Speaker 1 (00:00):

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Adam Roseman (00:21):

Welcome back everyone to the workplace safety review podcast. I'm Adam Roseman and a co-host of the podcast. I'm a shareholder in Greenberg Traurig's labor and employment practice group, and a member of the law firm's OSHA practice group. I'm usually joined by my co-host Michael Taylor who's the head of our OSHA practice group. But, as they say in the podcasting business, Mike is out on assignment today. But, today we are fortunate to have a very special guest. The director of NIOSH, John Howard. John Howard is the director of NIOSH and the administrator of the World Trade Center Health Program in the US Department of Health and Human Services. Dr. Howard was first appointed NIOSH director in 2002 during the George W. Bush administration and served in that position until 2008. In 2009, Dr. Howard worked as a consultant with the US Afghanistan health initiative. In September of that year, Dr. Howard was again appointed NIOSH director.

Adam Roseman (01:36):

He was reappointed for a third six year term in 2015 and a fourth term just last year in 2021. Prior to his appointments as NIOSH director and WTC health program administrator, Dr. Howard served as chief of the Division of Occupational Safety and Health in the state of California's Labor and Workforce Development Agency from 1991 to 2002. Dr. Howard earned a Doctor of Medicine from Loyola University of Chicago, a master's of public health from the Harvard University School of Public Health, a doctor of law from the University of California at Los Angeles, and a master of law in administrative law and economic regulation and a master of business administration in healthcare management.

Adam Roseman (02:19):

And both of those degrees are from George Washington University in Washington, DC. Dr. Howard is board certified in the internal medicine and occupational medicine, and he is admitted to the practice of medicine and law in the State of California and the District of Columbia. He has written numerous articles on occupational health policy and law, and most importantly, he has yet another returning guest to the Workplace Safety and Health Review podcast. Dr. Howard, welcome back.

John Howard (02:47):

Thank you very much, Adam. Pleasure to be here.

Adam Roseman (02:50):

Before we jump right into it, can you remind our listeners, very briefly, what NIOSH is and what your role is as the director?

John Howard (03:00):

NIOSH is a component of the Centers for Disease Control and Prevention in the Department of Health and Human Services. And our role within CDC is in occupational safety and health research and practice. We are in the same statute as OSHA, the Occupational Safety and Health Administration. The 1970 Occupational Safety and Health Act created NIOSH as a research organization for safety and health. Our

sister agencies are both CDC, in which we're a component, as well as OSHA and MSHA, the Mind Safety and Health Administration within the Department of Labor.

Adam Roseman (03:46):

Yeah, that's very helpful for our listeners. And certainly, it has been over two years that we as a country have been dealing with COVID-19. Sitting here more than two years later, is there anything you wish NIOSH did differently to assist employers navigate this pandemic or anything you wish you did differently when working with your sister agencies? I'm just curious, with a little bit of hindsight, where you think things could have improved.

John Howard (04:16):

I think one of the limitations that we have all had is an understanding the dynamics of the pandemic. When I talked to folks from the media and stuff, they said, "Couldn't you be more consistent in some of the advice that you gave?" For instance, at CDC, we withdrew the admonition about masking May 13th, 2021. That was premature in hindsight because within a month or two, around July 4th, we started to see the rise of a new variant Delta, which was very severe. Caused lots of hospitalizations and pneumonias, ICU admissions. And then as that came down, I think we were chastened by that because we did not make a whole lot of changes to that. We learned from our mistake. And then within a very short period of time, the end of November, came a wallop in terms of Omicron, which was less severe, but way more transmissible. We had, beginning of the first week of January, we had on average about 800,000 to a million cases per day.

John Howard (05:47):

We had never seen anything like that with Delta or the previous variants. I think we were quite circumspect after that. I think now what we're seeing is we're calling the shots as we see them in real time. We're saying, "Yes, our numbers are down. Our cases are down. Our hospitalizations are down for the first time. Our fatalities per day were less than a thousand last week. All that is good news. We think that we're in a good spot. But remember, each of us has to do a personal risk assessment in terms of whether we feel comfortable not wearing a mask indoors or in other places." I think in hindsight, we certainly would have loved to have some foresight about these events. But, the virus is smarter than us. And, remember that most of low income countries are only vaccinated to the tune of about 10 to 15%.

John Howard (06:59):

You have a lot of replication of various variants out there. And any moment another one could pop up. We're not sure about Omicron. South Africa certainly was the first to report it. But, within a day or two Netherlands had cases and then California had a case. Again, I have to explain to folks that we're not prescient at CDC. We're not sure we can say what's going to happen in April, May, and June of this year. But as you know, yesterday, FDA and CDC approved the second booster or the fourth shot, for folks 50 years of age or older, or who have some degree of immuno suppression by medication or transplant or cancer, et cetera. Each day I tell folks, be sure and listen to me today at this moment. But, don't take what I say more than two or three days from now, because it may not be true. Looking back, I'm not doing that. I'm still struggling with looking to the future and advising employers. What do we do now? And I think that's the big issue for me.

