rayburn House Office Building  
Washington, DC 20515

The Honorable Virginia Foxx  
Ranking Member  
Committee on Education and Labor  
2101 Rayburn House Office Building  
Washington, DC 20515

Dear Chair Adams, Ranking Member Keller, Chair Scott, and Ranking Member Foxx:

On behalf of the National Retail Federation (NRF), thank you for convening today’s hearing regarding COVID-19 and its impact on the American workforce. We write to share retailers’ experiences responding to and mitigating the spread of COVID-19 within their workplaces and explain why an emergency regulation would be counter to our shared objective of keeping our nation’s workforce safe. We recommend that the Occupational Safety and Health Administration (OSHA) continue to issue robust industry-specific guidance on how employers can best implement Centers for Disease Control and Prevention (CDC) guidance.

NRF is the world’s largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and internet retailers from the United States and more than 45 countries. Retail is the nation’s largest private-sector employer, supporting one in four U.S. jobs — 32 million working Americans. Contributing $3.9 trillion to annual GDP, retail is a daily barometer for the nation’s economy.

Over the past year, retailers have taken extraordinary and unprecedented efforts to mitigate the spread of the virus. Last spring, many retailers voluntarily closed their doors to assess operations due to the emerging pandemic. They successfully reopened after implementing social distancing rules, one-way arrows, and floor markings and mandating protective gear such as face coverings. The NRF was the first business group to call for and require the use of face
National Retail Federation  
March 11, 2021  
Page 2

coverings by associates and customers. Our members have increased tempo of store cleanings and upgraded cleanings to higher sanitation standards. Retail employees nationwide have been trained to practice COVID-19 hygiene and unfortunately been called upon to enforce state and local face mask mandates and other policies. Retailers have upgraded on-site infrastructure by installing pre-shift health screening stations and plexiglass shields at check-out counters. Combined, our industry has invested tens of billions of dollars in these mitigation and safety measures.

NRF and our members have worked and will continue to work extensively with the CDC, the National Institute of Occupational Safety and Health (NIOSH), OSHA, state and local health agencies, and our own safety and health experts to learn as much as we can about the virus and how to stop its spread. We have repeatedly adapted as scientific experts’ knowledge about the nature of COVID-19 has evolved. These measures described above, especially when combined with widely available COVID-19 testing, increased vaccinations, expanded immunity, and effective communication from federal leadership, permit U.S. retailers to keep their workers safe.

Retailers are concerned about the possibility of OSHA issuing a rigid, one-size-fits-all emergency regulation, particularly during a global pandemic that has already imposed substantial economic hardship.

First and foremost, the pandemic has been an unpleasant reality for one year. As such, the imperative for OSHA to declare an “emergency” and issue a standard has long passed.

Moreover, an emergency regulation may actually impede retailers’ ability to quickly adjust to the still evolving understanding of hazards and appropriate mitigation associated with COVID-19. Science is uncovering more about the virus every day, and researchers’ constantly shifting understanding of the virus, its mutations, and methods of spread means that any emergency OSHA standard would only freeze in time one set of mitigation protocols, when those protocols may subsequently need to change.

Moreover, as OSHA considers issuance of a standard, the agency should consider the unique nature of this hazard. By design, OSHA regulates hazards created by the nature of the workplace. COVID-19, however, enters the workplace from the outside and is not endemic to the workplace. In fact, there is scant evidence that employers generally, or retailers specifically, are the source of community spread of COVID-19. Employees face the hazard of COVID-19, not because they are employees, but because they are human beings living on this planet. The threat exists wherever they are, not just the few hours per day they are in their employer’s facility.

While OSHA rightfully expects employers to institute protocols to keep employees safe while they are at work, the agency should be wary of imposing inflexible and costly burdens on employers when there is ample evidence that the specific hazards are not work-related.

