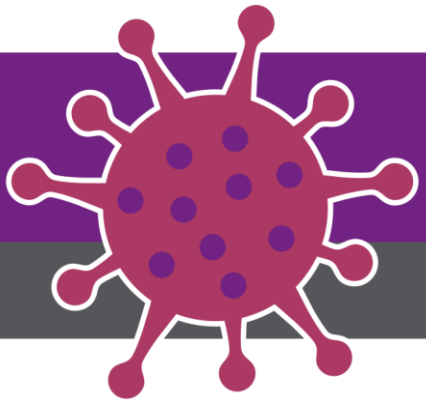
CORONAVIRUS DISEASE 2019
(COVID-19)

OSHA COVID-19 Emergency Temporary Standard (ETS)
Frequently Asked Questions (FAQs)



Trinity Health

Audience: All Colleagues
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COVID-19 Response Team Owner: Planning
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What's Changed: New Guidance

When developing any document (including a Preparedness and Notification Response Plan, Hazard Assessment, etc.), the Ministry needs to ensure that documents are compliant with State and Local regulations when those requirements are more restrictive.

Preparedness, Notification and Response Plan (PNRP) and Hazard Assessment (HA)	
Question	**Answer**
1. Which PNRP should I use?	The PNRP depends on your location's major line of business (e.g., if you have an administrative building on a hospital campus, you would use the Acute and Ambulatory Care PNRP).
2. Do I have to have a PNRP and HA for every clinic or other off-site location?	Yes, you need a PNRP for any location where we have colleagues. To the degree possible, we would recommend splitting up locations with separate PNRPs. You could list the ambulatory locations on one plan as long as you have any location specific information included in the PNRP and hazard assessment.
3. Does the PNRP apply to senior housing where no medical care is provided or Mission Health Ministries (MHMs)?	Yes, you need a PNRP for any location where we have colleagues. Except for application to any off-site healthcare support service locations (in this instance, use the Non-Clinical Administrative Settings PNRP), Continuing Care and our MHMs should use the Acute and Ambulatory Care PNRP.
4. How do I document participation of non-managerial and labor representatives in development and implementation of the PNRP and HA?	You are not required to document participation, however, there are typically communications that occur (e.g., small group meetings, emails, etc.) You should retain a copy of the group roster participating in this process.
5. Who is the primary owner of the PNRP at the Ministry to ensure it is implemented?	The Chief Human Resources Officer (CHRO) or a clear designee is responsible for ensuring the plan is completed and implemented. The CHRO needs the support and assistance of others from the Ministry COVID-19 Resources Team, infection

Preparedness, Notification and Response Plan (PNRP) and Hazard Assessment (HA)	
Question	**Answer**
	prevention, accreditation, colleague safety, employee/occupational health services, and others.
6. The PNRP requires a HA. Who is responsible for completing the HA and when does the HA need to be completed?	The HA should be completed by clear designees from each of the areas being assessed and must include non-managerial colleagues and labor representatives (if applicable). The HA must have been completed by July 6, 2021; this is an ongoing process, so the Ministry should continue to update plan and accompanying documents (Hazard Assessment, Job Task Inventory for Fixed Work Locations, and Well-Defined Area Checklist) as needed.
7. If we have completed a PNRP and/or HA previously, do I still need to complete the new PNRP and/or HA provided by System Office?	You need to compare your PNRP and HA to the documents provided by System Office to ensure your documents are in full compliance as the templates provided are based on the ETS, systemwide program standardization, and other considerations. If your plan and HA are cover the same requirements and are equally or more restrictive, then you do not need to complete the templates from System Office.
8. Where do we post the PNRP, HA, Mini Respiratory Protection Program (RPP), and other documents?	Post the PNRP, HA, and other documents except the Mini RPP on the Ministry intranet or equivalent so that it is available to all colleagues, but behind a public firewall. At this time, policies and procedures such as the Mini RPP should be located in the same space as other policies and procedures.

