



COVID-19 Risk Mitigation and Planning Toolkit

As more transmissible variants of COVID-19 spread in the United States, a stepwise strategy for “calibrating” risk mitigation strategies are needed as regional case rates fluctuate and workplaces needed to adjust policies to match community case rates and workplace vaccination rates.

COVID-19 Vaccination and Testing ETS

As of November 4, 2021, there are currently no outstanding Variants of Concern that haven’t already been addressed. This Toolkit has been updated (November 04, 2021) to address OSHA’s most recent Emergency Temporary Standard, [COVID-19 Vaccination and Testing ETS](#).

At this time, the CDC has authorized of booster vaccines¹ for various populations, including those working in high-risk environments (which includes the food and agriculture industries). Employees are eligible to receive a booster shot based on the following criteria:

- *Pfizer-BioNTech or Moderna Vaccine*: Anyone >65 years old and/or >18 years old if working in a high-risk setting can receive a booster **at least 6 months** after their second dose.
- *Johnson & Johnson Vaccine*: Anyone >18 years old can receive a booster **at least 2 months** after the first dose.

Additionally, the Pfizer-BioNTech vaccine has been authorized for children and teenagers, aged 5 years and older². For employers who may employ teenagers, please consider this into the updated OSHA ETS.

Justification for the ETS

Through various studies throughout the COVID-19 pandemic, OSHA has determined that unvaccinated workers face heightened and “grave danger” from the SARS-CoV-2 virus; much more so than vaccinated individuals. OSHA also highlights that “this ETS is necessary to protect workers who remain unvaccinated through required regular testing, use of face coverings, and removal of infected employees from the workplace.” Additionally, mutations to the SARS-CoV-2 virus have also, in various instances, become more transmissible and increasingly replicable, leading to various Variants of Concerns (VoCs) that had greatly impacted unvaccinated populations (e.g. Delta variant throughout 2021). Additionally, SARS-CoV-2 has caused many preventable hospitalizations and deaths.

Throughout the pandemic, SARS-CoV-2 has been transmissible in workplaces, especially in those where protective preventive measures (including physical distancing, good ventilation, etc.) could not be consistently maintained. As the food and agriculture sectors are high-risk due to the nature of work involved

¹ COVID-19 Vaccine Booster Shots (October 27, 2021) <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html>

² COVID-19 Vaccines for Children and Teens (November 04, 2021) <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html>

(either for employees or when facing customers), the ETS seeks to address the risks for individuals in these work settings. Throughout the pandemic, cluster outbreaks associated with food and agricultural industry work settings have occurred³.

Emergency Temporary Standard Effective Dates

The effective date for the ETS is November 5, 2021, which is the date the ETS was published in the Federal Register. Although the ETS becomes effective immediately, employers are not required to comply with the requirements of the ETS until the compliance dates, as follows:

Requirement	30 days after publication	60 days after publication
Establish policy on vaccination (paragraph (d))	X	
Determine vaccination status of each employee, obtain acceptable proof of vaccination, maintain records and roster of vaccination status (paragraph (e))	X	
Provide support for employee vaccination (paragraph (f))	X	
Ensure employees who are not fully vaccinated are tested for COVID-19 at least weekly (if in the workplace at least once a week) or within 7 days before returning to work (if away from the workplace for a week or longer) (paragraph (g))		X
Require employees to promptly provide notice of positive COVID-19 test or COVID-19 diagnosis (paragraph (h))	X	
Remove any employee who received positive COVID-19 test or COVID-19 diagnosis (paragraph (h))	X	
Ensure employees who are not fully vaccinated wear face coverings when indoors or when occupying a vehicle with another person for work purposes (paragraph (i))	X	
Provide each employee information about the ETS; workplace policies and procedures; vaccination efficacy, safety and benefits; protections against retaliation and discrimination; and laws that provide for criminal penalties for knowingly supplying false documentation (paragraph (j))	X	
Report work-related COVID-19 fatalities to OSHA within 8 hours and work-related COVID-19 in-patient hospitalizations within 24 hours (paragraph (k))	X	
Make certain records available (paragraph (l))	X	

OSHA has also developed an [ETS Frequently Asked Questions](#) page; please find it [here](#).

The following document and Toolkit summarize TAG's current recommendations to its clients based on guidance from the WHO, ECDC, OSHA, and CDC. It is broadly targeted at, but not limited to, the foodservice and food manufacturing and supporting industries, covering various topics. These recommendations are designed to keep workers safe and healthy while reducing the risk of illness. This document is not intended to provide legal advice; it provides recommendations based on current scientific and public health recommendations and rationale. The user should consult with legal counsel familiar with the laws in the jurisdiction where the facility or facilities in question are located. This document will continue to be updated as the science regarding SARS-CoV-2 transmission and vaccine efficacy evolves.

³ <https://www.federalregister.gov/d/2021-23643/p-94>

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I. Occupational Safety and Health Administration's (OSHA) Emergency Temporary Status (ETS) for employers with 100 or more employees

On September 9, 2021, the White House announced a six-point "Path out of the Pandemic" that includes a mandate for employers with more than 100 employees to either mandate vaccines or offer weekly testing for their employees.

Resulting from this, OSHA has released its COVID-19 Vaccination and Testing ETS (on November 04, 2021). Briefly, the White House has announced that companies with a workforce of 100 or more persons (at the overall corporate or worksite level) starting **November 05, 2021**, must ensure their workforce is fully vaccinated by January 04, 2022 OR employers may also choose to "adopt a policy requiring employees to either get vaccinated or elect to undergo regular COVID-19 testing [while also wearing] a face covering at work in lieu of vaccination".