For these reasons and others, the imposition of a one-sized fits all standard — especially one promulgated without the benefit of the normal notice and comment process — could hinder, not accelerate, employers’ efforts to protect their employees from the dangers of the COVID-19
National Retail Federation
March 11, 2021
Page 3

virus. In lieu of issuing an emergency standard, we recommend OSHA continue to issue robust industry-specific guidance on how employers can best implement CDC guidance.

In closing, American retailers have prioritized and will continue to prioritize the health and safety of our employees and our customers. We appreciate the Committee’s focus on this issue and look forward to working together to ensure the safety of workers nationwide.

Sincerely,

[Signature]

David French
Senior Vice President
Government Relations
Dr. Linsey Marr, Ph.D.
Professor of Civil and Environmental Engineering
Virginia Polytechnic Institute and State University
Blacksburg, VA

Dear Dr. Marr,

I would like to thank you for testifying at the March 11, 2021 Subcommittee on Workforce Protections hearing entitled “Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.”

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Monday, April 26, 2021, for inclusion in the official hearing record. Your responses should be sent to Jordan Barah 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
“Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections”
Thursday, March 11, 2021
10:45 a.m. (Eastern Time)

Chairwoman Alma S. Adams (D – NC)

1. Given the existence of aerosol transmission of COVID-19, do you think that the plastic partitions used on meat and poultry lines provide adequate protection for workers if they are only wearing cloth face coverings?

If not, what else can they do in meat and poultry processing plants to protect workers?

2. Are we still facing a shortage of N95 respirators in hospitals?

3. Can you tell us what you mean by a “high performance” mask? How does that differ from the cloth face coverings that you see everyone wearing?

4. Can you elaborate on what you mean by “good” ventilation?
Chairwoman Alma Adams (D-NC)

1. Given the existence of aerosol transmission of COVID-19, do you think that the plastic partitions used on meat and poultry lines provide adequate protection for workers if they are only wearing cloth face coverings? If not, what else can they do in meat and poultry processing plants to protect workers?

Plastic partitions can block large droplets that might transmit the virus in close, face-to-face conversations, but they do not protect against aerosol transmission. Air can easily flow around partitions, and aerosols can be carried in this air flow, wafting like cigarette smoke. Therefore, these partitions do not provide adequate protection for workers on meat and poultry lines who are wearing cloth face coverings. To protect workers, plants can provide better respiratory protection for workers, such as N95s, and improve ventilation to rapidly remove aerosols from the working area so that workers do not inhale each other’s exhaled breath.

2. Are we still facing a shortage of N95 respirators in hospitals?

According to a recent PBS article entitled “FDA says N95 face masks should no longer be reused,” US manufacturers have surpluses of N95s for sale, and hospitals have 3-12 month stockpiles. I do not have additional information beyond what I have seen in the media.

3. Can you tell us what you mean by a “high performance” mask? How does that differ from the cloth face coverings that you see everyone wearing?

A high-performance mask has two features: good filtration ability and good fit. The material in the mask is able to filter out, say, 80 percent or more of small aerosols, and the mask does not have gaps around the sides, where aerosols can leak in and out. Such a mask could be identified if it follows the new ASTM specifications for face coverings. On the other hand, a typical cloth mask that you see many people wearing might be able to filter out half of small aerosols; it often has gaps around the nose and cheeks that aerosols can easily pass through without being filtered. This is better than nothing but not adequate for workers who are sharing the air with others for many hours per day.

4. Can you elaborate on what you mean by “good” ventilation?

Good ventilation means that the air in a room is replaced with outdoor air often enough to control pollutant levels and odors. The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) is a professional society that publishes ventilation standards (Standards 62.1 and 62.2) for different types of rooms. These standards specify how much outdoor air should be brought into a building per occupant. For example, they recommend 5 cubic feet per minute per person in an office, 7.5 cubic feet per minute per person in a restaurant, and 10 cubic feet per minute per person in a warehouse. This might require that the entire volume of air in a room is replaced with outdoor air every 10-20 minutes, depending on the type of space and number of occupants. These standards are not always met. In poorly ventilated spaces, there is little exchange of outdoor air, and pollutants, including aerosolized viruses, can accumulate to hazardous levels.
Pascaline Muhindura, RN
Registered Nurse
COVID Progressive Care Unit, Research Medical Center
Kansas City, MO

Dear Ms. Muhindura,

I would like to thank you for testifying at the March 11, 2021 Subcommittee on Workforce Protections hearing entitled “Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.”

