



AMERICAN SOCIETY OF
SAFETY PROFESSIONALS

ASSP Coronavirus Ask the Expert Q&A Session With Deborah Roy, M.P.H., RN, CSP

March 18, 2020 | Edited Transcript

Please note: The information shared in our session, slides and transcript is based on the data that were available from trusted sources and the phase of response to the COVID-19 pandemic in the U.S. on March 18, 2020.

As the situation continues to change rapidly, please refer to the current guidance from your local or state public health organization.

Tim Fisher

This is Tim Fisher with the American Society of Safety Professionals. Thank you for being here today on our webinar that is going to deal with the coronavirus or COVID-19.

Our speaker is Deborah Roy who has extensive experience in this area. I'll give you a little bit of a breakdown on her background and why we think this is really going to be an interesting presentation. We want this to be informal question-and-answer session. So that's an important thing. We're going to have a resource list in the [PowerPoint presentation](#).

Our emphasis is to present this issue from the occupational safety and health professional's perspective. It's not meant to be a medical research and/or intervention discussion. So that's the important thing to remember. We're trying to look for practical things that you as an OSH professional can do in your workplace when dealing with COVID-19. We'll get into some questions and answer, we'll have some final comments.

Let me introduce Deb Roy. Deb is president of SafeTech Consultants Inc., and she provides safety consulting for global clients. Deb Roy has more than 35 years of occupational safety and health experience and is the past corporate director of health, safety and wellness, at L.L.Bean, and she has been involved in pandemic planning at work sites at the state and federal levels for the last 12 years. Roy wrote Preparing for a Pandemic: Lessons From H1N1 and that was published in the ASSP Professional Safety Journal in 2011. And ASSP interviewed Deb Roy about the COVID-19 outbreak and posted a very good online article titled The Safety Professional's Role in Planning for a Pandemic in March 2, 2020.

Where are we going with this and why is it important? You told us is you want to hear about the issue of implementation and practical aspects. Deb has a safety background. She has worked at the executive level. She's worked at the consulting level. She is a certified occupational health nurse and will give an interesting perspective from a variety of different perspectives.





Deb, let's start with an overview of what's going on with COVID-19, the pandemic and the response?

Deb Roy

Thanks, Tim. Hello and thank you all for joining us. I want to acknowledge that this novel coronavirus, now called COVID-19, will likely be one of the most challenging risks that we as occupational safety and health professional's experience in our careers due to the level of unknowns. With that, I'd like to start with a global perspective.

As of Monday, the total number of confirmed COVID-19 cases and deaths outside of China has overtaken the total number of confirmed cases and deaths in China. There are significantly more people recovered in China than the current active cases and the new hospitals quickly built for COVID-19 treatment now have all been closed. That's really good news. The peak confirmed COVID-19 cases in China happened around February 12, 2020. So it's been about five weeks since they hit their peak.

On the other hand, in South Korea, the peak confirmed cases happened around the beginning of March. And, thankfully, South Korea is also now seeing a smaller number of new cases a little less than three weeks after the peak. That means they seem to be on the far side of the epidemiologic curve.

Italy, on the other hand, appears not to have yet reached the peak of confirmed cases. They still have over 3,000 new cases a day. The COVID-19 death rate in Italy is something over 6% right now. And in fact, we won't know the true mortality rate of COVID-19 until after the pandemic is over. I'm sure you've seen a wide range of numbers that have been in the media. The entire country is now in lockdown in Italy, as are other countries such as Spain, France and Ireland, and we can reasonably expect to see other countries will use similar approaches to control the transmission of COVID-19. Iran, Spain, and Germany all have more than 1,000 new confirmed cases per day. Today the confirmed cases worldwide are over 200,000.

The goal of the public health response is really to flatten the curve and you've likely all seen this concept in the media. The idea is to use proactive practices, like we do in safety, to slow the rate of COVID-19 infection so that hospitals have the room, supplies, and health care workers for the patients who need care. Many people becoming ill in a short period of time could overwhelm the health care system, and that's what's happening in Italy right now. If, on the other hand, patients arrive at the hospital at a slower rate over several weeks, the resulting flatter curve means hospitals have a greater chance keeping up with the patient needs. Therefore, you're seeing the use of containment and now mitigation strategies such as social distancing to try to flatten the curve.