Well-Defined Area (WDA)	
Question	**Answer**
1. Does a WDA include: **a. Business office where the public might enter but usually cannot enter** **b. Education classroom** **c. Medical Records** **d. Office areas/spaces not directly involved in patient care (e.g., colleague department office, core laboratory)**	A WDA is a specific area where there is no reasonable expectation that any person with suspected or confirmed COVID–19 will be present. If the business office is restricted but there is still potential for the public to enter, there is a potential risk of exposure. The Ministry needs to determine the frequency of public access (e.g., if it is on rare occasion, it is reasonable to identify this as a WDA). This determination should be included in the HA. Medical Records offices, office areas, core laboratory areas, and other non-direct patient care spaces may have a similar exposure; it may be that the public has access to a small portion (such as a reception area), but that the rest of the area is restricted. In that scenario, the reception area would not be a WDA, but the remainder of the area could be a WDA (if determined through the HA).
2. If some colleagues are not vaccinated and other colleagues are vaccinated in an area that otherwise meets the definition of WDA, can the area still be considered a WDA?	Yes, however those who are not fully vaccinated and working in the WDA must wear a facemask, practice physical distancing, and physical barriers must be installed when physical distancing of at least 6 feet cannot be maintained.
3. Are physical distancing and physical barriers required in a WDA?	Yes, but only for colleagues who are not fully vaccinated**.**

Well-Defined Area (WDA)	
Question	**Answer**
4. If a fully vaccinated colleague is in a WDA, the colleague does not need to wear a facemask. Does the colleague need to wear a facemask when leaving the WDA (including when entering corridors not included in the WDA)?	Yes, if the colleague leaves the WDA and needs to travel through other areas of the Ministry (including common, shared spaces like a public corridor), the colleague must put on a facemask prior to leaving the WDA.
5. CDC recommendations for healthcare settings do not refer to WDAs. The CDC states that anyone (including colleagues, visitors, patients, etc.) entering a Ministry must wear a facemask. Are there spaces exempt from CDC recommendations for vaccinated colleagues similar to a WDA?	The CDC does not recognize areas as WDAs, but CDC guidance on infection prevention in response to vaccination does state that fully vaccinated healthcare personnel could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. CDC guidance documents are recommendations, but OSHA standards are regulatory requirements. However, the ETS states that the only time a colleague is not required to wear a facemask is while the colleague is eating and drinking alone at the workplace; if there is more than one colleague present, each colleague must be at least 6 feet away from any other person or separated from other people by a physical barrier. If this dining occurs in a WDA, and if the colleague is fully vaccinated, the colleague would not have to mask, practice physical distancing, or utilize physical barriers. The ETS takes precedence over CDC recommendations.

Physical Barriers and Physical Distancing	
Question	**Answer**
1. Do we need to install physical barriers at nursing stations?	No. The ETS states that physical barriers at fixed work locations are intended for spaces outside of direct patient care areas.
2. How do we determine whether barriers are feasible to install in fixed locations where colleagues cannot be separated by physical distancing?	The Ministry needs to determine and document why physical distancing of at least 6 feet is not feasible in fixed locations (e.g., lobby, reception area, etc.) and what alternative measures have been implemented. The Ministry must ensure the colleague is as far apart as feasible and implement layers of overlapping controls, including physical barriers, source control, hand hygiene, and ventilation. If a Ministry determines it is not feasible to install physical barriers, the Ministry must document why barriers are not feasible, and must document the additional protective measures being taken. Source controls (such as facemasks) are not a substitute for physical distancing. Both practices should be used together, where feasible, with other protective measures as part of a multi-layered infection prevention strategy. In rare situations where both physical distancing and physical barriers are not feasible, the Ministry should implement the remaining layers of overlapping controls, including enhancing PPE (e.g., facemasks or respirators, eye protection, etc.), hand hygiene, and ventilation. A fixed work location is different from a Well-Defined Area (WDA) because fixed work locations are in areas where there is some expectation of contact with patients/residents/clients outside of direct patient care. There is no reasonable expectation of contact with suspected or confirmed COVID-19 in a WDA.