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Monday, April 26, 2021, 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
“Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections”
Thursday, March 11, 2021
10:45 a.m. (Eastern Time)

Chairwoman Alma S. Adams (D – NC)
1. Are nurses and other workers at your hospital better protected because they were represented by a union? Can you describe why?

2. Can you describe what it’s like to wear a used N-95 day after day?

3. What was your response when you heard management say that providing surgical masks instead of N95 respirators was consistent with CDC guidance? How did this affect nurses’ level of stress?

Representative Ilhan Omar (D – MN)
1. Ms. Muhindura, I first wanted to thank you for your powerful testimony. My older sister is a nurse, and this is a topic that I’ve spoken to her about at length. I’m hoping to hear some more of your important insights on how better-informed policymaking could support you and your work. Can you explain in detail how an OSHA standard could’ve prevented an outbreak at your hospital?

2. I’ve also heard often from nurses that reusing an N95 mask is an uncomfortable practice, while also being very dangerous. Could you describe what it’s like to reuse an N95 day after day?

3. Finally, I’ve been a strong proponent of hazard pay as a way to alleviate some of the stress associated with your tireless work, but are there other economic policies that would help support our nurses?
“Clearing the Air: Science-Based Strategies to Protect Workers from Covid-19 Infections”
Thursday, March 11, 2021
Additional Questions for the Record – Pascaline Muhindura, RN

Chairwoman Alma S. Adams (D - NC)

1. Are nurses and other workers at your hospital better protected because they were represented by a union? Can you describe why?

Yes, the nurses and other health care workers at my hospital were better protected because of our union. My union, National Nurses United, started advocating for protections for workers two months before the pandemic started. Nurses knew that we were at risk of a major pandemic, and we knew that the hospital was not prepared to protect us and our patients if Covid-19 hit our community the way it was impacting other countries. It is because of our union advocacy that we were able to secure fit-testing for N95s and access to N95s on our unit. We have been able to speak up against the employer because we have the protection of the union. For example, union nurses campaigned against the dangerous attempted “decontamination” and re-use of N-95s. Through our union, we advocated to management to express our concerns about how the masks would be degraded in the process — we wore stickers and were very vocal with the administration. We were eventually successful, and the hospital stepped back from this dangerous practice.

I know nurses who work in non-union facilities, including my mom. The nurses that I know in non-union facilities have not had the vehicle of the union by which to advocate for the protections they need.

2. Can you describe what it’s like to wear a used N-95 day after day?

Wearing an N-95 day after day is not a good feeling. First, as nurses we are trained to know that N95s are supposed to be used for a single use only. We know that each time you reuse the same N95, you are at risk of exposure to the virus. When you wear an N95, you sweat into the mask. When you use the N95 for an extended use throughout a shift, or you reuse it day after day, you can feel sweat and snot soaking into the N95. Sometimes the outer part of the respirator will become soiled as you care for patients. Over time, you can feel the elastics get loose and the N95 stops fitting correctly. The risk for exposure is high when you are constantly taking off and then putting back on a contaminated N95.

3. What was your response when you heard management say that providing surgical masks instead of N95 respirators was consistent with CDC guidance? How did this affect nurses’ level of stress?