Adam Roseman (08:24):

Yeah. It seems to me then that you would tell employers, focus on the present. This virus doesn't fit neatly into our expectations or our whims. And that this is a function of be present and focus on the present and react accordingly. Am I getting that right?

John Howard (08:42):

I think you are Adam. February 25th, we changed the metrics that we used to help people understand where the pandemic was at. And states adopted that and locality schools, et cetera. We changed it from counting cases purely, or the percent positive tests. Those were the two things that we based it on since September of 2020. We changed that in February of 2021. Now what we look at, primarily, are the number of new hospital admissions because that does relate to the issue of having serious or medically significant disease. Because now, when you have a case in a country that has a lot of vaccinated people and a lot of people that have had COVID-19 and have antibodies to that, sometimes those cases now are a bit of like a cold. Maybe a little light flu. You don't even go to the emergency room.

John Howard (09:46):

To the extent that we've changed the nature of COVID-19, acute COVID-19. Counting a case really doesn't give you the right information of how bad things are. Rather, what we're doing is county hospitalizations, primarily, because that's really where we think we can distinguish the difference between a mere infection with COVID-19 and medically significant disease. And that's what we're telling employers to look at. Look at the area that your employees are coming from, which is usually a county. And what we have now are COVID-19 community levels, by county. 92% of American counties are in the low range. There's only less than 2% are in the high category and the rest are in the middle category. The risk calculation has changed. Now, what I say is that is your workplace milieu, that's your environment. But, then the next thing you have to take into consideration is the actual employee. That employee may have diabetes, hypertension, and COPD.

John Howard (10:59):

And that employee is different than a 19 year old that may have none of those conditions. They may be in the same county, coming into your workplace. Then the question, the third question is, after you figure out what is the issue with the individual and what's the issue with the virus in terms of how bad it is. And we know that the new variant be a .2 is less severe, more transmissible, but less severe. The third thing you look at is the workplace itself. Is physical residence required? Do you make employees come into the workplace? Are they physically proximate? Are they next to each other? How good is your ventilation? How long are they physically present and physically proximate? You take the consideration of the variant factors, you take the individual host factors, and you take the actual workplace factors. And that's not going to change whether it's today, six months, or a year from now because the virus is not going away and we're going to have to have a Corona normal attitude about it.

John Howard (12:05):

That's important adjustment that we're all making now. CDC is moving from this general mandates and national guidelines to more individual and workplace risk assessment. It takes a little more effort for an employer to figure out what exactly is going on in my workplace. What exactly is going on with my employees. As an example, employees now, a lot of them, a percentage of them who have had acute COVID-19, develop long COVID. Long haul or post COVID-19. Some of these folks may need reasonable accommodation for their brain fog, for their fatigue, et cetera. Employers now are not only in the business of protecting their employees from each other who may be carrying it into the workplace, the

virus, but also taking care of these folks that have had acute COVID-19, but are not fully back yet. The employment situation, I think, is getting a little more complex even.

Adam Roseman (13:12):

Yeah. I know Dr. Howard, that NIOSH is focused on studies. I always like reading studies online and it's helpful to put real data into your suppositions. Is there a NIOSH study regarding COVID that you think is particularly interesting or findings particularly interesting? Something that maybe a lot of folks don't know. Any kind of study related to the workplace, related to COVID. Do you follow?

John Howard (13:40):

Yeah. There are several classes of studies that we've done over the time of the pandemic. I think the earliest one is all of our field investigations that were done in protein processing plants, beef, pork, poultry plants, where we really learned then that the proximity issue was the mega trend. The mega risk factor in the workplace. We also learned then, early on, about ventilation, because we realized that ventilation by both air changes per minute, filtration, or disinfection, those were three important aspects that you could improve the profile of the workplace. We did a lot of publications in the MMWR, the Morbidity Mortality Weekly Report, which is CDC's official organ in the publication area. And I think those studies, early on, were extremely important. The other large number of things that we did had to do with guidance documents. In every imaginable industry, in manufacturing and agriculture, we did guidance for ventilation, we did guidance for testing, workers.

John Howard (14:58):

All of those kinds of things related to the helpfulness that we were trying to do for employers to help them through the situation. Early on, some of the earliest things had to do with symptom screening, with temperature checks, et cetera. Then we went into the testing era. Should we be testing employees? Should we be doing antigen testing? If we do, we did several papers. I authored one of them saying that if you're going to do that, you have to do serial testing. One shot won't do it. You have to do a multiple tests, et cetera. Is antigen better than PCR? PCR is lab based. Antigen takes a little shorter time. Employers were never keen on testing their employees. That was a medical thing. And, we agreed with them when it came to that. That we thought it was best to use some other types of engineering controls, administrative controls, and PPE.