Personal Protective Equipment (PPE) Including Aerosol Generating Procedures (AGPs)	
Question	**Answer**
1. Are we required to wear eye protection in these areas when caring for a patient who is COVID-19 negative or is otherwise not a Patient Under Investigation (PUI): **a. During a home care/hospice visit if we are not performing an AGP?** **b. When caring for patients/residents?** **c. When performing an AGP?**	The ETS only requires eye protection and other PPE like an N95 respirator, gown and gloves when caring for a PUI or those with acute COVID-19. Trinity Health's Infection Prevention and Control Guide however specifies that eye protection is required when within 6 feet or less of a patient, including those for whom COVID-19 is not suspected until the rate of infections in the health service area for the Ministry is at 10 active cases/100,000 population or less. Trinity Health's guides are based on CDC recommendations which OSHA ETS does cite as effective strategies for safe care. Therefore, for the scenarios in this question: a. Yes, eye protection is needed during a home care visit even if not providing an AGP until the rate of cases in the community is at 10 or less/100k population. b. Yes, this applies to care for all patients or residents until reaching the case rate threshold. c. For AGPs for any patient, N95 respirator and eye protection are required for AGPs for any patient until at or below the case rate threshold. If at or below this threshold use of respiratory and eye protection during AGP would be based on Standard and Transmission-based precautions.
2. What type of PPE are we required to wear when performing an AGP on a patient who is COVID-19 negative or is otherwise not a PUI?	PPE is based on the case rate of COVID-19 in the community. If this is at a moderate or higher level, the System PPE Guidebook specifies that an N95 respirator and eye protection be worn for AGP for all patients. A facemask is not enough. The level of PPE for AGP does change when rates are at a low level. When at this point the type of PPE is related to Standard and Transmission-based precautions.
3. Does OSHA require that we validate all PPE used?	No, however all PPE provided at our ministries undergoes due diligence by our Supply Chain leaders to assure it meets FDA and NIOSH specifications.
4. Do all colleagues in a healthcare services or healthcare support services setting need to wear a facemask, or is a facemask required only for colleagues providing direct patient care?	A facemask must be worn by all colleagues in healthcare ministries to provide source control and protection of the wearer once they enter the Ministry. The only exceptions would be when eating or drinking and, if the PNRP identifies WDA, for fully vaccinated colleagues in those areas.
5. When are gowns required as PPE?	When specified under Standard and Transmission-based precautions. PUIs and those with acute COVID-19 are to be on contact and droplet precautions, and gowns are a required part of contact precautions.

COVID-19 Exposure and Notification of Exposure	
Question	**Answer**
1. If a colleague refuses to be tested for COVID-19, how will it be determined that they can return to work?	The colleague must be removed from work for 14 days. Because the colleague refuses to be tested, the colleague will not be eligible for COVID-19 Pay and benefits from the date that the testing is refused.
2. Are we requiring that colleagues complete a COVID-19 test within an established number of	No, but a specimen for the initial test must be collected as soon as possible after close contact with someone with COVID-19 and repeated at least 5 days after the initial exposure. The timing of the subsequent test is dependent upon when the colleague notifies the Ministry of their exposure.

COVID-19 Exposure and Notification of Exposure	
Question	**Answer**
hours from the time the test is ordered?	
3. How do we administer a COVID-19 test to colleagues (e.g., employee/occupational health, independent pharmacy, etc.)?	Follow the established process that is in place at the Ministry. If you do not know how to get a colleague tested, reach out to your Ministry employee/occupational health department or equivalent, infection prevention, or your supervisor.
4. Respirators are not typically worn in the outpatient setting unless the patient is COVID-19 positive or is otherwise a PUI. If a patient was not a PUI at the time of care but later tests positive for COVID-19 and a colleague wore a facemask (not a respirator) and the patient also wore a facemask or face covering, is this considered an exposure?	The risk is low, however the ETS specifies that close contact means a colleague that spent a cumulative of 15 min. or more with the person with COVID-19 without wearing full PPE (i.e., N95 respirator, eye protection, gown and gloves) during the period the person with COVID-19 was potentially infectious. For this scenario, it depends on the time between the outpatient visit and diagnosis of COVID-19. If it was more than 2 days from time of exposure to time of diagnosis, the patient would not be considered infectious under the ETS. If it was 2 days or less, the patient would be considered potentially infectious. Since the colleague did not wear full PPE, the colleague meets the definition of close contact and must complete the exposure protocol including follow-up testing.
5. If a colleague gives verbal consent to release their name to other individuals that the colleague was diagnosed with COVID-19, can we release the name?	No, when notifying individuals that they had a potential exposure, the Ministry cannot include the employee's name, contact information (e.g., phone number, email address), or occupation**.**
6. How do we know whether the COVID-19 exposure or diagnosis is work-related or community-acquired during an outbreak?	The contact tracing and investigation process helps identify whether the case is work-related or community-acquired. If unsure, the case should be identified as work-related unless subsequent additional information determines otherwise. It is important to identify this as soon as possible to ensure we meet applicable OSHA reporting and recordkeeping requirements.