That was really hard for me to hear. To be honest, I was triggered because this CDC guidance was NOT based on science. The science on aerosol transmission and respiratory protections is very clear — it is unsafe for workers to be using a surgical mask when there is a virus circulating that is transmitted through aerosols. While I refused to follow this policy from my hospital, not everyone feels able to refuse to follow hospital policy. To be clear, nurses and other workers have gotten sick and have died because of this CDC guidance. The faulty and dangerous guidance from the CDC has added greatly to the stress
that nurses across the country have experienced. We feel that we have been abandoned by the agency that is supposed to follow science, but which has instead chosen to disregard science and put our lives at risk. It has been highly distressing. It is very difficult to fight for respiratory protections when the CDC refuses to recognize aerosol transmission of this virus, and therefore refuses to recommend the proper protections for workers.

Representative Ilhan Omar (D – MN)

1. Ms. Muhindura, I first wanted to thank you for your powerful testimony. My older sister is a nurse, and this is a topic that I’ve spoken to her about at length. I’m hoping to hear some more of your important insights on how better-informed policymaking could support you and your work. Can you explain in detail how an enforceable OSHA standard could’ve prevented an outbreak at your hospital?

If there was an enforceable OSHA standard, management would have taken their duty to protect us more seriously. The protections that all healthcare workers need for Covid are clear, scientifically proven, and they need to be universal in all healthcare facilities in our country. An OSHA standard would make that happen, because it would give workers the tools by which to ensure that health and safety protections are enforced.

Throughout the pandemic, my hospital management has not done the right things to protect workers. After my coworker Celio’s death, the union filed an OSHA complaint. After reading OSHA’s response, it was clear that OSHA could not cite my employer because OSHA doesn’t have a standard. As long as OSHA does not have a standard, our employers will not be held accountable for putting employees at risk. Nurses will continue to get sick and die if OSHA doesn’t create a standard.

2. I’ve also heard often from nurses that reusing an N95 mask is an uncomfortable practice, while also being very dangerous. Could you describe what it’s like to reuse an N95 day after day?

Wearing an N-95 day after day is not a good feeling. First, as nurses we are trained to know that N95s are supposed to be used for a single use only. We know that each time you reuse the same N95, you are at risk of exposure to the virus. When you wear an N95, you sweat into the mask. When you use the N95 for an extended use throughout a shift, or you reuse it day after day, you can feel sweat and snot soaking into the N95. Sometimes the outer part of the respirator will become soiled as you care for patients. Over time, you can feel the elastics get loose and the N95 stops fitting correctly. The risk for exposure is high when you are constantly taking off and then putting back on a contaminated N95.

3. Finally, I’ve been a strong proponent of hazard pay as a way to alleviate some of the stress associated with your tireless work, but are there other economic policies that would help support our nurses?

The economic devastation that has accompanied this pandemic has been felt by nurses in our work at the bedside, and many of us have also experienced personal economic impacts for our families during this time. I, like many nurses, would appreciate receiving hazard pay for our work in the pandemic. But there are other economic policies which would deeply help to support nurses, including:
- Paid family leave. Nurses have been in need of paid family leave for many years, and this need has been exacerbated during the pandemic. Only 23 percent of health care and social assistance workers in private industry have any form of paid family leave. It is important for the safety of our patients and our coworkers that nurses are able to stay home when family members are sick.

- We are increasingly learning about long-term health impacts of Covid-19, including long-term lung and heart damage, fatigue, and neurological impacts. Nurses and other health care workers who contract Covid-19 should have access to long-term health benefits. There should be no barriers to accessing any benefit programs for the long-term health impacts of Covid-19 for nurses and other essential workers.

- Comprehensive labor law reform through passage of the Protecting the Right to Organize Act would have important economic benefits and critical health care benefits for nurses and our patients. Right now, it is very difficult to organize a union at many hospitals across the country, because hospitals run anti-union campaigns and hire union busting consultants. In my hospital, having a union has been critical to securing health and safety protections for nurses, as well as negotiating strong contracts. It is necessary that the federal government improves labor law so that all nurses and all workers have the ability to organize a union should they choose to.