This ETS is being enacted to "protect unvaccinated workers from the risk of contracting COVID-19 at work", specifically in indoor conditions. The above guidance is not applicable towards employees who may be working in exclusively outdoor conditions as the risks for transmission/infection are lowered. Guidance for companies with less than 100 employees is still being evaluated.

This ETS supersedes and preempts any current state or local requirements banning or limiting "an employer's authority to require vaccination, face covering, or testing"⁴. However, States may submit their own plans to OSHA for review; these requirements must be as protective and effective as the current OSHA ETS. Therefore, until that occurs for the State by which a company is positioned, this ETS will take precedence.

Affected Employers (What is 100-or-more employees?)

When calculating the number of employees in your business, employers should count the number of individuals across the entirety of a business (at all locations, even those working-from-home), not simply the employees from one location (unless in a franchise-franchisee relationship, see below). Employees are characterized as both full-time and part-time employees. However, contractors do not count towards the number of employees working at a location. Therefore, this guidance is applicable to any company with 100 and more employees.

Temporary Employees:

- Temporary employees and seasonal workers that are directly hired by a company count towards the 100-person count.
- Temporary employees, specifically those provided by a "temp agency" are not counted towards the 100-employee count. Such individuals would not be covered by this guidance; however, it is imperative that you as an employer have an understanding and policy developed with "temp agencies" to ensure that such employees also comply with your business' policies (be that through mandated vaccinations OR through weekly testing/masking requirements).

⁴ ETS FAQs <https://www.osha.gov/coronavirus/ets2/faqs>

Franchise-Franchisee Employees: However, in franchise-franchisee relationships and situations, because of the individuality of a franchisee, the employees in a franchisee are counted as a separate entity than those at the franchisor.

Full-time Work-At-Home Employees: It is also important to note that employees who work-from-home, full-time do not have to abide by the ETS guidance as they are not interacting with others from their work (if they're only working from home); however, once such individuals to come into the office, they must abide by the guidance.

Unions: Unions are also covered under and must follow this guidance.

Coverage of 100-Employees

The number of employees calculated by a company, starting **Friday November 05, 2021** will be the standard for the employees within a company.

If a company has <100 employees on Friday November 05, 2021, they will not necessarily have to follow this ETS. However, if, at any point that same company hires and exceeds 100 employees, they will then begin to fall under this guidance. Similarly, if a company had at least 100 employees on November 05, 2021; but then lost employees to have an employee count less than 100, they **would still continue to be required to follow this guidance.**

What does "fully vaccinated" mean?

A fully vaccinated individual, as defined within these metrics are a person who is two (2) weeks post completing their primary vaccination with a COVID-19 vaccine, with "if applicable, at least the minimum recommended interval between doses in accordance with the approval, authorization, or listing that is: (i) approved or authorized for emergency use by the FDA; (ii) listed for emergency use by the World Health Organization (WHO); or (iii) administered as part of a clinical trial at a U.S. site". This also includes those who may have "mix-and-matched".

In this case, OSHA does not consider those who have been previously ill and may have developed "natural immunity" from antibodies from a previous inspection to be "fully vaccinated".

Templates for compliance with ETS

In order to comply with the ETS, OSHA has provided a "[Mandatory Vaccination Policy](#)" template for companies to use who prefer to move in the direction of mandatory COVID-19 vaccinations for its workforce. This template is adaptable with sections for employers to insert their company language and policies. OSHA encourages that employers who may implement a mandatory vaccination policy also "incorporating their policies and procedures for non-employees (e.g., visitors, customers) and for employees of other employers (e.g., contractor employees)." The "[Mandatory Vaccination Policy](#)" template can be downloaded [here](#).

In order to support companies to achieve compliance with the updated ETS, OSHA has provided a "[COVID-19 Vaccination, Testing and Face Covering Policy](#)" template so that companies can develop policies that provide employees with the choice of full COVID-19 vaccination or enacting regular COVID-19 testing and face covering use. This template is adaptable with sections for employers to insert their company language and policies. The "[Vaccination, Testing and Face Covering Policy](#)" template can be downloaded [here](#).

If you are requiring support with developing your policies and/or would like to discuss your policy prior to implementation, please contact TAG as we provide further support.

II. Two options for compliance

At this time, there are two options for compliance: (a) mandating vaccinations for the entire workforce; OR (b) allowing for unvaccinated employees to continue working by instilling mandatory testing and masking requirements. These two options are discussed below.

While it is likely that this ETS will face legal challenges, past precedent suggests that the rule requirements will stand until a final legal ruling is issued as OSHA is implementing these rules to address an immediate workplace hazard. With this new guidance, TAG recommends that companies make plans now for compliance with this ETS.

From the guidance, OSHA does not consider and will not consider previous natural infection as equivalent to vaccination.

Mandatory vaccination

An employer may decide that mandating vaccines for their workforce provides the most direct and long-term solution to reduce the risk of workplace transmission and demonstrate compliance with the anticipated ETS. An implemented Mandatory Vaccination Policy would dictate that all employees must be fully vaccinated, unless the employee falls into one of the following three counter-indications for not being vaccinated:

- Employee is medically unable to be vaccinated due to vaccine contraindications
- Employee “for whom medical necessity requires a delay in vaccination”
- Employee who is “legally entitled to a reasonable accommodation under federal civil rights laws because they have a disability or sincerely held religious beliefs, practices, or observances that conflict with the vaccination requirement”. For more information on this latter, please see section below on, Assessing disability and religious exemptions.

Similarly, there may be instances in which you might opt to provide different options for different aspects of the workforce (i.e. if a segment of the workforce interacts outwards frequently, you might mandate full vaccinations for such individuals while those who do not directly interact with customers may not necessarily need to be vaccinated, but then would require testing/masking for unvaccinated individuals).