So where do we stand in the U.S. right now? As of today [March 18, 2020], we have well over 6,000 total confirmed cases of COVID-19 reported and are now adding cases at over 1,000 per day, just like some of the European countries. We have over 100 confirmed total deaths reported so far. Testing is ramping up and in the next couple of weeks are testing capacity should significantly improve. We should expect the number of COVID-19 cases reported in the U.S. to increase





rapidly as more testing becomes available and this is because there was likely community transmission occurring prior to the testing availability.

Confirmed cases have now been identified in all 50 states and some US territories. The key to remember is that we're not yet at the peak of the epidemiologic curve and we don't know when that peak will occur. If you use the China and South Korea data as an example, after we reach the peak in confirmed cases, it will be another three to five weeks before the U.S. case counts are on the far side of the epidemiologic curve.

This is your challenge. Data on COVID-19 is changing every day. We will all learn more as research is available, but it will take time. Our event today is really intended to address COVID-19 from the perspective of the OSH professional and how the issue can impact the practice of safety. Let me encourage all of you on the call to submit your questions for review and discussion. I'll do my best to answer all of them. Let me give this back to Tim to discuss the technical issues because it looks like we already have questions coming in.

Tim Fisher

Going back to our agenda, a reminder that this will be an informal question-and-answer session. At the end of the presentation, we will try to answer any outstanding questions and post those with a [recording](#).

Let's start with this question: From a protocol perspective, what's the proper term to use? Is it coronavirus or COVID-19? I've used them interchangeably and have heard that coronavirus or corona is actually not the correct term.

Deb Roy

Coronaviruses are a group of viruses, and that includes this particular novel coronavirus. When we have something that is new, that hasn't been exposed in the human population before, we call it whatever the category is and it is novel whatever that category is. So, it's novel influenza, or novel coronavirus in this case. Coronaviruses include things like the common cold, but they also include things like SARS and MERS that have happened in the past in addition to the current which is called COVID-19.

Tim Fisher

From your perspective as an occupational safety and health professional and your background in health, how serious or severe do you see COVID-19 or the coronavirus? In other words, how serious of a threat is this for the occupational safety and health professional? And what are your thoughts on this being real or is it perhaps an over-exaggeration?

Deb Roy

I think the challenge with COVID-19 is that it is spread so efficiently. And what that means is that more than 80% of the people that actually do have this disease have mild symptoms. That means they may still be out in the community and potentially exposing other people. What happened with SARS and with MERS in the past is that those diseases were much more deadly. And in fact, MERS actually had about a 40% death rate and SARS had about a 10% death rate. Again, as I said at the beginning, we don't know what the actual mortality rates are for pandemics until afterwards. Until the calculations are done.





But the difference with MERS is that it was so deadly that people really didn't spread it very easily. They got sick quickly and, in fact, a large number died. In the case of SARS, it was spread more efficiently than MERS but not as efficiently as this particular disease because again people had a more severe case, typically quicker, so they weren't out and about working and out in the community. That's the real challenge with COVID-19 is that we have people that may actually be able to expose others and not realize that they're sick.

The other challenge is that because it is a novel coronavirus, meaning it's new, we haven't been exposed to it before. There is also no treatment known for it, even though over 80,000 people in China were recorded with confirmed cases. The fact is, China actually tried a lot of different treatments, but the fact is, there is no real treatment for this new disease. And the other part of that is that there's no vaccine. And although many of you may have seen on the news that there's already testing for possible vaccines, it will be 12 to 18 months before we actually see a vaccine that's available to the public.

Tim Fisher	That's a good point, Deb. You and I talked about the idea of hazard versus exposure. What are your thoughts on the issue of containment with COVID-19 versus other things that we've seen? Are we in the same ballpark or do you think it's a different game?
Deb Roy	I think it's much harder to contain, particularly once you have community transmission. What we do in public health initially is containment. Meaning that you identify the case of the individuals who have the disease and then you track their close contacts back to determine who might have been exposed and then you can quarantine or isolate those individuals. And that works pretty well. The challenge is, if people don't have very obvious symptoms, it's much harder to do that. To identify those cases. So consequently, you end up with exposures without understanding that there's a risk.
Tim Fisher	A lot of the questions that are coming in are on the issue of risk assessment and the impact that an OSH professional has and what he or she can do to prepare for COVID-19. What proactive steps can an OSH pro take in regard to addressing this issue from the risk assessment perspective? We know this issue is so much bigger than the OSH profession and ASSP. This deals with global health issues, different governments, cultures, etc. Is there anything that ASSP or the OSH professional can really do to address this? Deb, I've got to admit. This is something that I myself have continued to grapple with. What's your thinking on this? What can we really do?
Deb Roy	<p>I think there's a few things we can do. First of all, with our ability to do risk assessment, we can assess what the risks are to our populations and provide that guidance to our employers. I think that's the first thing. We can help leadership with those issues. And secondly, we can help with what social distancing strategies may be able to be used.</p> <p>So, for example, if you have telework capabilities in your operation, you can actually develop a checklist for teleworking for working safely at home. The federal</p>