COVID-19 Pay Benefits	
Question	**Answer**
1. Will colleagues be required to use PTO to cover medical removal due to COVID-19?	Colleagues will not be required to use PTO for approved time off related to vaccination and vaccination side effects. A new code (COVID 19 VACCINE) will be available for managers and timekeepers to use for approved time off. An approved administrative leave of absence related to removal from work due to COVID-19 will be paid using the COVID-19 Pay code previously used by your Ministry (commonly known as Extreme Condition Pay or COVID-19 Pay).
2. If a colleague was removed from work prior to July 6, 2021, and the colleague used their PTO to cover time away, will	No, the new benefits are effective 7/6/21 and are not retroactive to any previous date.

COVID-19 Pay Benefits	
Question	**Answer**
the colleague be reimbursed for that PTO?	
3. Is the COVID-19 Pay going to be retroactive for: **a. Colleagues who were removed from work due to COVID-19 exposure or diagnosis prior to July 6, 2021?** **b. Colleagues who were removed from work as a result of vaccination side effects prior to July 6, 2021?**	No, the new benefits are effective 7/6/21 and are not retroactive to any previous date.
4. Does COVID-19 Pay coverage include a diagnosis of COVID-19 as a result of a community-acquired exposure?	Yes, depending on the circumstances. The colleague involved needs to work through the specific circumstances with EHS/HR at their Ministry.
5. Is there a maximum time limit for COVID-19 Pay for: **a. Vaccination or Vaccination Side Effects?** **b. COVID-19 work-related exposure or diagnosis?** **c. COVID-19 community-acquired exposure or diagnosis?**	a. If the colleague receives the vaccine during work hours, a maximum of 4 hours per vaccine dose would be available. In general, it is expected that COVID-19 pay for vaccine side effects would not exceed one to two scheduled shifts immediately following a COVID-19 vaccination. b. There is no duration limit for work-related exposure or diagnosis situations in the ETS, therefore Trinity Health guides are based on CDC recommendations. The colleague involved will work with their local team on specific timing of return to work. c. There is no duration limit for community-acquired exposure or diagnosis situations in the ETS, therefore Trinity Health guides are based on CDC recommendations.
d. How do we define licensed healthcare provider (e.g., MD, DO, etc.)?	This is determined by licenses issued by the agency in the state in which the health professional works for a range of occupations.
e. When a colleague is removed from work due to a COVID-19 diagnosis, who can provide a medical clearance for the colleague to return to work?	Our System guides are based on CDC recommendations. These include a process for timing on return to work. The colleague involved will work with the Ministry's employee/occupational health services team or equivalent, and Human Resources.
f. If there is a colleague-to-colleague work-related exposure to COVID-19, do we remove both colleagues from work?	Not necessarily. The contact tracing process should identify other colleagues in close contact; the exposure assessment tool will help determine actions needed for close contacts.

Vaccination Status	
Question	**Answer**
1. How are we assessing/tracking the vaccination status of a colleague?	Colleagues who have received the vaccine need to submit documentation of vaccination. -Colleagues who have received the vaccine need to submit documentation of vaccination in the HR4U portal and receive an approval. -Colleagues may also use forms available through HR4U to request an exemption/deferral from vaccine due to contraindication or for strongly held religious beliefs. -The vaccination is available at no charge, even if you do not have insurance. -If you are requesting an exemption/deferral from vaccine due to contraindication or for strongly held religious beliefs, visit the Trinity Health COVID-19 Vaccination Resources site for more details.
2. If a colleague voluntarily discloses their vaccination status: **a. Does it need to be documented that the colleague voluntarily disclosed?** **b. Can we provide visible means of identification (e.g., badge sticker, pin, etc.)?**	a. See question 1 above. It does not need to be documented that it was voluntarily disclosed. b. No, visible means of identifying vaccine status should not be used.
3. Does asking a colleague about vaccination status violate HIPAA?	No, this is not a HIPAA violation. Also, the Equal Employment Opportunity Commission indicates employers can ask about vaccination status to support a safe workplace. However, we want to use a vaccine verification process as other employment protections can be implicated depending on how a colleague is asked.