The chart breaks down the pros and cons of implementing a Mandatory Vaccination Policy:

Mandating Employee Vaccinations	
Pros	Cons
Decreases the risk of workplace transmission and severe illness in employees.	May increase the likelihood that unvaccinated workers seek other employment options.
Removes the need for weekly testing.	Requires systems and processes to address disability and religious exemptions and reasonable accommodations for those exempt from vaccination.
Could allow all employees to work unmasked when community case rates meet the CDC definition of Low or Moderate.	If the definition of “fully vaccinated” changes in the future to include booster doses, then all non-exempt employees would need to receive an

additional dose for the employer to remain in compliance without testing.

A Mandatory Vaccination Policy must, at minimum, include the following information:

- Requirements for COVID-19 vaccination (including when vaccination must be completed by) and applicable exemptions
- Information on determining vaccination status and acceptable forms of proof of vaccination
- Information to support receiving a COVID-19 Vaccination, including paid time and sick leave as needed for vaccination purposes
- Notification of COVID-19 and removal from the workplace when COVID-19-positive employee(s) are identified (including how to return to work)
- COVID-19 testing (specific to those who are not fully unvaccinated)
- Usage guidelines for face coverings (specifically for those who are not fully vaccinated)

A template "[Mandatory Vaccination Policy](#)" template is available via OSHA's website and can be found [here](#).

Planning for vaccination tracking and testing

Asking an employee about their vaccination status

Relative to the Mandatory Vaccination Policy and other policies, employers must determine an employee's vaccination status by requiring proof of vaccination. While employers who implement mandatory vaccination policies will be required to collect proof of and verify vaccination status of employees, information on booster vaccinations do not need to be collected.

Documentation or other confirmation of vaccination provided by the employee to the employer is medical information about the employee and must be kept confidential.

Acceptable proofs of vaccination status include:

1. The record of immunization from a healthcare provider or pharmacy;
2. A copy of the COVID-19 Vaccination Record Card;
3. A copy of medical records documenting the vaccination;
4. A copy of immunization records from a public health, state, or tribal immunization information system; or
5. A copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) administering the vaccine(s).

The vaccination card should include the employee's name, the type of vaccine administered, the date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) that administered the vaccine.

If there are any missing pieces to documentation, an employee should either contact (a) their vaccination provider for a copy of the information; or (b) the health department from the state in which they obtained their vaccination(s).

Lost Vaccination Cards

In situations where an employee may have lost a vaccination card, OSHA has provided other ways for employers to verify an employee's verification status. Please find more information at [OSHA's ETS FAQs](#).

Assessing disability and religious exemptions

The EEOC allows for two types of exemptions from vaccination; disability (sometimes called medical) and religious exemptions.

An employee with a disability who does not get vaccinated for COVID-19 because of a disability must let the employer know that he or she needs an exemption from the requirement or a change at work, known as a reasonable accommodation. To request an accommodation, an individual does not need to mention the ADA or use the phrase "reasonable accommodation." The EEOC provides extensive guidance regarding disability related exemptions under Section K of its website, [What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws](#).

Section K.12 of the EEOC website provides guidance regarding religious exemptions. According to the EEOC, once an employer is on notice that an employee's sincerely held religious belief, practice, or observance prevents the employee from getting a COVID-19 vaccine, the employer must provide a reasonable accommodation unless it would pose an undue hardship. Employers also may receive religious accommodation requests from individuals who wish to wait until an alternative version or specific brand of COVID-19 vaccine is available to the employee. Such requests should be processed according to the same standards that apply to other accommodation requests.

EEOC guidance explains that the definition of religion is broad and protects beliefs, practices, and observances with which the employer may be unfamiliar. Therefore, the employer should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief, practice, or observance. However, if an employee requests a religious accommodation, and an employer is aware of facts that provide an objective basis for questioning either the religious nature or the sincerity of a particular belief, practice, or observance, the employer would be justified in requesting additional supporting information. See also 29 CFR 1605.

29 CFR 1605.1 states, "In most cases whether or not a practice or belief is religious is not at issue. However, in those cases in which the issue does exist, the Commission will define religious practices to include moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views. This standard was developed in *United States v. Seeger*, 380 U.S. 163 (1965) and *Welsh v. United States*, 398 U.S. 333 (1970). The Commission has consistently applied this standard in its decisions. The fact that no religious group espouses such beliefs or the fact that the religious group to which the individual professes to belong may not accept such belief will not determine whether the belief is a religious belief of the employee or prospective employee. The phrase "religious practice" as used in these Guidelines includes both religious observances and practices, as stated in section 701(j), [42 U.S.C. 2000e\(j\)](#)⁵.

If employees claim religious exemptions, employers should consider the following⁶:

- Presume a religious belief to be sincerely held, then be selective and cautious when requesting further verification and documentation.

⁵ <https://www.ecfr.gov/current/title-29/subtitle-B/chapter-XIV/part-1605/section-1605.1>

⁶ <https://www.venable.com/insights/publications/2021/06/employers-guide-to-the-religious-exemption>

- Be cognizant that religious beliefs are not static and are susceptible to change over the course of a person's life
- Remember that the fact that an individual is not a frequent observer of their faith or had not previously made their faith public does not necessarily limit its sincerity.

An accommodation does not have to be limited to what is requested by the employee. If the accommodation is legitimate and non-retaliatory, there is a wide range of potential accommodations at the employer's disposal. Should the employee elect not to accept the accommodation offered, and all other alternative accommodations would cause an undue burden, the employer can part ways with the employee.

TAG recommends that employers consult an employment attorney specializing in workplace exemptions and reasonable accommodations when considering either disability or religious exemption requests. A consistent, documented and transparent decision-making process reduces potential employer liability.