government, telework.gov, actually has a great checklist that you can use. And that actually is in our references that we'll provide for a link.

The other thing to keep in mind from a risk communication standpoint is oftentimes leadership doesn't understand what you have to do to get across to employees what the level of risk is. And I think OSH professionals have that capability of understanding that broader risk communication strategy and how to get that across. That means really being focused on scientific, factual information and providing it in a lot of different ways so that people can digest it as is appropriate for themselves.

I think that's probably one of the biggest things we can do is to provide that scientific information and also approach to leadership in our companies.

Tim Fisher

Excellent. When we're talking about companies, it's not just the United States. It's globally. And OSH professionals with global responsibilities are addressing COVID-19 in other countries or areas. What are your thoughts from the aspect of global occupational safety and health coordination or implementation? And an OSH pro in the United States, can they take active steps if they have facilities and operations in other countries?

Deb Roy

Well, I think all of us who are global OSH professionals have already been dealing with this issue for quite a while because right at the beginning when companies were starting to look at, do we limit international travel? OSH professionals in the U.S. were involved in that process often and had to make recommendations to leadership about what to do and where to restrict travel based on where there were hot spots in the world. I think that started pretty early on.

And yes, I think you can actually operate from the U.S. and help an organization in different parts of the world. And I'll give you a couple of examples. In my role at L.L.Bean, I was involved not only in the H1N1 pandemic response in 2009, but also when the earthquake, tsunami and, subsequently, the Fukushima disaster happened. And I actually worked with leadership in our Japan operations during that whole incident.

For example, one of our stores was actually at the epicenter of the earthquake, and we had a call center in Tokyo and a variety of stores throughout the country. And I was able to develop communications for our employees in the U.S., have them translated into Japanese, and then those pieces of information were sent to our employees in Japan to deal with real issues that they were facing at that time.

And I think that's an example of something that OSH professionals in the U.S. with global responsibilities can be doing right now. And also, as I said earlier, providing assistance with risk communication. How do you address those issues and then work with the country based on the cultural issues to get that communication across?

Tim Fisher

That's excellent. It's really important for the OSH pro in other countries to know about the rules and protocols that they're dealing with regardless of what's going on with COVID-19. So if you're dealing with other countries, shoot me an e-mail and I can probably direct you to some resources that might be able to help you.





Let me share a couple of the questions we've received: "We have a number of warehousing facilities moving items such as cleaning and hygiene products. These materials are being used to address the coronavirus and we cannot cease operations. I know it is not a perfect solution, but what are your thoughts at providing our workers in the warehouse with N95 respirators or masks and requiring that they wear them? I know it is not a perfect control, but what are your thoughts on an approach like this for the situation?"

And another question: "What are your thoughts on call centers? For my review, it looks like call centers potentially might meet a low exposure type based on reviewing guidelines for COVID-19. Our call center process requires employers - or employees, I should say - to work in the office. So remote work isn't an option that we can use as a protective measure. We've been brainstorming some strategies but wonder if you have any ideas or known strategies, besides good personal hygiene practices and cleaning, that can help us in protecting our employees?"

Do you see personal protective equipment as a viable option to protect workforces? We have seen a lot of statements online that supplying workers with N95 respirator masks. In its document, OSHA, for example, talks about high-efficiency air filters and ventilation practices. But with all that, what are your thoughts on that kind of approach and those two questions?

Deb Roy

First, remember that this is a droplet disease. So, as the person that asked the question talked about, they are already doing the cleaning. Cleaning high-touch surfaces is really important.