- Medicare for All, both an economic and health care policy, would drastically improve the lives of nurses, health care workers, and all our patients. By transitioning to a Medicare for All system, nurses and other health care workers will be able to provide better quality care to our patients, and we ourselves will have better quality health care when we need it without any financial barriers to care. Transitioning to Medicare for All would greatly reduce the many stresses that we experience at hospitals across the country today. Under the Medicare for All Act of 2021 introduced by Congresswoman Pramila Jayapal and Congresswoman Debbie Dingell, hospitals would be required to ensure safe staffing levels for all health care workers, including mandatory minimum nurse to patient ratios for registered nurses, which would drastically improve our health and safety at work while improving patient care.
Dr. David Michaels, Ph.D.
Professor of Occupational and Environmental Medicine
The George Washington University, former Assistant Secretary of OSHA
Washington, D.C.

Dear Dr. Michaels,

I would like to thank you for testifying at the March 11, 2021 Subcommittee on Workforce Protections hearing entitled “Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.”

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Monday, April 26, 2021, 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

“Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections”

Thursday, March 11, 2021
10:45 a.m. (Eastern Time)

Chairwoman Alma S. Adams (D – NC)

1. Meat processing companies and others have contested the OSHA penalties they’ve received for failing to protect workers from COVID-19 because, they claim, before OSHA and CDC issued their joint guidance for the meat industry on April 26, there was no possible way they could have known how to protect their employees. Is their defense accurate?

2. The Republicans assert that instead of an OSHA standard all the federal government needs to do to protect workers is to “focus on ensuring adequate vaccine supply and distribution to vaccinate all workers and providing timely public health guidance to our employers…” Do you think that vaccination and guidance are adequate to protect this nation’s workers?

3. Your testimony states: “the Bureau of Labor Statistics has decided that COVID-19 deaths will not be included in the Census of Fatal Occupational Injuries and that the Survey of Occupational Injuries and Illnesses will not produce estimates specifically covering COVID-19 illnesses.”
   - What are the consequences?
   - What can Congress do to address the failure of the federal government to assess the impact of COVID-19 on workers?

4. As you may know, the American Rescue Plan Act included a presumption of causation for federal and postal workers who are in contact with the public, patients or co-workers and contract COVID-19.

In your view, is this a model that should be extended to other federal workers’ compensation laws, such as the Longshore and Harbor Workers Compensation Act?

Representative Ilhan Omar (D – MN)

1. I wanted to first give you the opportunity to briefly respond to the claims made from a few of my Republican colleagues that it’s impossible to determine whether an infection in a meatpacking plant or other similar workplaces are work-related?

Have states found a way to address this problem?
2. Given your experience at OSHA, I was also hoping to get your thoughts on an ETS. While I’m encouraged by the developments of a potential OSHA ETS, I think we can possibly agree that this is the type of action that should’ve happened much earlier. What should OSHA be doing now to be better prepared for the next pandemic?

3. Finally, I wanted to bring up the need for a better national vaccine strategy. This vaccine rollout has been very rapid and widely effective for certain populations, but there have been some access and equity issues with vaccine distribution due to differing policies from state-to-state. As of March 2nd, only 18 states are prioritizing shots for grocery workers and just 32 states are vaccinating teachers first. As a member of the Biden-Harris Transition COVID-19 Advisory Board, are you worried about the negative effects that this patchwork of local policies will have on worsening existing health disparities especially for people of color who are commonly in these frontline roles?

4. What are some early lessons that we can take from this pandemic to improve (racially) equitable vaccine allocation and distribution?
May 5, 2021

Attached please find my responses to the Questions for the Record submitted following the Workforce Protections Subcommittee Hearing “Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections” held Thursday, March 11, 2021.

David Michaels, PhD, MPH
davidmichaels@gmail.com
Chairwoman Alma S. Adams (D – NC)

1. Meat processing companies and others have contested the OSHA penalties they’ve received for failing to protect workers from COVID-19 because, they claim, before OSHA and CDC issued their joint guidance for the meat industry on April 26, there wasn’t possible way they could have known how to protect their employees.