Implementing an Unvaccinated Employee & Testing Policy

If an employer chooses to forgo a Mandatory Vaccination policy and instead keep unvaccinated (or partially vaccinated) employees on-staff, the employer will be required to ensure that unvaccinated (or partially vaccinated) workers are (a) regularly tested for COVID-19 and (b) continue to wear face coverings. This is, most importantly, to protect unvaccinated employees and unvaccinated workers, while also protecting employees from becoming infected by unvaccinated individuals. This policy is applicable to unvaccinated and partially vaccinated employees who report to a workplace where others (coworkers or customers) are present. If this policy is followed and an employee works from home, exclusively, this employee does not necessitate testing/masking.

Following this policy:

- employers must ensure that unvaccinated employees are tested for COVID-19 at least once per week (minimum of every 7 days).
- Additionally, employers must require unvaccinated employees wear face coverings. While you may have implemented other preventive controls and safety precautions (i.e. physical barriers, physical distancing, etc.), these precautions are supplementary to and do not override the two necessary aspects of: (a) weekly testing of unvaccinated employees; (b) requisite masking of unvaccinated employees.

If an unvaccinated individual is very infrequently (i.e. once per month) coming to work where there are other individuals around, such an individual must be tested AND present negative test results within seven (7) days of coming to the workplace. An unvaccinated employee and untested employee MUST NOT come to work without proof of a negative COVID-19 test; simply wearing a face covering is not enough.

Individuals who are not yet fully vaccinated (which includes waiting two weeks post the last dose of their vaccination) must continue to be tested on a weekly basis until they become fully vaccinated (see definition above).

Additionally, testing results of unvaccinated employees are to be maintained by the employer. This information is considered medical information and must be maintained as such; information and results may not be disclosed. Such records should be kept for as long as the ETS remains in effect.

Testing unvaccinated or partially vaccinated employees

If an employer chooses to forgo mandatory vaccination and instead opt for a testing/masking policy, OSHA has determined that it is **not** the responsibility of the employer to pay for an unvaccinated employee's COVID-19 testing as "the agency does not believe it appropriate to impose the costs of testing on an employer where an employee has made an individual choice to pursue a less protective option". Similarly, employers of individuals who refuse to be vaccinated are not required to pay for face coverings for said employees.

OSHA ETS allows for both diagnostic PCR/molecular-based and antigen COVID-19 testing, despite antigen testing's diminished sensitivities in identifying asymptomatic people compared to a molecular test. Under the ETS, a "COVID-19 test" must be a test for SARS-CoV-2 that is:

- cleared, approved, or authorized, including in an Emergency Use Authorization (EUA), by the U.S. Food and Drug Administration (FDA) to detect current infection with the SARS-CoV-2 virus (e.g., a viral test);
- administered in accordance with the authorized instructions; and
- not both self-administered and self-read unless observed by the employer or an authorized telehealth proctor.
 - This means that an over-the-counter COVID-19 test is allowable; however, an employee may not self-administer or self-read the test and results unless the employer or an authorized telehealth individuals is present.

Note: Antibody tests **are not** covered nor allowed as part of testing requirements. For further information on the various tests available, please see TAG's COVID-19 Toolkit v5.0.

Employer-provided testing

If an employer does continue to opt to offer testing to its unvaccinated employees, there are several important logistical questions:

- Will the company conduct testing itself or contract with an outside provider?
- Will the testing be conducted onsite as employees arrive at work, or offsite prior to arrival?
- What type of test will be used (PCR or antigen) and what is the time to result?
- Will the employer receive the test results at the same time as the employee?
- If only the employee receives the results, how will the employer verify the result and how will the employee report a positive or negative result?
- What is the policy if an employee misses their scheduled weekly testing or fails to report a result?
- What contact tracing resources does the company have if there is delay between the test and receipt of results?

These questions demonstrate the complexity of setting up and maintaining a workplace testing program.

Tracking employee vaccination status and weekly testing

Vaccine tracking and weekly testing	
Pros	Cons
Decreases the risk of workplace transmission by testing unvaccinated workers on a recurring basis.	Unclear how long testing will be required or the availability of testing. Testing results must be reported to the local or state health departments and accurate data management is needed.

Doesn't mandate employee vaccinations and removes the need to track and manage disability or religious exemptions and requests.	Cost associated with employee testing. If an employee requires the employee to pay for testing, this may result in increased employee turnover.
Could allow all employees to work unmasked when community case rates meet the CDC definition of Low or Moderate.	Need to regularly track who has been tested and who hasn't and at what frequency. Need to develop policies and procedures to address employees who miss testing or fail to report results.
Reduces likelihood that unvaccinated workers will seek other employment opportunities unless employee-borne testing costs are significant.	Vaccinated employees may consider moving to a "fully vaccinated" workplace or request accommodation if they feel uncomfortable working in a mixed vaccination population.

Recommended testing approaches

Based on TAG's experience working with several companies and testing providers, we believe that either pooled PCR testing or onsite antigen testing (while under observation by employer or authorized telehealth proctor) provides the most sustainable and cost-effective approach to testing for most employers. The following table describes the pros and cons of both platforms.

Test Type:	Pros	Cons
Rapid Antigen (Abbott BinaxNOW, Quidel QuickVue)	<ul style="list-style-type: none"> - Quick time to result - Doesn't require a reader - Relatively inexpensive - Can be self-administered and self-read (with proper training and a CLIA waiver) 	<ul style="list-style-type: none"> - Lower sensitivity (false negative rate) in asymptomatic cases compared to molecular tests - Availability may be limited in Fall and Winter 2021-22
Pooled PCR Testing	<ul style="list-style-type: none"> - Relatively inexpensive for a molecular test - Highly sensitive and specific (few false positives or negatives) - Sample can be collected at home and pooled at work 	<ul style="list-style-type: none"> - Data management can be cumbersome - Must be administered by a third-party - Shipping and analysis time - 24 to 96 hours for results - The time between sample collection and results can create close-contacts at work and home that should be tested or quarantine (depending on vaccine status)

When considering a testing program or approach, TAG can assist in evaluating the pros and cons for particular facilities or locations based on current vaccination rates and test availability.