But with a droplet disease, you really need to think about what the risks are for this kind of operation. In the case of both warehouses and call centers and more traditional industry, think about what the risk is. If someone is coughing and they are ill, generally you'll see in the literature anything from 6 to 10 feet max that a droplet can move when somebody coughs. For the most part, we think 6 feet is about typical. And in that case, the droplets are large enough that they drop onto surfaces. The key here is the hygiene and the cleaning of surfaces will address that particular issue, and then the social distancing will address the rest of that.

The idea of using masks in a warehouse where it's a large, cavernous space doesn't seem appropriate from the level of risk. You want to think, remember under the hierarchy of controls, to start at the top as opposed to the bottom. And it's very easy in an uncertain situation like we're in to just go to protecting the worker at the individual level, but that doesn't necessarily solve the problem, nor is it the right approach given the fact that we really need to reserve N95 masks for health care workers right now. Because we are dealing with sporadic shortages and given the fact that this is a global pandemic, the supplies are getting depleted in various places over time and there will be some ramp-up time before we have replenished supplies.

I think it's really important to think about, how do we appropriately protect those people? And not necessarily with PPE. Also, keep in mind that in a warehouse





often times people are wearing gloves just for other reasons. Because you're handling cardboard and so forth. So as long as people are using good hygiene and they're working in areas where they have at least six feet distance between people there's not a lot of risk.

In the call center situation, the key there is the same. You want to space people out. You want to make sure workstations are clean. You want to stagger people coming into shifts so that you don't have, number one, a lot of people there at the same time, or going to breaks at the same time. Those kinds of things are really the best opportunities. And again, both of those scenarios I think are low risk.

Tim Fisher

Excellent. Deb you mentioned surfaces, and we have received several questions on the issue of latency of this virus and distribution. What about the impact of the virus on business operations, such as material handling or transportation? And by this, for example, can the COVID-19 virus survive on a pallet or a box? Say I'm working in a facility in another country and I ship it to the United States. What is the latency of the virus? What's its viability? How does this impact distribution?

Deb Roy

I've really paid attention to this one. There actually were some questions on the WISE [ASSP's Women in Safety Excellence Common Interest Group] Facebook page in regard to this issue, and I've been trying to follow the research on this. We're early in the process with a new virus. There is old data on coronaviruses in general, but each coronavirus seems to act differently.

NIH [National Institutes of Health] just came out with a pre-publication study that was just posted online about a week ago and in that study, they actually looked at different surfaces. So, for example, plastic or stainless-steel surfaces, the virus seems to last about two to three days max. And what's interesting with that is what they're not sure of is that the virus is actually viable at that point. So, although somebody might cough and the big droplets fall on a surface, they're not really sure that that virus, if you then touched it with your hand and then touched your eyes, nose or mouth actually would cause the disease. So more to come on that. That's something that needs to be further studied.

Right now, we're talking about a two- to three-day window for the viability. But I want to be careful. If you read the fine print in the study, they talk about the fact that they did this at a standard temperature and humidity. They don't know what happens if you've got higher or lower temperatures or dryer conditions. They do feel that the virus will desiccate fairly quickly in drier conditions. And I'm thinking about, up here in Maine in a warehouse, if you have a cool warehouse and it's very dry at this time of the year, low humidity, the virus may not live very long in that situation. So that's those kinds of surfaces.

The other more important one from the standpoint of shipping is corrugated cardboard. So, the testing done on cardboard surfaces is that it only lasts about 24 hours. And the desiccation issue is an issue there, too, in terms of low humidity. Although the product may actually be on the surface of the cardboard, it may not be able to transmit the disease at that point. And if you think about how long it takes for a package to get to someone through the mail generally it's more than 24 hours. And if you're thinking about boxes that are coming over traditional shipping