John Howard (15:56):

We did research with ASTM on what they called the barrier face covering, which was a scientifically based way to evaluate whether or not the mask, the face covering that you were using, was of high quality. Our scientists worked with them to produce that standard, which came out in February of 2021. I think over the pandemic, we've done a number of different things. We did lab based studies, looking at what we call a coughing mannequin and a breathing mannequin. We put a mask on the coughing mannequin to see how much of the particles were trapped by the mask. And we put the mask on the breathing mannequin to see how well protected they were. All of those studies were published, about nine of them. I would say that over the last two years, we've been busy, both in the field and in the lab.

Adam Roseman (16:55):

Let me ask, going forward, OSHA, and we've had a lot of discussions on this podcast, and Mike and I have talked with, with folks at OSHA that they're in the process of turning the healthcare emergency

temporary standard, potentially, into a permanent standard. They're down that road right now. Is NIOSH playing any role in that? Is it helping OSHA develop that standard? And, what's your role in that, if any?

John Howard (17:19):

Sure. Our role, both statutorily and on a staff level is to assist OSHA so that they have the best science foundation for whatever they do. And certainly I think the audience is familiar with our work in silica, which goes back to the mid '70s. Finally, 49 years later, OSHA decided to do a silica standard. We were grateful that. Better late than never. We can't determine the pace of OSHA rule making. But, they rely on our research for anything that they do, especially with regard to this project that you're talking about or taking their healthcare COVID-19 ETS and turning it into a more permanent standard. We suffered with them through all of their ETSs that they did over the years. And, believe me suffering is the right word, because it was extremely difficult when they decided to do an ETS.

John Howard (18:18):

And I cautioned them that, even my slide presentations don't last for more than a day or two before they're outdated. And I didn't understand how you could actually write an ETS that would not be really trivialized by CDC science. They took on an amazing job. It didn't work out in the end for them. But, I think doing a permanent standard where you take your time and you try to figure out, the next pandemic that comes, how do we protect the healthcare workforce? Which of course in the beginning in 2020, as you know, was a significant issue. We didn't have enough personal protective equipment, et cetera. We didn't know about testing. We were way behind in testing. Now they have the opportunity to say, "What are the pivotal elements of a standard that would protect healthcare workers?"

John Howard (19:12):

Now, I've cautioned them to say, "Please just don't limit it to COVID-19." We have the bloodborne pathogen standard. I think a nice compliment to that is the aerosol pathogen standard, where you take into consideration the various pathogens that can be aerosolized that result in transmission in the healthcare workplace. And there's a class of those. We actually have a list at NIOSH because we did some research in this area vis a vis, a congressional request that we had that came out of the Ryan White Act, to actually have a list of those kinds of diseases to alert first responders, police, and fire. I'm hoping that after they have their public meetings and think about for a while, I'm hoping that they'll expand their current view of the COVID-19 permanent standard to an aerosol pathogen standard.

Adam Roseman (20:13):

Would you like to see something that looks, at least somewhat, like the aerosol standard out in your previous employer, cal OSHA?

John Howard (20:22):

Yeah.

Adam Roseman (20:23):

Okay. I just wanted to make sure. And I've read that standard. That standard obviously goes far beyond COVID. It was way before COVID, anyway. That's what you're envisioning for federal OSHA.

John Howard (20:33):

Yeah. It takes OSHA such an investment of time and resources that it would seem to me, if you're going to start on that road, be as broad as you can at the beginning. You may have to narrow it for whatever reason. But, why start out on a narrow road when we all know there are a number of aerosol transmitted pathogens that could pop up at any time in the future. I think it's important to start out broadly and then narrow as you go down the road.

Adam Roseman (21:11):

Dr. Howard, last question. We've got safety professionals that listen to this podcast. What steps should they take to prepare for the next pandemic? Or the next infectious disease? Are there any words of advice you would give them to help them prepare and get their workforce prepared?

John Howard (21:27):

I think the best thing that I would do is say, take out your COVID hierarchy of controls, your list of things that you worked on. The engineering controls, the administrative controls, the hazard elimination, your symptom screening and your temperature checks. Make a whole list of those. Keep those handy and develop an infection control plan so the minute that you hear, from CDC, that there's another thing that we're worried about. We're not exactly sure about its contour. We're not exactly sure where in the country it is. Be able to take out that infection control plan, that hierarchy of controls, and be able to say, "Here's our plan. Let's work the plan, depending on the intensity, the severity, how broadly this particular agent that we're seeing." And I bet it's going to be a virus, probably, that will pop out from some part of the world and will affect us.

John Howard (22:30):

I think if we had done that with Ebola, if that had been done when the first case hit Dallas, we would've been able to teach our healthcare workers how both to dawn personal protective equipment, as well as doff personal protective equipment, which turned out to be the way the transmission occurred in that hospital in Dallas. Again, I think having an infectious control plan built into your safety and health management plan is important, so that you're ready when the next one comes.

Adam Roseman (23:05):

Dr. Howard, thank you so much for joining us. Thank you for all the work you do at NIOSH. Thank you for helping the public and employers. And for our audience, join us next week for the next episode of the Workplace Safety Review podcast. Stay safe, everybody. I'm your host, Adam Roseman.