For a full list of COVID-19 tests that have received an EUA:

- [Antigen tests](#)
- [Molecular tests](#)
- [Serology/antibody tests](#) (these are not allowed to be used as part of the ETS)

Testing Individuals Who Previously Tested Positive for COVID-19

Because it is possible for employees who have tested positive for COVID-19 to continue to test positive for COVID-19 (even if they are no longer infectious), the employee does not have to "undergo COVID-19 testing for 90 days following the date of their positive test or diagnosis". However, the unvaccinated employee must continue to wear a face mask upon returning to work.

Planning for Employee Vaccinations

In accordance with the ETS and to support vaccinations, regardless of policy followed, employers will be required to provide (for each vaccination during work hours):

- Up to four (4) hours of paid time during work hours and
- Reasonable paid sick leave time

As needed to support vaccinations throughout their workforce. This may include one or two vaccination doses; the above applies to all doses needed. The above two points are also applicable for employers who decide to do on-site vaccinations at the workplace. **Employers may not ask employees to use their own personal time or sick leave to get vaccinated.**

However, if employees do experience side effects related to their vaccinations, employers can allow employees to use paid sick time or leave to recover. This time **must** be paid. If an employee is vaccinated outside of work hours, you as an employer must still provide reasonable paid sick leave time for the employee to recover.

Despite this, in order to encourage vaccinations and to build trust and support amongst one's workforce, TAG does not recommend that employers require employees take personal time to recover from side effects. Instead, TAG recommends that this recovery time (sick time) be implemented to support employees' recovery.

III. Positive COVID-19 Cases, close-contacts, and quarantine

Any employee (vaccinated or unvaccinated) that tests positive for COVID-19 must be removed from the workplace, immediately. The employee may not return to work until the employee:

- receives a negative result on a COVID-19 nucleic acid amplification test (NAAT) following a positive result on a COVID-19 antigen test if the employee chooses to seek a NAAT test for confirmatory testing (AKA: if an employee tested positive on an antigen test, they should rest with a molecular test, for which if they are negative on said test, they may return to work);
- meets the return to work criteria in CDC's "Isolation Guidance", including:
 - Isolating for 10 days since the onset of symptoms (onset day is Day 0), while also
 - Being 24 hours without a fever without using fever-reducing medication, and
 - Having improved COVID-19 symptoms OR
- receives a recommendation to return to work from a licensed healthcare provider.

General CDC guidance recommends that fully vaccinated people do not need to quarantine if they are a close-contact of a known COVID case⁷. The CDC also recommends that someone who is a vaccinated close-contact should wear a mask and be tested 3-5 days after their most recent exposure to known COVID case. They may discontinue masking if they receive a negative test after 3-5 days. The following are some hypothetical scenarios where an employer may want to take additional protective actions to reduce the risk of workplace transmission.

Scenario	CDC or OSHA Recommendation	Additional considerations
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⁷ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html>
www.AchesonGroup.com info@AchesonGroup.com

<p>Scenario 1 - An unvaccinated (or partially vaccinated) employee is exposed to a fully vaccinated coworker who has just tested positive for COVID.</p>	<p>The positive fully vaccinated employee should isolate for 10 days from the date of the positive test or symptom onset.</p> <p>The unvaccinated employee should quarantine for at least 7 days (if testing out of quarantine)</p>	<p>Consider testing the unvaccinated as soon as they're identified as a close-contact.</p> <p>They may test positive before they're symptomatic. Testing early allows for additional close-contacts to be identified and stops the chance of workplace transmission.</p>
<p>Scenario 2 - An unvaccinated (or partially vaccinated) employee is exposed to a COVID-19 positive individual.</p>	<p>According to OSHA's ETS, the unvaccinated individual does not need to quarantine unless they themselves test positive for COVID-19. However, see, Scenario 1 above (re: CDC's Recommendations).</p>	<p>Consider testing the unvaccinated as soon as they're identified as a close-contact.</p> <p>Unvaccinated employee should quarantine for at least 7 days (if testing out of quarantine) as they may test positive before they're symptomatic. Testing early allows for additional close contacts to be identified and stops the chance of workplace transmission.</p>
<p>Scenario 3 - A fully vaccinated employee is a close-contact of a confirmed COVID case in the workplace.</p>	<p>The positive fully vaccinated employee should isolate for 10 days from the date of the positive test or symptom onset.</p> <p>The fully vaccinated close contact employee can continue to work while masking and should be tested 3-5 days after their exposure.</p>	<p>Consider having the fully vaccinated close contact wear an N95, KN95, KF94, or similar mask to reduce the risk of workplace transmission until they can be tested.</p> <p>The fully vaccinated close contact could also be tested as soon as they're identified as a close contact and again between Day 3 and 5. Testing a close contact more than once reduces the risk of workplace transmission. Either a rapid antigen or molecular test can be used.</p>
<p>Scenario 4 - A fully vaccinated employee lives at home with a household member who has tested positive and is a confirmed COVID case (this household member could be either vaccinated or unvaccinated)</p>	<p>The fully vaccinated close contact employee can continue to work while masking and should be tested 3-5 days after their exposure.</p>	<p>Because the employee's close contact is a household member, the risk of infection is higher. Consider testing the employee more frequently than CDC guidance (once every 2-3 days starting from the time they're a known close contact) OR have the fully vaccinated quarantine until their household member is released from isolation and test</p>

		the employee before they return to work. If the employee develops symptoms they should be tested and isolated immediately.
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IV. Framework for managing a mixed-vaccination workforce