	<p>systems, it's many days or weeks. So, the possibility of actually contracting the disease that way is pretty low.</p>
Tim Fisher	<p>Deb is talking about studies and materials, but I note that OSHA has guidance out that is getting some significant distribution. What are your thoughts on this information from the implementation perspective?</p>
Deb Roy	<p>The OSHA document is really brand new, and I think they did a phenomenal job with it. What I like in the OSHA document, it goes through the different levels of risk for different kinds of operations. It allows you to categorize, just like you would normally, for different work settings and different jobs. I think that is a really useful part of the OSHA document.</p> <p>But in the OSHA document, they refer to CDC a lot. And the reason they do is because this is a virus, the best information on the technical aspects of the virus really are found in the CDC material. If you're looking for the more technical aspect of the virus and the health issues, then you'd go to CDC. If you're looking for the more practical planning and evaluation pieces, I would go to the OSHA document. And then the other one—and we have all of these, by the way, in the references. The other one is WHO, the World Health Organization. They have some phenomenal material in their documents as well, including a myth buster section, which I really liked.</p>
Tim Fisher	<p>This is a good lead-in to other questions we received about OSHA. In the OSHA document, OSHA notes that the employer should isolate and remove workers either carrying COVID-19 coronavirus or who have been exposed to it, but there are other issues involved with this. Can companies and organizations implement testing and enforcement protocols?</p>
Deb Roy	<p>In this particular case, if somebody is testing positive for COVID-19 or suspected to be exposed, they would need to be out of the workplace for the 14-day period. The idea there is really to protect the rest of the workforce by either isolation or quarantine. And then once you've done that, then you address other issues related to those individuals.</p>
Tim Fisher	<p>Now seems a good time to discuss compliance. This is not a standard compliance issue. But from the compliance perspective, if an OSHA pro is following the OSHA bloodborne pathogens standard, do you believe that they're okay? Or from a compliance perspective, what more do you think needs to be done? And that leads to another question. The OSHA document specifically discusses the General Duty Clause, and this should be a good indicator to all of us that more is expected than just simple compliance. What do you think about this, when we talk about the issue of OSHA compliance and existing materials and rules?</p>
Deb Roy	<p>The key here is that the bloodborne pathogens standards actually don't address directly COVID-19 droplets or sputum. I think you can use the bloodborne pathogens standards as a framework and I think that's the expectation that OSHA has and that's why they talk about the General Duty Clause. The idea is you use it as a framework to actually protect those individuals.</p>





For healthcare workers, for example, you would need to be sure they have the proper protection based on the type of work that they do. For the average health care worker who might be doing occupational therapy or physical therapy, for example, those individuals in working with the patient need to have appropriate protection, but the tasks they're doing likely don't produce aerosols. What that means is these large droplets that I mentioned earlier are large. Aerosols are actually very small droplets that disperse in the air. And those kinds of traditional healthcare activities with a patient don't produce that. Those individuals, for example, could be wearing a surgical mask that actually protects from the large droplets in case the person coughs, but they're not typically exposed then to aerosols.

On the other hand, if somebody is intubating a patient, that's an aerosolizing procedure. And in that particular case, they need to use tight-fitting face masks and the remainder of the clothing, the PPE, in order to protect themselves from that aerosolized product. So that's the difference as I see it from a bloodborne pathogens standpoint.

Tim Fisher	You make a very important point—it is not just a question of a mask. It's gloves and the whole thing and the assessment and the hierarchy of control.
Deb Roy	Again, just like we would normally do when we're doing a PPE hazard assessment, you really need to look at, what is the risk to the individual based on the work? And depending on the work, then you apply the appropriate protection. So, if, in fact, the individual is wearing a mask in this particular case with a virus you obviously need to wear other protection. Gloves. Potentially a face shield, depending on which procedure you're doing, or at least safety glasses, and you probably have a gown. And all of that needs to be managed appropriately as well, so that there's not actually a cross-contamination in doffing that equipment.
Tim Fisher	OSHA posted guidance about COVID-19 and recordkeeping, then subsequently revised that guidance. What are your thoughts on the overall compliance perspective or your views or opinion on the whole thought of recordkeeping and COVID-19?
Deb Roy	<p>I was watching this with OSHA because I was fascinated to see that they did change their position, and I expected it because COVID-19 is very different than colds and flus, so there was a lot of confusion related to that.</p> <p>From the beginning, I saw this just like when we have dealt with TB outbreaks. So, for example, any time you have an infectious disease outbreak in a workplace, that is a recordable case. They do specify that colds and flues are different. But the fact is, that is not the case here.</p> <p>In the new guidance, OSHA does say - and again, this is using the exact same process that you use normally to determine a recordable case - you start with, is the case a confirmed case of COVID-19? And in that case, the employee then would identify as a case at that point and they would have confirmed laboratory analysis.</p>





So that would be the first question, are they a true case?

The second is, is the case work-related? And that's the usual definition of whether or not the case is work-related. For example, in healthcare, it might be a little more straightforward. You've got a positive patient, and you know who actually took care of that patient. You can then test those individuals, and you know who's positive.