Is their defense accurate?

No, it is not. The guidance issued by CDC and OSHA on precautions employers needed to implement to prevent virus spread were issued in early and mid-March 2020, more than a month earlier. Many hundreds of workers were infected between the issuance date of these documents and April 26. Many of these infections could have been prevented if the meat employers had followed those recommendations.

In addition, it is now clear that, as far back as 2006, government officials predicted that a pandemic could threaten critical businesses and warned them to prepare. Meatpacking companies largely ignored these warnings.¹

2. The Republicans assert that instead of an OSHA standard all the federal government needs to do to protect workers is to “focus on ensuring adequate vaccine supply and distribution to vaccinate all workers and providing timely public health guidance to our employers…” Do you think that vaccination and guidance are adequate to protect this nation’s workers?

No. There is compelling evidence work remains a major source of transmission of a deadly virus. Reports of work-related transmission, leading to community cases, continue to be reported on a regular basis by state Departments of Health. Here are a few examples:

Michigan: https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98177_102857--80.html

In addition, the most recent data from Maryland’s contact tracing efforts report that work outside the home is the most frequently identified risk location/activity reported by infected individuals: https://coronavirus.maryland.gov/pages/contact-tracing

These are just a few examples. Most states do not report these data, but it is reasonable to assume the increased risk of workplace transmission leading to additional community cases exists throughout the country.

At this moment in time, the nation is in crisis. It is, in fact, an emergency. We are seeing rapid spread of increasingly infectious virus variants. Governors are announcing that soon all density restrictions have or will be lifted, and some governors have dropped mask mandates all together.

It is apparent to me that while the success of the vaccination program to date is reducing transmission and risk, it is not adequate to assure the safety of workers at work, the mission of OSHA.

3. Your testimony states: “the Bureau of Labor Statistics has decided that COVID-19 deaths will not be included in the Census of Fatal Occupational Injuries and that the Survey of Occupational Injuries and Illnesses will not produce estimates specifically covering COVID-19 illnesses.”
   • What are the consequences?
   • What can Congress do to address the failure of the federal government to assess the impact of COVID-19 on workers?

While we know that very large numbers of workers have been sickened or killed by SARS-CoV-2, even in industries like healthcare or long-term care which have been the focus of national attention. We know even less about the impact of the pandemic other industries. Better data collection would help us better understand the impact of the pandemic on workers, as well as on employers and industries. This would be of importance in providing compensation payments to workers with occupational exposures, as well as provide vital information to help prepare for the next pandemic.

Congress could direct BLS to work with NIOSH to attempt to measure illnesses and deaths in selected industries and locations where data are available, as well as to develop a plan to ensure BLD is capable of collecting complete and accurate statistics on infectious disease should another pandemic occur.

4. As you may know, the American Rescue Plan Act included a presumption of causation for federal and postal workers who are in contact with the public, patients or co-workers and contract COVID-19.

In your view, is this a model that should be extended to other federal workers’ compensation laws, such as the Longshore and Harbor Workers Compensation Act?

Yes. Workers who risked their lives coming to work at the height of the pandemic, and as a result were not adequately protected from exposure, deserve compensation payments if they become sick.
Representative Ilhan Omar (D – MN)

1. I wanted to first give you the opportunity to briefly respond to the claims made from a few of my Republican colleagues that it’s impossible to determine whether an infection in a meatpacking plant or other similar workplaces are work-related.

Have states found a way to address this problem?

It is not uncommon for politicians and meatpacking executives to blame disease spread among meat workers on factors outside the plant, particularly in the home. For example, when the pork producer Smithfield Foods had to close its Sioux Falls, South Dakota plant after more than 1,000 workers were infected, South Dakota Governor Kristi Noem blamed the problem on the workers’ home lives, asserting “99% of what’s going on today wasn’t happening inside the facility.”