Calibrating Risk Control Measures based on Vaccination, Case, and Test Positivity Rates

As case rates and positivity rates fluctuate nationally, the table below describes the “Levels” of risk reduction measures dependent on current outbreak variables (case and test positivity rates) and **workforce** vaccination rates. The case-rate and test-positivity thresholds are lower than they would be for a largely susceptible population because we expect to see case rates decrease as vaccination rates increase. This results in an updated definition of what represents community spread based on case rates. For example, high community spread levels in a susceptible population were characterized by daily case rates of 14-25 cases per 100,000 people. However, in an increasingly vaccinated population, high community spread levels could be redefined as ten or more (≥ 14) cases per 100,000 people because fewer people are susceptible to infection.

The primary measures of interest are case rate and vaccination rate. However, the test-positive rate is informative for indicating if there is adequate testing capacity in a jurisdiction. Test-positive rates greater than 10% suggest that the case rate is likely an underestimate of the true incidence of infection in the population.

	Percentage of Employees Fully Vaccinated		
		Mixed Vaccinated Workforce (<85% Fully Vaccinated)	Highly Vaccinated Workforce (>85% Fully Vaccinated)
Average Daily Community (City, County, State) Case Rate and Test Positive Rate (for at least one week as rates are rising and at least two weeks as rates are declining)	High (≥ 14 cases per 100K or $\geq 10\%$ test positive rate)	Level 4 - Masking for all employees and other control measures	Level 3 - Masking for all employees and other control measures
	Substantial (8-14 cases per 100K or $\geq 8\%$ test positive rate)	Level 3 - Masking for all employees and other control measures	Level 2 - Masking for all employees
	Moderate (< 8 cases per 100K and/or $< 8\%$ test positive rate)	Level 2 - Masking for all employees	Level 1 - Masking for all employees until more information on the Delta variant is available

Levels of Risk Mitigation "Calibration"

All Levels of risk mitigation "calibration" or reduction must be done in compliance with state and local requirements. Risk mitigation measures required by public health authorities should not be changed or removed unless or until allowed in the applicable jurisdiction. State and local requirements should always take precedence when dialing back risk mitigation measures.

Level 4- High Risk of Transmission - community case rates are sufficiently high to increase the risk of workplace transmission

- Masking of all employees (vaccinated and unvaccinated is recommended)
- Maintain all current risk mitigation programs. These typically include but are not limited to (see OSHA guidance measures below as well):
 - Workplace de-densification with staggered shifts and telecommuting
 - Physical distancing
 - Mask usage
 - Employee illness monitoring and surveillance
 - Improved ventilation and air purification
 - Employee testing programs
 - Limiting access to non-essential areas such as gyms, etc.
- Fully vaccinated employees do not need to quarantine if they are close contacts of a known or suspected COVID-19 case. However, if employees experience symptoms, they should quarantine until they are tested using an antigen or PCR test. Fully-vaccinated employees should continue to follow all other risk mitigation requirements at work.

Level 3 - Substantial Risk of Workplace Transmission

- Masking of all employees (vaccinated and unvaccinated is recommended)
- Relaxing of other Level 4 risk control measures can be considered

Level 2 - Moderate Risk of Workplace Transmission for Vaccinated Employees

- Continued masking of all employees (vaccinated and unvaccinated is recommended)

Level 1 - Easing temporary ventilation, physical distancing, and face coverings

- Masking may be relaxed if vaccination rates in a workplace exceed 85% and daily average community case rates are less than 8 per 100K
- Continue employee illness monitoring - no symptomatic employees allowed on site without prior approval (allergies, symptoms that are side effects of medications, etc.)
- Improvements made to ventilation and air handling/treatment systems
- Continue hybrid work models to accommodate for absenteeism due to school or daycare closures

Workplace testing

In addition to the required OSHA ETS testing, several relevant testing use-cases can be considered for additional risk-management and control:

- ❑ **Randomized surveillance testing:** randomly testing employees (both vaccinated and unvaccinated, depending on vaccination rates) regularly
- ❑ **Targeted testing:** Testing employees that cannot regularly physically distance or have higher-risk interactions
- ❑ **Assurance testing:** Testing all employees regularly (until at least 85% of employees are vaccinated)
 - Once 85% of employees (or a community) are vaccinated, only unvaccinated employees could be tested to monitor for asymptomatic or presymptomatic infections in the workforce.
- ❑ **Close-contact testing:** Testing of vaccinated employees who have been exposed to a confirmed case of COVID-19. Fully vaccinated persons do not need to quarantine and should be tested 3-5 days after their last exposure.

For some testing use-cases, the frequency of testing can be determined based on the testing platform.

An ongoing hierarchy of controls based on OSHA's updated COVID-19 guidance

As cases decrease and the CDC, state, and local jurisdictions relax control measures, the United States is entering a new post-pandemic "normal." With less than 60% of the population fully vaccinated, COVID-19 will remain in circulation in the U.S. for the foreseeable future. On June 10, 2021, the Department of Labor and the Occupational Safety and Health Administration (OSHA) published updated guidance for workers and employers on mitigating and preventing the spread of COVID-19 in the workplace⁸.