In the case of another type of workplace, it might take a little longer before you know that you've got a confirmed case in the workplace. But once you have a confirmed case in the workplace, you have to look at, did they have close contact with people in that workplace?

All the public health departments have a definition of what's a close contact when they're doing contact tracing. Now, there is some variability because public health is state by state in the U.S. What I've seen, on average, is a 15-minute close contact exposure. Close contact meaning within six feet of that individual. And when they have individuals that meet that definition of close contact and they test positive it's assumed that that case is related to the other case. So that's what you would look at from a work-relatedness standpoint.

And again, you may need to record it and then come back and address it later once you have more information but understand that's generally how you determine if it's work-related.

Then thirdly, if the first two are positive you consider whether the case involves one or more of the general recording criteria. And the general recording criteria are the same as they always are. Is it medical treatment beyond first aid, is it days away from work, etc.?

Let's take the case of somebody who has mild symptoms, and they're out of the workplace for two weeks because they're positive for COVID-19 and they're caring for themselves at home. In that case, they wouldn't meet the medical treatment, but they would meet the days away from work. In that case, as long as one and two are positive and three is positive, then you have a case that's recordable.

If you have somebody that has a more serious case of COVID-19 and they're hospitalized, you automatically now have met the medical treatment and, obviously, you're also going to meet the days away from work. So that case would also be recordable in that case.

Tim Fisher

Here's our next question: What about workers coming back to a facility or location after the 14 days or perhaps they've been in an area that's had a high level of exposure. Should there still be isolation of this worker, should it be remote working, or what would be your way to try and address this kind of issue?

So Deb, are we basically still talking social distancing? Are there other ways we can proactively manage this or approach this?

Deb Roy

Again, there's been some variability on this, but for the most part, when somebody recovers, they generally will be retested twice. And as long as they have a





negative test twice, they're considered recovered and they're safe to go back in the workplace.

Now, again, it's a new virus, so we don't have all the answers at this point. That appears to be the safe situation. That that person would then have antibodies against this disease in the future. You may have heard about some cases out of China where people were released to go home and then they ended up being positive again. There's a lot of evaluation right now about whether people can be re-infected. The theory at this point is that we think that because of space in the hospitals that people were actually released before they actually were completely recovered, and that it's not that they're re-infected but that they haven't yet recovered, and later they test negative again and they do recover. So again, it's a little bit of a moving target but that's being continually evaluated as we go.

Tim Fisher

This one ties back into the comments about warehouses and call centers. What steps can the OSH professional take in facilities with large access areas such as a large-scale company cafeteria? Do you have any insights on large eating or congregation areas in companies or organizations during the duration of this health exposure? I know that we've talked about schedules and different things, but what's your thinking on this?

Deb Roy

I'll go back to hygiene's important. People still need to wash their hands. Not touch their face. Cleaning of high-touch surfaces is critical. All of that is the baseline.

Then in a large cafeteria, as you suggested, there are some things that you can do similar to what we're doing in the community. I'm here in Maine, and we only had our first case last Thursday, and all of the bars and restaurants are now closed. They're allowed to do takeout or curbside pickup.

You can use that same concept in a worksite cafeteria, where you can stagger the shifts of people coming into the cafeteria so that you don't break down that social distancing, but you can also prepackage the food. So instead of having live, hot food stations where people are going to congregate, you can prepackage food. Allow so many people in at a time so that they can distance themselves and then they can purchase their food and then move into the larger space in order to have their meal. So that's one way to address that.

You can also further stagger lunch breaks or break times. And also keep in mind that shifts are a critical piece as well. If you separate the shifts more so that there's time in between that allows for cleaning in between one shift and the next. It also means that people are not comingling when they're coming into the workplace or going out of the workplace. All of that can be done to try to allow for social distancing in a safe way so that people can still do jobs that are highly critical during a pandemic.

Tim Fisher

What about workers in facilities who already have existing health issues that the OSH professional may or may not be aware of? Such as a worker who is suffering from respiratory and heart disease. But if the OSH professional isn't aware of the situation with the employee in the first place, what can be done? Is there anything proactively that they can do to address this?