This is clearly incorrect. In many meatpacking plants, the large numbers of workers who have been sickened is powerful evidence of workplace transmission. In these cases, where hundreds of workers have been infected, workplace exposures are driving transmission in both workplaces and communities. It is difficult to prove if the exposure actually occurred at work. In some ways, that should not be significant, because the risk community exposures is highly elevated because of conditions in the meatpacking plant.

Contact tracing helps provide a window into the importance of meat plant exposures in spreading the disease in the workplace and then around the community. A powerful example of this is a contact tracing effort of the Nashville TN Department of health, as reported by The Tennessean. Here is an excerpt:

Without a doubt, the largest and most impacting coronavirus cluster in Nashville was at the Tyson Foods facility in Goodlettsville, a bone-white building on the edge of Interstate 65 where about 2,800 employees carve and pack beef and pork for grocery stores. At least 280 people were infected at the facility between March and May and a few more infections trailed in July. The facility is directly and indirectly linked to at least 280 more infections at 10 other clusters, according to the contact tracing data reviewed by The Tennessean.

Waller, the epidemiologist, described the Tyson outbreak as a “kickoff” for spreading the virus among essential workers. Once at the meatpacking facility, the virus spread through carpoolers and multi-generational homes to other job sites, she said.2

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More precise proof of the spread of the virus within a workplace can be accomplished through genomic sequencing – examining the exact mutations in the virus obtained from individual cases can enable investigators to determine the source of each person’s infection. This is expensive and rarely done. However, Dr. Parasie Kenny, a tumor geneticist, sequenced the virus found in workers at a meat plant in Pottsville, Iowa and residents of the area. According to the Washington Post:

Looking at the Postville cluster — more than two dozen yellow dots linked by three distinctive mutations — it was clear to Dr. Kenny what happened. The sub-strain started with a single case. But in the crowded conditions of the meat processing plant, it exploded.1

The virus spread depicted on the chart below is likely to be similar to those at other meatpacking plants. We know relatively little about the virus spread at other meatpacking facilities because the industry has generally unwilling to share any data about cases or transmission at their facilities.

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2. Given your experience at OSHA, I was also hoping to get your thoughts on ETS. While I’m encouraged by the developments of a potential OSHA ETS, I think we can possibly agree that this is the type of action that should’ve happened much earlier.

What should OSHA be doing now to be better prepared for the next pandemic?

OSHA and the federal government in general, must soon start serious preparations for the next pandemic. OSHA needs to issue standards that require employers to protect workers from pathogens that are airborne or spread by skin contact. For OSHA to be successful in promulgating this standard, the CDC formally acknowledges that both SARS-CoV-2 and influenza can be spread by exposure to aerosols, or tiny particles that have different aerodynamic properties than droplets. Failure of the CDC to do this has held back efforts to protect workers in healthcare and other industries.

3. Finally, I wanted to bring up the need for a better national vaccine strategy. This vaccine rollout has been very rapid and widely effective for certain populations, but there have been some access and equity issues with vaccine distribution due to differing policies from state-to-state. As of March 2nd, only 18 states are prioritizing shots for grocery workers and just 12 states are vaccinating teachers first. As a member of the Biden-Harris Transition COVID-19 Advisory Board, are you worried about the negative effects that this patchwork of local policies will have on worsening existing health disparities especially for people of color who are commonly in these frontline roles?

I am very much worried about inequitable vaccine distribution, which will likely exacerbate existing health disparities. I was a member of the National Academics’ expert panel that developed “A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus” and we raised our concerns about these issues last year, advising states to prepare to address these issues in their vaccination programs.5

4. What are some early lessons that we can take from this pandemic to improve (racially) equitable vaccine allocation and distribution?

Significant efforts and resources must be devoted to these efforts. These should be focused on alerting these communities, using culturally appropriate approaches and tools, of the availability and importance of the vaccination program, and physically going into these communities to educate and engage prioritized populations. In addition, substantial efforts must be made to make the vaccine accessible and convenient.

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Whereupon, at 12:48 p.m., the subcommittee was adjourned. [ ]