Hierarchy of Workplace Health Controls for Respiratory Illnesses including COVID-19

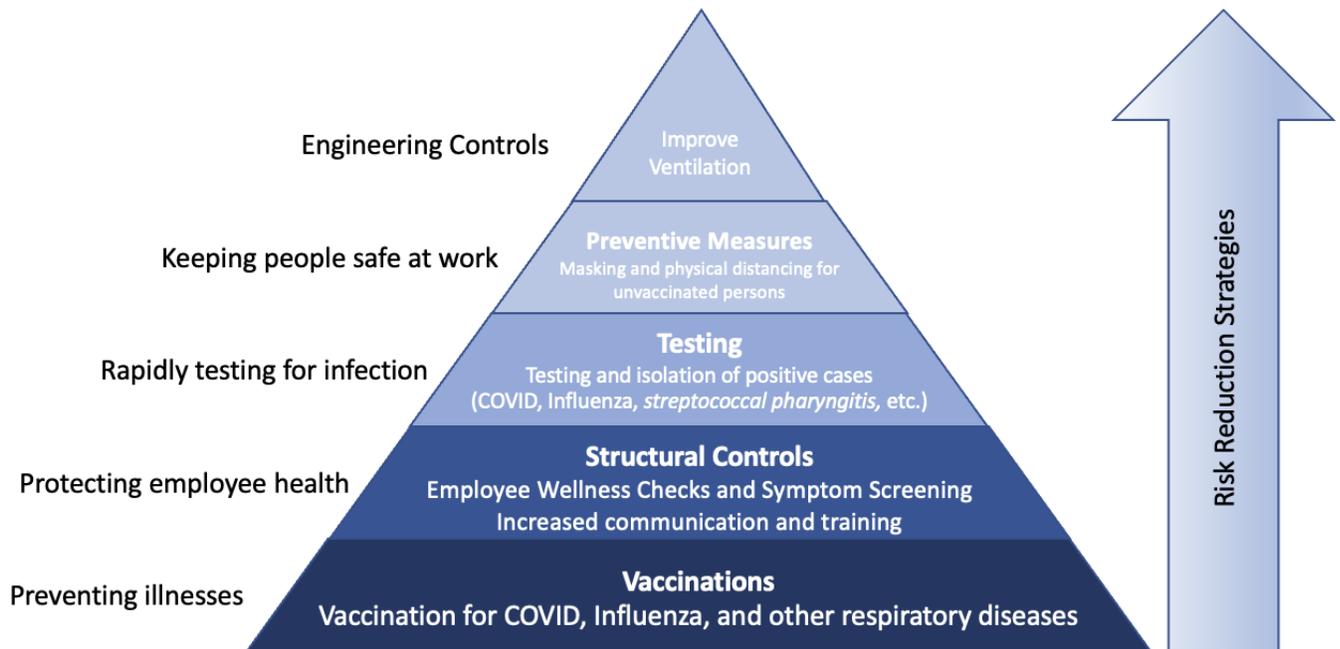


Figure 1. Hierarchy of Controls for COVID-19 and other respiratory illnesses in the Post-Pandemic "New Normal" based on OSHA Guidance

This approach considers the following:

1. Vaccination for COVID, influenza, and other respiratory diseases: The greater proportion of the population that is vaccinated, the lower the risk of transmission and illness in that population. Ongoing vaccination campaigns can reduce the likelihood of symptomatic illnesses, leading therefore to a decreased need for testing and isolation.
2. Screening for respiratory symptoms:
 - People who are actively symptomatic with COVID-like symptoms should be screened and sent for testing.
 - People who are actively symptomatic should **not** be in public or in the workplace until they are tested, and a definitive diagnosis can be made.
 - If someone tests positive for COVID-19, **unvaccinated close-contacts** should quarantine per CDC guidance⁹.
3. Testing and isolation of positive cases: people testing positive for COVID-19 and other respiratory illnesses should isolate until their symptoms resolve and they are no longer infectious.

⁸ <https://www.osha.gov/coronavirus/safework>

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html>

4. Masking: per OSHA guidance, unvaccinated workers should **continue** to mask and physically distance (remain at least 6-feet apart) whenever possible.
5. Ventilation: ongoing capital investments in ventilation and air handling systems can further reduce the risk of communicable (infectious) disease transmission in indoor spaces.

OSHA Measures Appropriate for Higher-Risk Workplaces with Mixed-Vaccination Status Workers

A new COVID-19 worker protection publication issued by OSHA on June 10, 2021, provides further guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace. In the guidance's Appendix, OSHA addresses Measures Appropriate for Higher-Risk Workplaces with Mixed-Vaccination Status Workers. These measures apply to all higher-risk workplaces, including "manufacturing, meat and poultry processing, high-volume retail and grocery, and seafood processing," **focusing on where there are any unvaccinated** or otherwise at-risk workers.

OSHA has issued the publication as guidance, and the measures are not technically requirements. The guidance calls for businesses to differentiate between vaccinated and unvaccinated employees. However, a lack of implementation may put a business at risk of legal liability should an outbreak or work-related transmission occur in a facility.

OSHA has provided specific guidance to "higher-risk" workplaces which include food manufacturing, groceries, and restaurants. According to OSHA:

In these types of higher-risk workplaces - which include manufacturing, meat and poultry processing, high-volume retail and grocery, and seafood processing - this Appendix provides best practices to protect unvaccinated or otherwise at-risk workers. Please note that these recommendations are *in addition to* those in the general precautions described above, including isolation of infected or possibly infected workers and other precautions.

In all higher-risk workplaces where there are unvaccinated or otherwise at-risk workers:

- Stagger break times in these generally high-population workplaces, or provide temporary break areas and restrooms to avoid groups of unvaccinated or otherwise at-risk workers congregating during breaks. Unvaccinated or otherwise at-risk workers should maintain at least 6 feet of distance from others at all times, including on breaks.
- Stagger workers' arrival and departure times to avoid congregations of unvaccinated or otherwise at-risk in parking areas, locker rooms, and near time clocks.
- Provide visual cues (e.g., floor markings, signs) as a reminder to maintain physical distancing.
- Implement strategies (tailored to your workplace) to improve ventilation that protects workers as outlined in CDC's Ventilation in Buildings and in the OSHA Alert: COVID-19 Guidance on Ventilation in the Workplace.