Deb Roy	<p>This is part of the communication strategy. It's really going out to the workforce and letting people know that if indeed they have certain diseases, they should self-select through the regular process that you have for ADA accommodation. In this example, cardiovascular disease, a variety of respiratory diseases, like emphysema, COPD, asthma, anybody that's immunocompromised, including diabetes, all of those people would be at higher risk.</p> <p>The idea is to have the OSH professionals remind them that there is an ADA process and to use that process to self-identify. From that, the opportunity is if indeed that person can telework, they should be one of the first people offered that as an ADA accommodation. If they are not somebody who can telework based on their job, then you have an opportunity at that point to use whatever benefits might be available. There may be disability benefits that are available, or there might be Family and Medical Leave Act. In the U.S., that's how we would approach it. In other countries with national medicine, there are often other systems that are available to have those individuals safely protected from the workplace.</p>
Tim Fisher	<p>Next how about this question: I see you've [ASSP] been talking a lot. What is ASSP proactively doing to address its own events, such as the upcoming PDC? Are we walking the walk and talking the talk?</p>
Deb Roy	<p>I appreciate that question as a board member. Obviously, we've spent a lot of time talking about how we're going to address these issues at the board level and with the senior staff. As of today, we are still planning to present Safety 2020 June 23 to 25 in Orlando, FL. And we do know that many of our members have travel and conference registration restrictions at this time and we're extending our early registration deadline through Monday, April 27 in order to accommodate that.</p> <p>I also want to just mention we are closely monitoring the latest guidance from CDC and the World Health Organization and we'll continue to evaluate this depending on the information that we receive.</p> <p>I will tell you that all of the meetings that were scheduled, we had regional operating committee meetings scheduled through the end of April, all of those are now virtual. And all live training that was scheduled between now and the end of April has been postponed to a later date.</p> <p>And I'm happy to say that the ASSP staff, with a lot of hard work by the technology group in the office in Park Ridge, has moved our 85 employees to a complete virtual operation. So, everybody in the office has the capability to work from home and are doing so at this time. I do feel that we are addressing that issue.</p>
Tim Fisher	<p>Let's look now at the three slides of references. The first slide lists resources from ASSP, Centers for Disease Control, OSHA and the World Health Organization.</p>
Deb Roy	<p>We've mentioned the CDC. There is a general coronavirus page and that is listed here. There is a myriad of pieces of information there, including focused on workplace, on that website.</p>





I'll go back up to the ASSP website. There is actually a coronavirus page. And if you go on the homepage, it's right at the top. You'll see that link and you can see the remaining materials that we have on the ASSP website.

The OSHA document that I mentioned, which is the brand-new Guidance on Preparing Workplaces for COVID-19, the link is here, as well as the general index for the World Health Organization COVID-19 page.

On the next slide, this first reference is actually the one I mentioned on surfaces. This is the NIH study. That is a pre-publication study. The next is the CDC Implementation of Mitigation Strategies. This is a great document to use if you want to further flesh out your pandemic plan with detailed stages. This has really good information.

The Johns Hopkins Global Cases tracker is my favorite case tracker. There are a whole variety of them out there. I will caution you that they're all a little bit different in terms of the numbers. For those of us that are geeky about it, realize they won't all be the same. But if you're using the same tracker, you'll see change over time. This just happens to be the one I've been using.

You'll see the OSHA recordkeeping information. The link here is to the ASSP information that references the details of the OSHA recordkeeping standard and that change that I mentioned today.

On the third page, there's the telework safety checklist that I mentioned. It's actually for federal government employees, so it's readily available. It's a great checklist that just looks at all of the safety, including ergonomic issues, to address when people are working from home.

Next is the WHO document. And again, this is new. This just came out this week on March 16. And again, like the CDC one, this is a really nice document that shows you all sorts of different response actions. You can use this to flesh out your own pandemic plan for your workplace. It's a great reference.

And then finally the WHO risk communication document, which I really like. It goes through the process of how to do risk communication specific to this topic.

Tim Fisher

Let's talk about the online ASSP Community. Our practice specialties, common interest groups and some other groups are sharing info to deal with COVID-19. You just need to log in to community.assp.org [using your ASSP account information, then look for the COVID-19 tab].

Here is my contact information for additional questions: tfisher@assp.org.

Deb, final comments for those on the call today?

Deb Roy

Thank you, Tim.





AMERICAN SOCIETY OF
SAFETY PROFESSIONALS

I want to thank all of you for participating today. I know that all of you are stretched right now with everything you're dealing with in your workplace, so I do appreciate you being on the call, and hopefully, you'll find the Q&A helpful.

And as Tim said, if you have further questions, please send them to him [at tfisher@assp.org].