OSHA Recordkeeping, Severe Event Reporting (SER), and Workers' Compensation	
Question	**Answer**
1. If a colleague is diagnosed with community-acquired COVID-19 but may be covered under state-specific workers' compensation benefits, is this OSHA recordable?	OSHA recordability is separate from compensability under workers' compensation. See "Colleague Work-Related Incident Reporting Frequently Asked Questions" and "Workers' Compensation Frequently Asked Questions" for additional information.
2. If a former colleague was diagnosed with work-related COVID-19 but the person has since left the Ministry, we may not be informed of their death or hospitalization. How do we address this?	Your responsibility for reporting and recording work-related events encompasses reporting what you know. If you are not made aware of the fatality, hospitalization, or illness, you are not responsible for reporting. Upon being made aware of the event, you must proceed within the timelines identified.
3. Does a fatality or hospitalization as a result of complications that may not be directly related to COVID-19 need to be	This is determined on a case-by-case basis. We recommend consulting with Legal Services (Donelle Buratto) and Non-Clinical Loss Control/Insurance and Risk Management Services (Renée Patterson) if you are unsure.

OSHA Recordkeeping, Severe Event Reporting (SER), and Workers' Compensation	
Question	**Answer**
reported because the colleague had a previous diagnosis of COVID-19 (even if the fatality or hospitalization is not directly a result of COVID-19)?	
4. For states that report COVID-19 cases under the rebuttal, is the presumption for "work relatedness" for OSHA recordability and reportability reporting defined by whether the case was accepted by Trinity Health's Third Party Administrator?	OSHA recordability is separate from compensability under workers' compensation. See "Colleague Work-Related Incident Reporting Frequently Asked Questions" and "Workers' Compensation Frequently Asked Questions" for additional information.

Screening Colleagues, Patients, and Visitors	
Question	**Answer**
1. When a colleague enters the building to go to work, are they required to wear a facemask (or obtain one at the entry) and do they have to wear it while they are in transit to their non-clinical work area?	Yes, the facemask must be worn at all times unless eating or drinking or for those who are fully vaccinated and in a WDA.
2. Does screening include physically taking a temperature or subjective temperature monitoring?	Temperatures are taken either in person or using a device that identifies the colleague who has answered questions about any symptoms of COVID-19 or close contact with someone with COVID-19 prior to each assigned work shift.
3. When self-screening prior to reporting to work, does the colleague have to document self-screening?	The colleague needs to follow their Ministry's self-screening process.
4. If a Ministry is not using the text message system for screening prior to reporting to work, does the Ministry have to have someone screen colleagues at the entrance or can there be signage posted reminding colleagues that they must notify their supervisor if they meet criteria?	Colleagues who are not using the electronic application need to enter the Ministry through the main point of entry that visitors enter and are asked symptoms and exposure questions in person.

Screening Colleagues, Patients, and Visitors	
Question	**Answer**
5. We currently screen for a much wider group of symptoms in our colleague screening. Does this allow us to limit screening questions to temperature and loss of taste/smell?	No, the screening must include all symptoms that CDC has identified as those of possible COVID-19.

Mini Respiratory Protection Program (RPP) the non-COVID-19 full Respiratory Protection Program	
Question	**Answer**
1. Does the mini RPP apply to non-employed medical staff or other non-employed individuals such as contractors?	The Ministry must share its PNRP and associated documents with other employers, and other employers must share their documents with the Ministry. The Ministry is not responsible for ensuring non-employees comply with the Mini RPP (e.g., providing the notification in Appendix B of our Mini RPP), but it is in the Ministry's best interests to communicate with non-employees when the Ministry identifies a situation that could expose our colleagues or third parties to unsafe practices.
2. When can a colleague provide their own respirator instead of using one provided by Trinity Health?	A colleague can provide their own respirator under the Mini RPP whenever a facemask is required. The colleague must present their respirator, must receive the notification identified as Appendix B in the Trinity Health Mini RPP template, and must sign the acknowledgement. The Ministry should also confirm that the colleague's proposed respirator meets Trinity Health's requirements. A checklist is being included in the PPE Guidebook to provide guidance on Trinity Health requirements. Where a respirator is already required by Trinity Health, the colleague must follow the guidelines identified in the PPE Guidebook on the COVID-19 Resources Site because this use is covered under OSHA's non-COVID-19 full RPP (not the Mini RPP specific to the ETS).
3. When performing an Aerosol Generating Procedure (AGP), the Ministry must provide a respirator. Does that mean that a colleague cannot wear their own respirator in these instances?	Where a respirator is already required by Trinity Health, the colleague must follow the guidelines identified in the PPE Guidebook on the COVID-19 Resources Site because this use is covered under OSHA's non-COVID-19 full RPP (not the Mini RPP specific to the ETS).
4. When a colleague provides their own respirator instead of wearing a facemask, what are the requirements for fit testing that respirator?	Under the Mini RPP, a colleague must receive a notification from the Ministry that covers colleague responsibilities for using their own respirator voluntarily instead of wearing a facemask where a facemask is required. The Mini RPP exempts respirators from fit testing and medical evaluations when the use is voluntary. The colleague must maintain their respirator, follow the requirements in the Mini RPP, and must complete their own seal check.
5. If a colleague provides their own respirator instead of wearing a facemask, how do we: **a. Review the respirator to ensure it is compliant with Trinity**	The Ministry can establish a process for validating that the respirator meets Trinity Health's requirements and for providing the acknowledgment (Appendix B). A checklist is being included in the PPE Guidebook to provide guidance on Trinity Health requirements.