In workplaces (or well-defined work areas) with processing or assembly lines where there are unvaccinated or otherwise at-risk workers:

- Working on food processing or assembly lines can result in virus exposure because these workplaces have often been designed for a number of workers to stand next to or across from each other to maximize productivity. Proper spacing of unvaccinated or otherwise at-risk

workers (or, if not possible, appropriate use of barriers) can help reduce the risks for such workers.

In retail workplaces (or well-defined work areas within retail) where there are unvaccinated or otherwise at-risk workers:

- Suggest masks for unvaccinated (or unknown-status) customers and other visitors.
- Consider means for physical distancing from other people who are not known to be fully vaccinated. If distancing is not possible, consider the use of barriers between work stations used by unvaccinated or otherwise at-risk workers and the locations customers will stand, with pass-through openings at the bottom, if possible.
- Move the electronic payment terminal/credit card reader farther away from any unvaccinated or otherwise at-risk workers in order to increase the distance between customers and such workers, if possible.
- Shift primary stocking activities of unvaccinated or otherwise at-risk workers to off-peak or after hours when possible to reduce contact between unvaccinated or otherwise at-risk workers and customers.

Unvaccinated and otherwise at-risk workers are also at risk when traveling to and from work in employer-provided buses and vans.

- Notify unvaccinated and otherwise at-risk workers of this risk and, to the extent feasible, help them limit the number of such workers in one vehicle.
- Make sure all unvaccinated and otherwise at-risk workers sharing a vehicle are wearing appropriate face coverings.

V. Ventilation

As of May 7, 2021, the CDC has updated its reflection of the “current knowledge about [modes of] SARS-CoV-2 transmission” to be characterized through the “inhalation of the virus,” making SARS-CoV-2 an airborne virus. Transmission occurs through exposure to “infectious respiratory fluids.” Ultimately, the CDC declares there are three principal ways of transmission:

1. inhalation of very fine respiratory droplets and aerosol particles;
2. deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye by direct splashes and sprays; and
3. touching mucous membranes with hands that have been soiled either directly by virus-containing respiratory fluids or indirectly by touching surfaces with the virus on them.

Additionally, previously discussed, COVID-19 infection risk varies by the number of viral particles a person is exposed to, which can be influenced by multiple factors (including humidity, sunlight, temperature, the mass of particles, volume of particles, etc.). However, the CDC also highlights that it is possible to transmit (and become infected) the virus “in the air farther than six feet” away from the infectious source.

As has been discussed in TAG’s COVID Toolkit, factors that can increase the risk of infection include:

- Being in an enclosed space without adequate ventilation or air handling since aerosolized particles can build up in the air space.

- Increased inhalation of respiratory fluids if a person is engaged in an activity requiring exertion or louder voice (projecting of the rate or speed of particles like through coughing, sneezing, speaking, sneezing)
- Being exposed for a longer period of time ($t > 15$ minutes).

A recent research study, published in the *Proceedings of the National Academy of Sciences of the United States of America*, title "[A guideline to limit indoor airborne transmission of COVID-19](#)," provides a model for understanding and measuring the risk of transmission and what can be done to decrease risk indoors.

The researchers postulate that an infectious dose of SARS-CoV-2 is about ten aerosol-borne virions. Overall findings reveal that the risk of transmission can be reduced in large rooms with high air exchange. However, the use of air filtration was still not as important of a factor as wearing a face mask. The use of face coverings (and face masks) can continue to reduce the risk of transmission dramatically; however, activities (in a room) that do involve increased respiratory activities (loud talking, physical activity, etc.) can also increase the risk of transmission. The researchers illustrate their findings to (a) estimate maximum occupancy and (b) exposure time in two scenarios/case studies, assuming that those within the room are "engaged in relatively mild respiratory activities like quiet speech or rest."

In a situation in which there are about 20 individuals who may be interacting with one another in a singular space (and at "resting respiration"), the "safe time after an infection individual enters the room (for normal occupancy and without masks/face-coverings) is 1.2 hours for natural ventilation and 7.2 hours with mechanical ventilation". However, if a mask is used, the safe time increases to 8 hours and 80 hours, respectively. In such a situation, even with a 'normal' 6-hour day, as long as masks are worn and adequate ventilation is used, transmission would be decreased. If higher respiratory activities are done, the "safe" time limit will decrease.

OSHA also shares these resources on improving indoor air ventilation:

The virus that causes COVID-19 spreads between people more readily indoors than outdoors. Improving ventilation is a key engineering control that can be used as part of a layered strategy to reduce the concentration of viral particles in indoor air and the risk of virus transmission to unvaccinated workers in particular. Some measures to improve ventilation are discussed in [CDC's Ventilation in Buildings](#) and in the [OSHA Alert: COVID-19 Guidance on Ventilation in the Workplace](#). These recommendations are based on ASHRAE [Guidance for Building Operations During the COVID-19 Pandemic](#). Adequate ventilation will protect all people in a closed space. Key measures include ensuring the HVAC system(s) is operating in accordance with the manufacturer's instructions and design specifications, conducting all regularly scheduled inspections and maintenance procedures, maximizing the amount of outside air supplied, installing air filters with a [Minimum Efficiency Reporting Value \(MERV\) 13](#) or higher where feasible, maximizing natural ventilation in buildings without HVAC systems by opening windows or doors, when conditions allow (if that does not pose a safety risk), and considering the use of portable air cleaners with High-Efficiency Particulate Air (HEPA) filters in spaces with high occupancy or limited ventilation.