Mini Respiratory Protection Program (RPP) the non-COVID-19 full Respiratory Protection Program	
Question	**Answer**
Health-approved respirators? **b. Provide the colleague with the acknowledgement identified as Appendix B in the Mini RPP?**	
6. OSHA requires annual fit testing through their non-COVID-19 full RPP when a respirator is required for the job function being performed (e.g., in an Airborne Infection Isolation Room, etc.) In the event a colleague fails any part of the annual OSHA fit testing, is the colleague prohibited from working in the area(s) of care in which these provisions are applied?	No, the colleague is not initially prohibited from working in these areas where a respirator is required. If they cannot meet requirements for medical evaluation and/or fit testing, the next step is to provide them with a respirator that does not require fit testing or medical evaluation (e.g., loose fitting respirators).
7. Should we resume annual fit testing as required under the non-COVID-19 full RPP for all colleagues where we may have previously limited the fit testing process when respirators were in critical shortage during the pandemic?	Annual fit testing should be resumed if the Ministry has not yet done so. The following information is from the PPE Guidebook: The original exemption was only applicable to Powered Air Purifying Respirators (PAPRs) in times of critical supply shortages of fit-testing kits or solutions. A Ministry at that time had the option to consider foregoing fit-testing requirements for properly sized NIOSH-approved tight-fitting PAPRs for protection against COVID-19 as long as the Ministry complied with all other applicable requirements of the full RPP. When an N95 or better respirator is required AND when is not possible to fit test all affected workers due to a shortage of respirators or fit-testing supplies, a tight-fitting PAPR, without initial or annual fit-testing is categorized by OSHA as more protective than not using any respirator.

Airborne Infection Isolation Room (AIIR) and Ventilation Systems	
Question	**Answer**
1. If the Ministry has an AIIR on another nursing unit (not a unit that typically cares for COVID-19 patients), is it expected the COVID-19 positive patient is placed in that room?	There is a Trinity Health guide that instructs Ministry on appropriate bed placement for a PUI or a patient with acute COVID-19. When available these patients should be admitted to an AIIR. If there are a large number of cases needing admission, the Ministry should activate a dedicated cohort unit.
2. Our Department of Public Health suggested we scale back our temporary AIIRs that use portable negative air machines. Is this ok?	Yes. If incidence of cases of COVID-19 are decreasing the Ministry's pandemic response team can work with facilities manager to de-escalate use of temporary AIIRs that were brought online to respond to a surge of cases. The Facility manager can store the negative air machines in case a surge returns.

Cleaning, Disinfection, and Hand Hygiene	
Question	**Answer**
1. Does the alcohol-based hand sanitizer need to be readily available to patients and visitors throughout the Ministry?	Yes.

Training	
Question	**Answer**
1. Is there a deadline to complete all training?	Training must be complete by July 21, 2021.
2. If we completed the PNRP HealthStream training currently available: **a. Are colleagues required to complete the same training?** **b. Are there new training topics not previously covered?**	a. Colleagues will not have to retake the full prior training. However, due to new training requirements in the ETS and recent developments, Trinity Health is developing supplemental training that will be required. More information will be provided soon on how to complete this training prior to July 21, 2021. b. There are new topics, and we are expanding coverage of certain existing topics.
3. How do we provide interactive training?	Trinity Health is developing options for interactive training.